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NOONGAR WOMEN'S BIRTH EXPERIENCE

2014

Judith Pamela Wilson

School of Nursing and Midwifery

The University of Notre Dame Australia

This thesis is the report of a research study submitted in fulfilment of the requirements for the degree of Doctor of Philosophy

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Glossary of Terms

Indigenous: As the term ‘Indigenous Australian’ is a collective term describing both Aboriginal and Torres Strait Islander peoples, it is not used in the present study in this context, as “most Aboriginal and Torres Strait Islander peoples prefer terms that better reflect their cultural identity” (National Health and Medical Research Council [NHMRC], 2003, p. 2).

Aboriginal: When reference is made to information regarding Aboriginal people only, the term ‘Aboriginal’ is used.

Aboriginal and Torres Strait Islander peoples: The phrase Aboriginal and Torres Strait Islander peoples is used when referring to both Aboriginal people and people from the Torres Strait Islands. The word ‘peoples’ is used rather than ‘people’ in order to emphasise the many different groups of Aboriginal and Torres Strait Islander peoples.

Antenatal Care: Routine health advice, screening and surveillance of pregnant women provided by health professionals, such as midwives, general practitioner medical doctors and obstetricians.

Antenatal Education: Childbirth educational programs designed for expectant and new parents that aim to prepare for pregnancy, birth and early parenting including breastfeeding. These educational sessions are usually held at a hospital and will be offered to the woman when she attends her first antenatal care visit.

Difference Blindness: This term acknowledges and affirms the right of people to have different values, norms and aspirations. The term demonstrates the researcher is not blind to the difference. The National Health and Medical Research Council advise in their publication Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research that “those involved in research should recognise and minimise the effect of difference blindness through all stages of the research process” (National Health and Medical Research Council [NHMRC], 2003, p. 16).

ABSTRACT

This qualitative study used a descriptive interpretive approach that drew heavily on the methodological underpinnings of interpretive phenomenology in order to explore the lived experience of Noongar women in childbirth. The aim of the study was to give voice to Noongar women, who despite having poorer outcomes than the wider population, remain marginalised and mute in childbirth reform. The purpose of the study was to acknowledge as authoritative, Noongar women's wisdom and understanding of their childbirth experience.

This study was conducted at the cultural interface, by a non-Indigenous researcher who implemented a collaborative and power sharing model of enquiry. Ten Noongar women were interviewed from 2011 to 2013 from the city of Perth and two regional locations in the south-west of Western Australia. The study was grounded in the work of hermeneutical philosopher, Gadamer and was guided by van Manen and Creswell for interpretive thematic analysis. Five emergent themes revealed that women experienced increased levels of vulnerability; described family as central to birth; understood their present lives were connected to a past history that would influence future generations; were culturally challenged and experienced prejudice and racism at the time of childbirth. Each theme identified elements of tension and trauma, adding considerable negative physical and psychosocial load to the health and wellbeing of the individual woman. Moreover, participants descriptive experiences alluded to a western biomedical model of maternity care that continues to under represent the needs or wants of Aboriginal and Torres Strait Islander women. Despite the challenges experienced along the childbirth continuum, women described birth as a joyful experience. However, they did not experience woman centred care nor did they receive sufficient culturally appropriate options from which to make choices in the care actually received.

Insights gained from this study will provide a much deeper understanding of the birth experience for Noongar women so that clinicians, educators and policy makers can plan and deliver more culturally congruent and effective maternity care. The recommendations within this study, if adopted, have the potential to echo the voice of Noongar women throughout the maternity care debate in Western Australia, so

that culturally congruent and sensitive woman centred care can be developed, leading to appropriately culturally aligned childbirth choices.

DECLARATION

I declare that this thesis is my own account of my research and contains as its main content work which has not previously been submitted for the award of degree or diploma in any university or other institution. To the best of my knowledge, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

Signed

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DEDICATION

This study is dedicated to Noongar childbearing women and their babies past, present and future.

CHAPTER 1: INTRODUCTION

Phenomenon of interest

This chapter presents an overview of the research, including the aim, purpose and justification for studying the phenomenon. Contextualisation of the study and justification for potential of the methodological approach are then demonstrated. Further to this, de-colonising strategies are explicated and background for the study is provided. Finally the thesis structure is presented.

This thesis describes a study that was conducted to explore the lived experience of childbearing Noongar women in order to give voice to, and acknowledge as authoritative, their wisdom and understanding of this phenomenon. The ultimate aim of the study was to come to understand what it means for a Noongar woman to experience childbirth. In the context of this study the term ‘childbirth experience’ encapsulates the lived experience of pregnancy, birthing and the early postnatal period along a childbirth continuum. All of the women who were participants of this study are Noongar women and all birthed in Western Australia on Noongar country; some in country and regional hospitals and others in hospitals within the capital city of Western Australia and its metropolitan area. Participants in the study reflected upon and shared stories and experiences of the birth of their most recent child, which occurred within two years prior to interview.

An interpretive phenomenological perspective was used in this study that is commonly referred to as hermeneutics and has, at its core, an ontological rather than an epistemological philosophical stance. That is, in analysis, or hermeneutic phenomenological reflection of data through a process of reduction and interpretation, the researcher was guided, for the most part by the writings of Gadamer (1975-2001), Van Manen (1990) and Creswell (2013). In this way the meaning of the phenomenon as described by the participants, was methodically and systematically explicated. The essential notion of the experience was derived from themes which emerged from data enabling a thick and rich account of the essence of the experience.

Aim of the Study

Australian Aboriginal and Torres Strait Islander peoples have significantly poorer maternal and neonatal outcomes than the wider population (Hancock, 2007; Kildea, 2006; Sayers & Powers, 1997). Childbirth, described as a key cultural marker (de Souza & Rymarz, 2007), could be considered an event that is only fully understood from within the culture. Not only is there a paucity of available published research studies exploring birth for Aboriginal and Torres Strait Islander women, they remain mute and marginalised in the childbirth debate. This consideration provided impetus for the researcher to ask a group of Aboriginal women in Western Australia to share their experience of how it is *to be* a Noongar woman who has lived the childbirth experience. The aim of this study, therefore, was to give voice to a group of childbearing Noongar women who had given birth within the previous two years, in order to explore and gain an understanding through their eyes, of the subjective experience of this phenomenon.

Purpose and Justification of Study

In recent decades, an abundance of qualitative research has given voice to childbearing women throughout the western world, resulting in an understanding of what they want and how they feel about birth. Research of this nature has contributed to improved outcomes and greater satisfaction in the birth experience (Green & Baston, 2003; Harrison, Benzies, Rempel, & Kimak, 2003; Hollins Martin, 2008). Paradoxically, this is not the case for Australian Aboriginal and Torres Strait Islander women who are underrepresented in the literature. As a consequence, in Australia, advances in maternity care such as woman-centred models of childbirth are based solely on the experiences and preferences of the dominant non-Indigenous society. In short, the voices of childbearing Aboriginal and Torres Strait Islander women are not heard. It is posited therefore, and reflected in the present study, that in order to improve maternity healthcare provision for Aboriginal and Torres Strait Islander women in Australia, their voice must be heard.

The purpose of the study was to understand and value Noongar women's experience and wisdom around childbirth as authoritative knowledge on their birth. This respect for Noongar women's wisdom, acknowledges the individual and

collective contribution of Noongar women in the research process and outcomes (National Health and Medical Research Council, 2003). The privilege of access to insights of this experience has the potential to inform maternity care clinicians, educators and policy makers on what is really important to Noongar women across the childbirth continuum. Once fully understood and synthesised, this knowledge would form an evidence base for translation into professional practice. Any insights from the study that promote better understanding of birth will enable more accurate predictions about future challenges, or lead to interventions that will enhance the quality of life of Noongar women and their families.

Researcher Orienting to the Phenomenon

The commencement of any phenomenological research according to van Manen (1990) is identification of a topic of deep interest. The researcher of the present research is oriented to the lifeworld as an Australian midwife, nurse and educator. It is because of a profound interest in midwifery in the Australian context that the researcher was able to orient herself in the phenomenological hermeneutic mode to the question of how it is to be a Noongar woman experiencing childbirth. Further exploration of the researchers positioning in the study and phenomenological reduction are addressed in later chapters of the thesis.

Context of the Study

It is acknowledged that a vast number of uniquely different linguistically, culturally and spiritually diverse Aboriginal and Torres Strait Islander groups exist in Australia. Given this heterogeneity, the futility of general exploration becomes clear and moreover, the value of confining the focus of research to one specific cultural group becomes obvious.

More than this, the cultural distinctiveness of Aboriginal and Torres Strait Islander peoples is highly valued by them (National Health and Medical Research Council, 2003). Given this diversity, it is the responsibility of researchers to recognise and minimise 'difference blindness' in the research process. To be 'blind' to the uniqueness or 'difference' of individual Aboriginal groups within Western Australia, for instance, is to ignore the cultural features particular to an Aboriginal group which

comprise an individual Aboriginal person's identity. To this end, exploration of the lived experience of childbirth in the present study was confined to one Aboriginal group of women in Western Australia.

The Noongar people are the original occupants of the land on which Perth the capital city of Western Australia sits. They are also the original owners of land to the north, southwest and east of Perth, which comprises many 194,000 square kilometres (Kormendy, 2003). Within Noongar country, the majority of the Aboriginal population live in metropolitan Perth and regional cities, however, their land also covers rural areas (MacRae et al., 2013). Noongar people are a heterogenic minority group who, because of their extremely low population within the urban setting, have often been described as hard to locate or find (Dudgeon & Ugle, 2010). Refer to Figure 1 Map of Noongar Lands below.

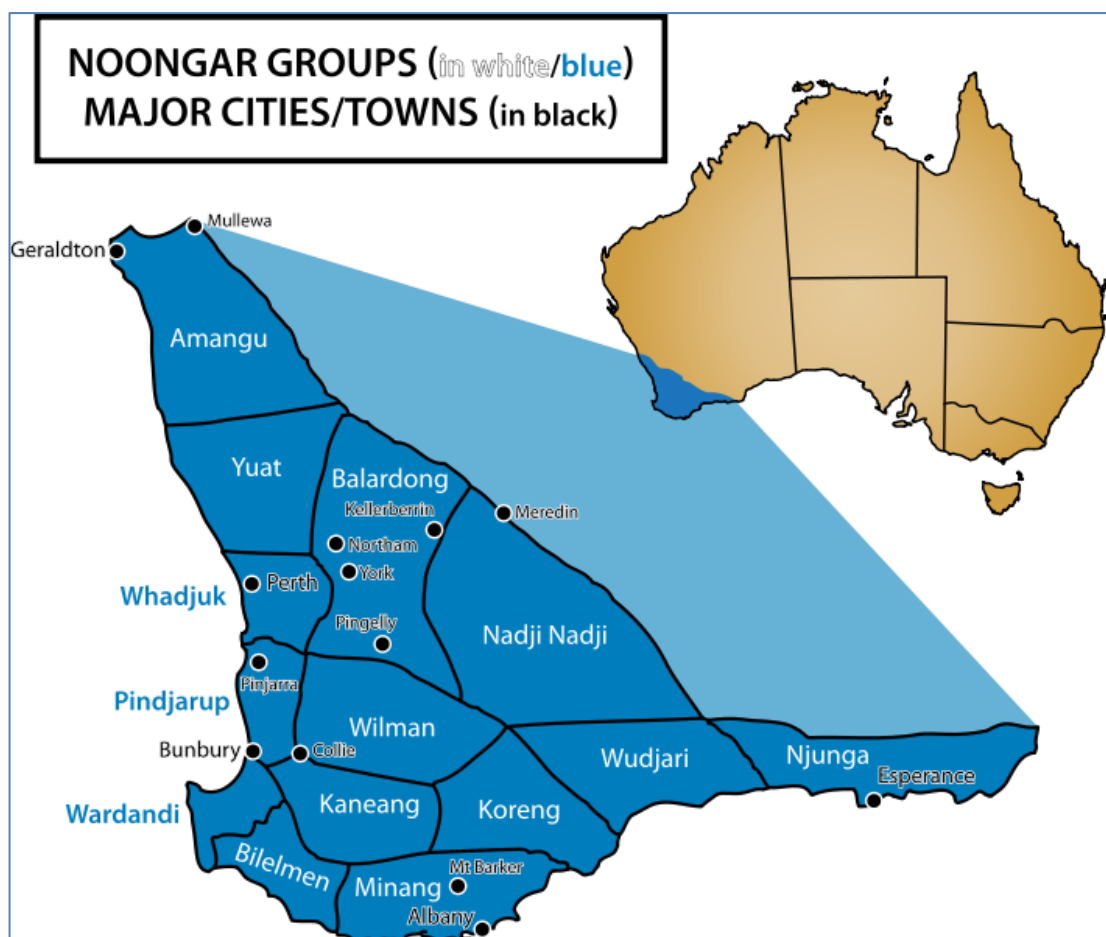


Figure 1 Map of Noongar Lands

Reference: South West Aboriginal Land and Sea Council <http://www.noongar.org.au>

As the researcher resides in the city of Perth, it was decided that focusing the study on Noongar women's birth experience would enable greater access to participants and research outputs could more readily be disseminated. Only Noongar women who birthed on Noongar land were included in the study. That is, no Noongar woman who birthed in another state of Australia or outside of the vast area of Noongar land within the south west of Western Australia was included in the study. This wide geographical expanse of Noongar lands comprises some 194,000 square kilometres (Kormendy, 2003). Given the density of the Noongar population within the city of Perth and the south western cities of Bunbury and nearby Busselton, the decision was taken to confine recruitment of participants to these areas. These cities were also more practical to access, given the relative close proximity and the need for the researcher to return many times to country areas.

Justification of Potential of Methodological Approach

Interpretive phenomenology, or hermeneutics, derives from an ontological perspective in that it is concerned with the study of *being*. This philosophical stance is considered most suitable to understanding the lived experience of Noongar women, because only Noongar women themselves can understand their own experience. As the researcher is non-Indigenous every effort to ensure cultural propriety was considered and applied within this study. Further, the non-Indigenous researcher could not claim to understand or describe the Noongar woman's birth experience without the guidance and support of Noongar women. De-colonising strategies and particular power sharing and inclusive approaches implemented within this research are discussed in the section below and throughout the thesis. As previously described, Aboriginal and Torres Strait Islander women have been marginalised and muted in the childbirth debate. It was therefore considered imperative that the present research gave voice to Noongar women about their birth experience.

Gadamer's concept of the hermeneutic circle provided a methodological framework for this interpretive phenomenological study (Gadamer, 2001; Schneider & Whitehead, 2013; Schneider, Whitehead, Elliott, Lobiondo-Wood, & Haber, 2007). The hermeneutic circle is an interplay between gaining understanding in the form of an ontological perspective provided by the participants and analysing data in

a manner described by van Manen (1990 p.167) as “working the text”. In order to deepen understanding and contextualisation of the phenomenon, in addition to textual analysis of interviews, the researcher included observations, thoughts, ideas and self reflective notes in the form of semi-structured memos. The process of data analysis was initially based on Creswell’s (2013) spiral analysis method for qualitative research; subsequently however, data was interrogated at a deeper level based on the classic writings of van Manen (1990).

Decolonising Strategies

In order to conduct this research in a culturally appropriate and sensitive manner the non-Indigenous researcher was vigilant to identify personal colonising behaviours. This included reflection on *whiteness theory* and the concept of *othering and de-othering* (Taylor & Guerin, 2010). Born and raised in Australia, the researcher who is of Caucasian decent, made a conscious decision to acknowledge and reflect on post-colonial attitudes, advantages and behaviours in an ongoing manner throughout the study and beyond. De-colonising attitudes and behaviours were enhanced by the adoption of several strategies that were implemented within the study. These assured cultural appropriateness, rigour and compliance with the guidelines for ethical conduct in Aboriginal and Torres Strait Islander health research (National Health and Medical Research Council [NHMRC], 2003).

An Aboriginal Women’s Reference Group was initiated to advise and guide the researcher throughout the study. Importantly, this group was convened in the conceptual phase of the study and has functioned in active partnership with the researcher and supervisors throughout the duration of the study. Regular meetings of the group provided a space where the researcher could receive advice on matters such as interview technique, cultural challenges and primary theme formation. Members of the group participated in analysis of data, collectively and on an individual basis, advising on interpretation of cultural mores embedded within data. This collaborative power sharing model approach to research ensured the cultural integrity of the study was optimally preserved.

Valuable guidance from the Aboriginal Women’s Reference Group enabled the researcher to demonstrate and reinforce dignity and respect to Noongar women

who participated in the study, thereby encouraging mutual trust. The input of the reference group demonstrates how the researcher attempted to eliminate ‘difference blindness’ as it sought to ensure the distinctiveness of Noongar culture was appreciated and respected (National Health and Medical Research Council, 2003). Such strategies evidence the researcher’s accountability to Noongar individuals, families and communities with a particular focus on beneficence within the research process.

Research Relevance

The study population was confined to Noongar women and, in keeping with qualitative methodology, there was no intent to generalize results as applicable to other Aboriginal groups. Instead, particular insights which resulted from the findings could possibly demonstrate transferability to other groups or populations. Study findings are said to be transferable if they are assessed to fit well to contexts outside the immediate research parameters (Schneider & Whitehead, 2013). It is in the presentation of context and rich description that the reader is then able to determine if the findings have applicability to other settings.

Each woman interviewed shared her unique story of childbirth and as such, these stories are not representative of all childbearing Noongar women. A self-selection bias is acknowledged due to purposive sampling, in that selected participants were able to articulate more compellingly than others. Paradoxically, these limitations were necessary to yield the depth and richness of data necessary for the study, adding to its confirmability and trustworthiness.

This study is seen to be important as the conclusions it yields promote a better understanding of birth, which in itself may enable more accurate predictions about future events, or lead to interventions that could enhance the quality of life of Noongar women.

As this study is primarily for the benefit of Aboriginal people, it will be reported and disseminated in a manner that is culturally appropriate and accessible to Aboriginal people. The initial sharing of knowledge occurred by when transcriptions of individual participant interviews were offered to participants during the data gathering phase of the research study. These were enthusiastically received by the

women. A subsequent knowledge translation plan for outcomes of the study is offered on page 209 in the final chapter entitled Summary and Recommendations.

Background to the Study

Australian Aboriginal and Torres Strait Islanders have, for over 40,000 years before colonisation, had organised systems and practices that contributed to their overall health (Wise, 2008). The dismantling of these systems and practices by colonisers led to disastrous health consequences resulting in social inequity, disadvantage and powerlessness, which continue to the present day (Campbell, Pyett, & McCarthy, 2007; Korda, Banks, Clements, & Young, 2009).

One significant area of health compromise is the poor birth outcomes for Aboriginal and Torres Strait Islander women, which have been associated with subsequent long term morbidity for infants (Sayers & Powers, 1997). Despite a lack of progress emanating from the implementation of a western biomedical model of healthcare, assumptions that this is best practice persist (Tsey et al., 2007). Further to this, it could be asserted that the technocratic western medicalised model of midwifery care is valued more highly by childbearing healthcare consumers today than ever before.

Aboriginal and Torres Strait Islander women, subjected to a 'supervalue' on technology with the dominant ideologies about what is best for them and their babies, experience a collision of cultures, and a different understanding of what constitutes health (Kornelsen, Kotaska, Waterfall, Willie, & Wilson, 2010; Watson, Hodson, & Johnson, 2002). Sonn (2004) describes this dilemma as conflicting worldviews and cultural frames of reference, which include a differentiated understanding of personhood.

Cultural Diversity

While the present study is confined to exploring pregnancy and childbirth experiences of Aboriginal women from the Noongar community, literature reviewed in the following chapter most often describes Indigenous Australian women. As the term 'Indigenous Australian' is a collective term describing both Aboriginal and

Torres Strait Island peoples, it is not used in the present study in this context, as “most Aboriginal and Torres Strait Islander peoples prefer terms that better reflect their cultural identity” such as Noongar (National Health and Medical Research Council [NHMRC], 2003, p. 2). The term Aboriginal and Torres Strait peoples is specifically used in this study to reflect their cultural diversity. When reference is made to information regarding Aboriginal people only, the term ‘Aboriginal’ is used. The most culturally specific term ‘Noongar’ is used whenever possible.

Knowledge Gap

Noongar people, an Aboriginal group and the original owners of the land of the Swan River Settlement and the South West region of Western Australia (Figures 1 & 2), are rarely mentioned in the literature and despite an extensive search, no qualitative research that appears to address or document the actual experiences of childbearing Noongar women was found.

Following an extensive literature review presented in the second chapter of this study, a gap in the knowledge and understanding of Aboriginal and Torres Strait Islander women’s birthing experiences and preferences was identified. It is therefore asserted that this knowledge gap severely limits the provision of culturally appropriate and effective healthcare outcomes. The present study positively contributes to the body of knowledge and understanding of professional midwifery practice, with regard to Noongar women’s pregnancy and childbirth experiences.

Noongar women have spoken; they have shared their pregnancy and childbirth experiences and have provided valuable insights which can be considered by healthcare professionals, educators and policy makers for the provision of more culturally congruent and effective maternity care.

Conclusion and Structure of the Thesis

This initial chapter has introduced the research by providing an overview of the study, context and background. Several affiliated topics of concern have been initiated and will be expanded upon throughout the thesis. The following Chapter 2 situates the study within an extensive review of the literature, providing in part, an

historical and contemporary contextualisation of factors impacting on and contributing to Noongar women's birth experience. Chapter 3 presents the philosophical and methodological underpinnings of the study, providing evidence of methodological fit to the phenomenon of interest. Chapter 4 provides extensive detail of the tools and procedures utilised for data production. Chapter 5 details the process of interpretive analysis demonstrating transparency of procedure and auditability of findings. Chapter 6 presents the findings of the study, utilising a unique model of textual representation. Chapter 7 discusses the findings of the study by juxtaposing these with relevant literature in order to explore the relevance, usefulness and possibilities of research outcomes. Finally chapter 8 summarises the study, acknowledging its limitations and offering recommendations for practice and suggestions for future research.

CHAPTER 2: LITERATURE REVIEW

Introduction

The purpose of this chapter is to situate the study within the available literature. Physical psycho-social, political and cultural factors pertaining to and impacting upon Noongar women of today and their birth experience, are presented in order to contextualise the topic and justify the need for exploration of their birth experience, from their own perspective.

Accessing Phenomenological Literature

The question of whether to access phenomenological literature in the initial or later stages of the hermeneutic study remains an unanswered and moot point. The concern of researcher biases skewing interpretation of literature and therefore becoming more difficult to suspend for the task of interpretation is contested in the literature (Van Manen, 1990). However, while these sources allow the researcher to realise personal boundaries and limitations of interpretive abilities, they also enable limits to be challenged and abilities' expanded (Van Manen, 1990).

The researcher in the present study gave careful consideration to the timing of accessing literature concerned with the phenomenon of interest. As there is a dearth of literature that explores the lived experience of Australian Aboriginal and Torres Strait Islander women in childbirth, and no studies to be found that explored Noongar women's birth experience, the researcher was confident that early exposure to literature would enhance rather than detract from the rigour of the study.

Given that the purpose of the literature review below was to inform and contextualise the study, of some concern and considerable consequence was the fact that the researcher has lived and worked as a nurse and midwife in Australia, for the most part, over the past fifty years. Consequently attitudes, understandings, knowledge, opinions and experiences of Aboriginal people were considered to be ingrained and a possible deterrent to unbiased interpretation of data. In a concerted effort to mitigate this, prior to gathering literature to inform the study, the researcher engaged in a process of phenomenological reduction, which enabled identification and suspension of biases, impressions, assumptions and tacit knowledge regarding Aboriginal people in general and Aboriginal childbearing women specifically. This

process was enhanced by a 'self-interview' in which the researcher audio recorded projected outcomes of participant's views and feelings about childbirth. This was transcribed and reflected upon by the researcher. These processes are explained in detail later in the Methodology Chapter headed 'Contextualising researcher assumptions'.

Many advantages were realised by accessing phenomenological sources early in the study including contextualising the phenomenon of interest with information relating to contemporary and historical aspects concerning the subject. Another clear benefit was gained by accessing works of national and international scholars. One example was the work of Kornelsen (2012) who conducted a study which explored birthing at home for First Nation women in Canada that was guided by a community research advisory committee. Very early in the preparatory stages of the present study, the researcher was motivated by this strategy which led to the formation of the Aboriginal Women's Reference Group. Early exposure to this concept enabled the researcher to seek formal cultural guidance in the formation stages of the present research. It was therefore with enhanced insight of personal assumptions that the researcher cautiously and critically reviewed a substantial body of work early in the study.

Context

Since colonisation, Aboriginal and Torres Strait Islander peoples have been marginalized and discriminated against resulting in escalating social problems arising from an attempt of forced assimilation to a white society (Parker, 2010; Robertson, Demosthenous, & Demosthenous, 2005; Zubrick et al., 2010). Attempts at eradication of language, culture and beliefs have resulted in a dispossessed, disempowered and unhealthy people (Roe, 2010; Sonn, 2004; Walters, 2012). As a consequence of this cultural denigration, confidence has been undermined to a point where the voices of Aboriginal and Torres Strait Islander Australians have been muted (Kildea, 2006; Walters, 2012).

Today, Aboriginal and Torres Strait Islanders make up less than 3% of the total population of Australia and have the poorest health outcomes. The maternal and infant mortality and morbidity rates, often used as a measure of the health of a country, reflect a gap that exists between Aboriginal and Torres Strait Islander

peoples and non-Indigenous Australians (MacRae, et al., 2013), which is unacceptably wide with the worst health status being realized by this group (Murphy & Kildea, 2010).

Since the days of colonisation, attempts to improve health outcomes for Aboriginal and Torres Strait Islander peoples have consistently achieved little overall impact (Herceg, 2005; Kildea, Stapleton, Murphy, Kosiak, & Gibbons, 2013; Wise, 2008). Accurate identification of the size, scale and nature of health problems that Aboriginal and Torres Strait Islander peoples are facing has not been achieved (MacRae, et al., 2013; Wijesekere, 2008). In addition to this, the majority of health interventions have focused on a western biomedical reality; failing to translate to improvements in health (Maher, Spurling, & Askew, 2014; Watson, Hodson, Johnson, Kemp, & May, 2002). Attitudes of directing and fixing, held by the dominant culture, have paradoxically perpetuated the problem (Tsey et al., 2007). While research and subsequent improvements in the care of childbearing women in Australia has been both inclusive and collaborative in achieving woman-centred care (Green & Baston, 2003; Wilson & Sirois, 2010), this is not so for Aboriginal and Torres Strait Islander women (Dietsch, Shackleton, Davies, McLeod, & Alston, 2010). It would seem there is minimal published data that asks what Aboriginal and Torres Strait Islander women feel or what is important to them (Ewen, 2011; Hancock, 2007).

To this end, the reviewed literature illustrates the poor outcomes experienced by Aboriginal and Torres Strait Islander women in relation to pregnancy and birth, by exploring both historic and current factors that contribute to this compromised state of health. Further to this, the literature reveals an obvious cultural disconnect (Morgan, 2010), which impacts on and contributes to gross health inequities (MacRae, et al., 2013) and begs the question – why not simply ask Aboriginal and Torres Strait Islander childbearing women what they think?

Poor Birth Outcomes and Vulnerability of Aboriginal and Torres Strait Islander Women and Babies

The disproportionate rate of negative birth outcomes for Australian Aboriginal and Torres Strait Islander women and babies, as compared to their non-

Indigenous counterparts, has been reported widely and with increased frequency for well over a decade (Eades et al., 2008; Kildea, et al., 2013). While Australian maternity services have improved, resulting in better overall outcomes, the disparity between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians remains stark (Wise, 2008). The fertility rate of Western Australian teenage Aboriginal women was more than five times that for all teenage women in Western Australia according to MacRae et al. (2013), who also report that babies born to Aboriginal and Torres Strait Islander mothers comprised 7.8% of all Australian births in 2011. Further to this, Western Australian babies of Aboriginal mothers were twice as likely to be of low birth weight as their non-Indigenous counterparts in 2010 (MacRae, et al., 2013). In 2009-2011 the infant mortality rate for Aboriginal people in Western Australia was 2.4 times the rate for non-Indigenous infants (MacRae, et al., 2013). The maternal mortality ratio for Aboriginal and Torres Strait Islander women in 2003-2005 (the most recent period for which detailed data are available), was almost 3 times that of the non-Indigenous population (Sullivan, Hall, & King, 2008).

While the rate of low birth weight of Aboriginal and Torres Strait Islander babies is disproportionately identified, relative to the wider Australian population (MacRae, et al., 2013), factors influencing the increased incidence are multilayered and complex (Eades, et al., 2008). It has been long understood that “birth weight is probably the single most important factor affecting neonatal mortality” with an associated increased incidence of adult morbidity (Sayers & Powers, 1997, p. 524).

A study of Aboriginal and Torres Strait Islander health behaviours and outcomes from 1950 – 1991 revealed that lifestyle morbidities, such as high cholesterol and increased body mass index, were almost entirely new from 1957 and these behaviours were linked with low birth weight. As far back as 1997 it was postulated that low birth weight and serious adult disease were associated with these environmental influences (Hoy, Norman, Hayhurst, & Pugsley, 1997). Further to this, research exploring low birth weight in Aboriginal and Torres Strait Islander populations found pre-term birth, rather than intrauterine growth restriction to be the most common cause (Rousham & Gracey, 2002). While Freemantle et al., (2006) elucidate that economic status and the availability of health care, impact on preterm birth, birth weight and neonatal death. Additionally, an evaluation of maternal infant

health over the 12 year period from 1998-2009 found the difference in low birth rate between cohorts of Aboriginal and Torres Strait Islander and non-Indigenous babies had remained constant (Kildea, et al., 2013). Given the timeline presented above, it is important to note recent reports indicate that babies born with a low birth weight continue to have a greater risk of poor health and mortality and are more likely to develop significant disabilities (Tomlin & Joyce, 2013).

Most recently an overview of the health of Aboriginal and Torres Strait Islander peoples in Western Australia in 2013 revealed a continued and severe health compromise. Aboriginal and Torres Strait Islander women have more children at a younger age and more likely to be mothers in their teenage years. They also have a shorter life span, with the median age for death occurring at a significant 30.2 years less than for Western Australian non-Indigenous females. Additionally, babies of Aboriginal and Torres Strait Islander mothers are 2.4 times as likely to die in the first year of their life (MacRae, et al., 2013).

Factors contributing to poor infant outcomes have been identified as including maternal risk taking behaviour (Hancock, 2007; MacRae et al., 2013), malnutrition including anaemia (Maher, et al., 2014; Tursan d'Espaignet, Measey, Carnegie, & Mackerras, 2003), infections, alcohol (Panaretto et al., 2006), low body mass index and smoking (Passey, Gale, & Sanson-Fisher, 2011). Socioeconomic status, clearly a determinant of health (Korda, et al., 2009; Li, Mattes, Stanley, McMurray, & Hertzman, 2009), has a consistently been associated with a range of health outcomes (Feldman, 2009). Whilst Titmuss, Harris and Comino (2008) concur, they assert other factors including “dispossession, discrimination, sense of control and power, identity and stress contribute to the seemingly intractable health and social problems” (p.495). In addition to these risk factors, racism with resultant low self-esteem, depression and hostility, have been found to contribute to poor health outcomes of Aboriginal and Torres Strait Islander peoples (Larson, Gillies, Howard, & Coffin, 2007; Rickwood, Dudgeon, & Gridley, 2010; Roe, 2010).

Consequently, relative to the wider Australian population, Aboriginal and Torres Strait Islander children experience significant disparities in rates of infections, developmental delay, vision and hearing impairment, speech difficulties, nutritional deficiencies, hospitalisations, as well as accidents and injuries, representing an

increased overall morbidity (McHugh & Hornbuckle, 2010). It may be reasonable to surmise therefore that a different approach to addressing poor birth outcomes is necessary to realise significant improvements in this dire social and health inequity.

If the health consequences of years of colonisation and assimilation policies are to be addressed, it may be asserted that a precise needs assessment is required. The accurate collection of population data is necessary to predict trends, inform policy and provide services (Wijesekere, 2008). Accurate health assessment and reporting is necessary to reflect the true impact need and to ensure that benefits from public policy are equitable (Wise, 2008). The complexities of gaining such data for the Aboriginal and Torres Strait Islander population of Australia are apparent when considering birth or fertility rates. Wijesekere (2008 p.34) warns about confining fertility rates to Aboriginal or Torres Strait Islander mothers, explaining that “consideration must be given to the prevalence of intermarriages between Indigenous and non-Indigenous partners”. Aboriginal or Torres Strait Islander birth can result from one or more Aboriginal or Torres Strait Islander parents and also when the unknown father is Aboriginal or Torres Strait Islander. It could be asserted that achieving equitable antenatal healthcare for Australian women is significantly impacted by this challenge, particularly given that nationwide recording of Aboriginal and Torres Strait Islander births and deaths was first achieved in 1996 and could not be considered accurate because only the ethnicity of the mother was recorded (Wijesekere, 2008). This concern is resonated by Sayers and Powers (1997), who claim that “the term Aboriginality hides a great deal of heterogeneity and risk factors are likely to be different within the population” (p. 524).

Further, the unproblematised use of Aboriginality as a marker of health risk (Nelson, Macdonald, & Abbott, 2012) suggests homogeneity of a people that is misleading and suggestive of colonising behaviour. Additionally, categorisation of a race without acknowledging the individuality and diversity of the peoples that constitute it, displays blindness to difference at the level of personhood, which is limiting and destructive in the extreme. Minimisation of “difference blindness” is a critical element of the value of respect demanded by Aboriginal and Torres Strait Islander peoples and the research community in Australia as evidenced in their guidelines for research of Aboriginal and Torres Strait Islander peoples (National Health and Medical Research Council [NHMRC], 2003, p. 12).

Identifying actual and potential risk factors in pregnancy and childbirth could be seen as an obvious and important step in preparing women for birth and mitigating adverse outcomes. Good antenatal education, including parenting classes and education about health and wellbeing in pregnancy, influences a woman's self-confidence (Hollins Martin, 2008) and may be described as an early transition to motherhood. Aboriginal and Torres Strait Islander women are more likely to access antenatal care later in their pregnancy and consequently, less frequently (Herceg, 2005; McHugh & Hornbuckle, 2010). Suggested reasons for failure to access antenatal care in a timely manner include geographical, economic and cultural barriers (Kildea, et al., 2013; Rumbold & Cunningham, 2008). A small but growing body of research has been conducted exploring, establishing and evaluating culturally appropriate antenatal programs (Carter, Lumley, Wilson, & Bell, 2004; Health Workforce Australia, 2013; Herceg, 2005; Maher, et al., 2014; Rumbold & Cunningham, 2008), finding that despite political and financial challenges, some valuable successes have been achieved with women accessing antenatal education and care more readily and frequently.

Aboriginal and Torres Strait Islander mortality rates were considerably higher when compared with death rates of indigenous populations in the United States of America, Canada and New Zealand, aligning closely to the Newly Independent States of the former Soviet Union (Ewen, 2011; Paradies & Cunningham, 2002). Research from Azerbaijan, a country from the former Soviet Union, reports the recent recognition of the importance differing cultural perspectives contribute to health, with particular reference to the significant contribution of women's own views as a part of improving maternity services (Chalmers & Quliyeva, 2004). Therefore, considering the evidence presented above, it is clear that poor birth outcomes for Aboriginal and Torres Strait Islander women reflect a failure in health policy and provision, which has ongoing negative effects at individual, community, State and National levels. Inequalities in health have aptly been described as "in the final analysis, the most critical measure of a socially [un]just society" (Wise, 2008, p. 506).

Health Inequalities

Injustice could describe the improvements in quality of maternity care for childbearing women of the developed world, compared with that of Aboriginal and Torres Strait Islander Australian women. A plethora of research conducted over many decades, exists both nationally and internationally, exploring ways to improve birthing practices. Women's satisfaction with levels of inclusion in decision making (Harrison, et al., 2003; Molkenboer, Debie, Roumen, Smits, & Nijhuis, 2008), preferences in intra-partum care (Hundley & Graham, 2001), feelings of control [or lack of] and its consequences (Green & Baston, 2003) and factors influencing choice of birth attendant (Wilson & Sirois, 2010), are a small representative example of the consistent effort to improve birth experiences and outcomes. The qualitative research paradigm is widely used to elicit an understanding of what is important to women, recognizing that women can best identify issues that affect them. Such inclusive practices provide women with the means to inform and improve healthcare, to ensure they receive a positive, holistic and empowering childbirth experience (Dietsch & Davies, 2007).

There is however, a paucity of available studies of the birth experiences from the perspective of Australian Aboriginal and Torres Strait Islander women. Far from providing choice and power to childbearing women, some research findings unexpectedly revealed overt negative non-inclusive and patronizing behaviour by healthcare professionals (Dietsch, et al., 2010; Hancock, 2007). Sonn (2004, p. 307) describes the different ways of 'knowing' of Aboriginal and Torres Strait Islander peoples, asserting non-Indigenous research has "often been conducted in an ethnocentric and exploitative manner – Aboriginal people were the objects of an outsider's gaze". To this end, it may be asserted that the voice of the childbearing Aboriginal woman is vital in formulation of models and strategies to improve quality outcomes.

It is reported that living in communities with rich social capital, which is conceptualised as a state of living with a high degree of community participation and social cohesion, results in better physical and mental health outcomes (Berry & Welsh, 2010; Miller & Buys, 2008). Biddle (2012), who conducted a comprehensive measure of social capital for the Australian Aboriginal and Torres Strait Islander

population with a sample of 7823 Aboriginal and Torres Strait Islander peoples over the age of 15 found that social capital is both an indicator and determinant of wellbeing. Others have identified that feelings of control and fulfilment in pregnancy and childbirth contribute to satisfaction and emotional wellbeing (Green & Baston, 2003; Maher, et al., 2014; McHugh & Hornbuckle, 2010). Conversely, individuals who have lower status within society and a lower degree over their circumstances have relatively poorer health (Pholi, Black, & Richards, 2009).

Poverty, described as the “single most important determinant of health” for Aboriginal people (Pattel, 2007, p. 10), impacts on every aspect of physical and psychosocial health and wellbeing. Socioeconomic disadvantage and inequity results in decreased ability to access and afford healthcare, increasing risk across the healthcare spectrum in ways such as limited access to emergency dental care (Roberts-Thomson, Luzzi, & Brennan, 2008), decreased ability to adapt to new knowledge about causes and management of disease (Korda, et al., 2009) and increased incidence of illicit drug induced deaths (Najman, Toloo, & Williams, 2007). It has been posited that those who have the greatest need have the highest degree of risk and usually lower literacy and personal resources. Further to this, they are least well served by existing services, have low access rates and when services are received, they have subsequent high attrition rates (Robinson, Tyler, Jones, & Silburn, 2012, p. 344). The Australian healthcare system has long been assessed as unfair with reports that services were inequitable since those with the greatest need did not utilise services most often (Moorin & Holman, 2006). Further to this, when healthcare is accessed, many Aboriginal and Torres Strait Islander women experience significant cultural, financial and social challenges when admitted to an acute healthcare setting (Kildea, 2006).

Reports of miscommunication, language barriers and cultural and spiritual dissonance with health care professionals (Lewis, 2011), are often compounded with feelings of loneliness and fear (Watson, Hodson, Johnson, & Kemp, 2002). Without fully understanding the preferences of women, there is a risk that care will become midwife centred (Hancock, 2007; Hundley & Graham, 2001), resulting in a power differential between the health professional and the woman (Taylor & Guerin, 2010). As Pattel (2007) elucidates; when Aboriginal people feel uncomfortable or disempowered they often say little and walk away or vote with their feet.

Dietsch & Davies (2007, pp. 9-10) describe the ‘nocebo’ effect as one that encompasses direct iatrogenic concepts and “more hidden influences such as the effects of inadequate communication and systematic power imbalances between women and health professionals”. As long ago as 2003, Lock and Gibb described the power of the place of birth, asserting that women who enter hospital are in unfamiliar territory with an ensuing loss of personal power. For Aboriginal and Torres Strait Islander women, enforced interaction with a dominant culture can lead to powerlessness (Dietsch, et al., 2010), evidenced in ways such as exclusionary practices (Grant & Francis, 2008) and interpersonal discriminatory behaviours in the form of demeaning comments by healthcare providers (Larson, et al., 2007). Far from providing culturally competent engagement, power, whether displayed overtly or communicated in subtle forms such as assumptions, symbols and discourse, reinforces disadvantage related to colonisation (Sonn, 2004).

Health professionals are in powerful and responsible positions that can be used to facilitate empowerment and increase capacity of the clients in their care. Paradoxically, research findings exposing misuse of power over Indigenous women by midwives have been reported in Australia (Dietch, et al., 2010) and South Africa (Kruger & Schoombee, 2010), with descriptions of bullying, deception and disrespect. The long term traumatic consequence of a negative birth experience has been found to have lasting effects; including post-traumatic stress disorder, antenatal depression in the next pregnancy and avoidance of future pregnancies (Stadlmayr et al., 2006). Clearly then it is incumbent on leaders at strategic levels to identify the pervasive effects of cultural and organisational racism that exists within professions, disciplines and institutions (Rickwood, et al., 2010). All systems must take responsibility for their role for engaging in and perpetuating discrimination and prejudice, implementing effective measures to mitigate exclusionary behaviours. A collaborative and concerted effort is required at all levels in the organisation to ensure Aboriginal and Torres Strait Islander peoples are treated with respect, openness and non-patronising conversation and service (Durey et al., 2012).

Although overall healthcare in Australia is steadily improving, advantaged people continue to realize a disproportionate benefit of health (Feldman, Warr, Tacticos, & Kelaher, 2009; Korda, et al., 2009). Given that the Aboriginal and Torres Strait Islander population is significantly more disadvantaged on all major

health indicators than any other group in Australia (Morgan, 2010), there is an obvious and urgent need to identify ways and means of ensuring a more fair and just system. In maternity care provision an obvious and fundamental strategy is to ensure inclusivity, ascertain the needs of the community and in so doing, redirect the locus of control to Aboriginal and Torres Strait Islander childbearing women, positioning them at the centre of their care and giving them voice.

Health Disadvantage and Conflicting Cultures

Urban Aboriginal and Torres Strait Islander women of childbearing age are often faced with conflicting cultural identities (McLennan & Khavarpour, 2004). A large proportion of the Aboriginal and Torres Strait Islander population live in the urban settings (de Souza & Rymarz, 2007). In the major cities where there is a greater diversity of Aboriginal peoples, individuals may not be highly visible, which can lead to disconnection from culture and increased marginalisation (Dudgeon & Ugle, 2010). This can lead to a difficult dual reality when individual Aboriginal or Torres Strait Islander people live within a cultural home and socialise in a western society (de Souza & Rymarz, 2007).

Difficulty with perception of identity can result when Aboriginal and Torres Strait Islander children, teenagers and young adults live within a cultural home and go to school or work within the dominant non-Indigenous society (de Souza & Rymarz, 2007). Cultural conflict arises when beliefs that are held within Aboriginal culture differ from those of the dominant culture (Flemming et al., 2006). Western individualism is diametrically opposed to the cultural frame of the collective community-centred society which reflects the Aboriginal and Torres Strait Islander worldview (Sonn, 2004; Watson, 2007).

A contrasting paradigm and resultant cultural disconnect with western realities of health, is the dichotomization of clinical and social concerns, particularly as clinical management takes precedence (Kornelsen, Kotaska, Waterfall, Willie, & Wilson, 2010). Dual cultural reality was identified in findings of a study by Watson et al. (2002), in which a purposely recruited group of Aboriginal professional women from the Northern Territory were interviewed about Aboriginal and Torres Strait Islander birthing in changing social environments. It was asserted that grandmothers,

aunts and sisters should be involved in the birth; however, recognition that some women would prefer their husbands or partners with them reflected a merging of traditional and modern realities.

The involvement of intergenerational female relatives in Aboriginal and Torres Strait Islander birth provides support and a continuation of history. Further to this, the context of birth includes place and community, with alienation felt in new environments (Kornelsen, et al., 2010). As in many societies, Aboriginal women are central to the community and have been described as “the moral guardians of society and ones to lead initiatives for positive social changes” (Kenny, 2006, p. 559). It may be postulated that unless non-Indigenous Australian health providers begin to ask Aboriginal and Torres Strait Islander women what they consider important for the health of their people, dire social consequences will continue to occur.

Inequalities in health for Aboriginal and Torres Strait Islander peoples, including high levels of family violence (Cripps, 2010; Wendt & Baker, 2013), reflect specific social determinants of health described as including “history of colonisation, poverty, racism, unemployment, lack of education and training, and a lack of access to appropriate health services” (Campbell, et al., 2007, p. 305). An historical study of birth in Australia from 1857 – 1985 reveals the vital importance of early nurturing and a stable home (McCalman & Morley, 2008); highlighting the ensuing long term negative consequences when these are absent.

Colonisation, Racism and the Stolen Generation

Throughout the ages childbirth has had a spiritual or magical dimension that is described by some as a ‘non-ordinary state of consciousness’ (Lahood, 2006). Beliefs and legends of Aboriginal and Torres Strait Islander peoples spirituality and dreaming are described as an “ancient storehouse of condensed memory [which] winds back through ever returning cycles of reproduction and ritual dreaming for up to 9000 years” (p.6). Throughout history stories, legends and art have been the method of teaching Aboriginal and Torres Strait Islander ways to future generations (Barton, 2003), with childbirth and culture being essentially entwined (Lahood, 2006). The dreaming is the embodiment of Aboriginal spirituality which comprises beliefs and values that are passed on through the generations. Spirituality, central to

everything that is significant, connects and comprises of identity, country, family and culture (Kickett, 2011).

Since colonisation, structures of white supremacy and cultural arrogance have continued to a point where Aboriginal and Torres Strait Islander peoples experience “chronic ongoing stress” on a daily basis (Atkinson, Nelson, & Atkinson, 2010, p. 136). For some 200 years, Aboriginal and Torres Strait Islander culture has been systematically disavowed, disempowered and displaced (Cooper, Baturo, Warren, & Doig, 2004).

Gross injustices were suffered by Aboriginal and Torres Strait Islander peoples in the days of colonisation, when idealism and white supremacy provided context for the “release of individual and cultural superego aggression with its hatred and punishment” (Walters, 2012, p. 150). Men were massacred and women were ‘saved’ to be spent as currency in the colonial economy (Schlunke, 2001). The Myall Creek massacre which occurred in northern New South Wales 1838, was one of the most famous massacres of Aboriginal people in Australia. The abuses of Aboriginal women never came to court; Aboriginal people could not swear an oath as it was believed they were wholly ignorant. This was by no means an isolated event of its kind. As Schlunke (2001, p. 61) states “Colonial terror cannot be measured”.

Petchkovsky, San Roque, Napalijarri Jurra and Butler (2004) interviewed nine adult members of the Stolen Generation who were selected for evaluation for a group court action against the Commonwealth in 1996. The youngest was 50 the eldest 74. Their age at separation ranged from two and a half years to 12 years of age. Forced removal of part Aboriginal children from their Aboriginal and Torres Strait Islander mothers was government policy over the period of 1914 to the late 1960s (Petchkovsky, et al., 2004; Walters, 2012). Children who were removed from their parents experienced a life where institutionalization replaced parenting and training and schooling replaced emotional connections. The complex living tapestry of kinship that interconnects and legitimizes Aboriginal and Torres Strait Islander people with each other and their country was stolen. Attacks on linking were successful strategies to nullify a race. Children were taken from their parents and great physical distance was placed between the child and home. Visits from relatives

were obstructed and expression of language and culture prohibited. Stolen Generation children were often abused and suffered lifelong effects of depression, as well as an inability to engage and participate in life. They existed in a state of hyper-vigilance, irritability and estrangement from others including their own children. Participants describe being unable to show love to their children, as a result of being *unparented* parents. The physical and psychological ramifications of such ongoing trauma were great; having consequences for generations to come (Petchkovsky, et al., 2004).

Present day women of childbearing age are grandchildren or great-grandchildren of these victims of the Stolen Generation. A national survey in 2004 revealed that 40% of Aboriginal and Torres Strait Islander people aged 15 years or over reported that they, or one of their relatives had been removed from their natural family (Tsey, et al., 2007). Thus, a resulting disruption to cultural connections and intergenerational transmission of parenting practices is described by Morgan (2010).

Aboriginal and Torres Strait Islander peoples today continue to experience many forms of racism. For example, interpersonal racism has a cumulative effect and impacts negatively on health (de Souza & Rymarz, 2007). A study in 2007 calculated the odds for Aboriginal people reporting racially based negative treatment were 3.6 times greater than for non-Aboriginal people (Larson, et al., 2007). Qualitative studies highlight the importance of early self-mastery and resilience need by young Aboriginal and Torres Strait Islander children in the face of such challenges (Malin, Campbell, & Aguis, 1996; Morgan & Drew, 2010).

The consequences of an horrific and prolonged era of colonialism and the Stolen Generation have had dire, multifaceted and transgenerational consequences (Atkinson, et al., 2010). Clearly then, to view the consequences of perpetual trauma in Aboriginal communities today, without reference to the violent colonial history of this country is “to look too simply at a complex and layered landscape” (Watson, 2007, p. 97). One could ask then, at what point will these injustices be addressed and how is healthcare reform possible without empowering Aboriginal and Torres Strait Islander women to direct that change.

Empowerment Strategies and Interventions

Cultural values and beliefs of Aboriginal and Torres Strait Islander peoples encompass a worldview that is very different to the dominant western society (Kruske, Belton, Wardaguga, & Narjic, 2012; Malin, et al., 1996). This includes a belief in the connectedness between living things and the land, and a consciousness that family and community constitute the individuals place in the world (Kickett, 2011; Vicary & Bishop, 2005).

Australia remains a predominantly western society with whiteness and western ideology as the power and privilege default position against which all else is measured (Health Workforce Australia, 2013; Taylor & Guerin, 2010). In an effort to address the poor health outcomes for Aboriginal and Torres Strait Islander peoples, assumptions persist that best health practice, knowledge and effort is born of the generosity of outsiders (Tsey, et al., 2007). As a consequence healthcare has largely been directive driven with initiatives and interventions imposed on Aboriginal and Torres Strait Islander peoples, rather than fostering the capacity to exert greater control and influence over their social circumstances (Campbell, et al., 2007). The continuation of passive engagement has become a measure of self-perpetrating helplessness. Morgan (2010) claims such helplessness can result from recurring situations in which individuals have no sense of control over events in their lives. Further to this helplessness, loss of hope and purpose has resulted in a piecemeal array of broken promises and increasing ill-health of the community, when quality information and initiatives fail to translate into practical solutions (Tsey, et al., 2007).

Rather than an inclusive approach to the health of a people, there appears to be a dearth of Aboriginal and Torres Strait Islander led initiatives. Clearly a different approach is needed with cultural support and inclusiveness being the cornerstone of health reform. By developing relationships and ensuring community members are able to participate in planning and decision making for Aboriginal and Torres Strait Islander health initiatives, Aboriginal and Torres Strait Islander controlled steering groups will be able to assist health services to provide culturally appropriate and effective care (Kruske, 2011). Research which centres on actively listening to the stories of Aboriginal and Torres Strait Islander peoples, may shift the locus of power

so that culturally acceptable healthcare solutions can be generated from within. Empowerment; being a process by which individuals, groups and communities gain increased control and mastery over their lives (Taylor & Guerin, 2010), will be achieved only when Aboriginal and Torres Strait Islander leaders are central to the solution. This will ensure that programs and initiatives fit with and are accepted by the communities they lead (Campbell, et al., 2007; Kruske, 2011). This measure of capacity building will result in “enhancement of their sense of self-worth, resilience, belief in their capacity to improve their social environment and ability to reflect on root causes of problems, find solutions and address immediate family difficulties” (Tsey et.al. 2007 p. S36).

To this end non-Indigenous researchers and policy makers have a responsibility to acknowledge the inequalities of power and resource distribution to which their own efforts may contribute (Durey, et al., 2012; Tsey, et al., 2007). Facilitating the inclusion of solutions that are culturally appropriate in order that Aboriginal and Torres Strait Islander people can better develop a sense of self, place and purpose is essential (de Souza & Rymarz, 2007). Aboriginal and Torres Strait Islander peoples’ concept of health is holistic and encompass a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity (McHugh & Hornbuckle, 2010). It may be reasonable to suggest therefore, in order to improve the health and wellbeing of women and babies and overcome substantial disparities in maternal and neonatal outcomes (McHugh & Hornbuckle, 2010), the voice of Aboriginal and Torres Strait Islander women must be heard.

Voice

The enormity and range of health problems facing Aboriginal and Torres Strait Islander peoples can seem so complex that inaction is borne of a perception of hopelessness (Morgan, 2010). Aboriginal and Torres Strait Islander women are central to the community (Pattel, 2007) and can take ownership of identifying needs and solutions, particularly with respect to Women’s Business (Kenny, 2006; Lucashenko, 1994). It is vitally important to incorporate Aboriginal and Torres Strait Islander authoritative knowledge around birthing in order to inform appropriate care provision for Aboriginal and Torres Strait Islander childbearing women (Kildea, 2006). So fundamental is the importance of the power to shape and influence debate

and decisions on policy and resources, that the Commission on the Social Determinants of Health (2007) identified this as a key determinant of health (Wise, 2008). A collaborative relationship between non-Indigenous healthcare providers and Aboriginal and Torres Strait Islander women is possible (Murphy & Kildea, 2010). However, in order to achieve this, it may be asserted that research must reflect the voice of Aboriginal and Torres Strait Islander women, so that birth can be culturally sensitive and secure, safe and relaxed.

Indigenous populations worldwide, who have been victims of colonisation, suffer poorer health on a number of levels compared to the dominant society (Carter, et al., 2004; Kenny, 2006; Kornelsen, et al., 2010; Morgan & Drew, 2010; Petchkovsky, et al., 2004; Van Herk, Smith, & Andrew, 2011). Despite efforts to improve health outcomes, Australian Aboriginal and Torres Strait Islander peoples remain more disadvantaged than indigenous peoples from other western countries (Murphy & Kildea, 2010).

Diluting the public voice of Aboriginal and Torres Strait Islander peoples seems to have been politically driven to disempowerment according to Poroch (2006). The concept of voice comprises the undertaking that self-expression in a personal, unique and uninhibited manner is the right of the individual (Suarez-Ortega, 2013). Understanding of the subjective experience of Aboriginal and Torres Strait Islander peoples, particularly the relationship between spirituality and well-being, will result in better informed and therefore, more effective health professionals and culturally appropriate health care services (McLennan & Khavarpour, 2004).

Birth outcomes for Aboriginal and Torres Strait Islander women are significantly poorer than that of other Australians, with this differential remaining constant, despite overall national improvements (Wise, 2008). As the reviewed literature attests, improvements in the quality of pregnancy and childbirth for the majority of Australian women have been effected largely in response to a qualitative, inclusive and consultative approach that places the woman at the centre of her care, involving her directly in the decision-making process. Conversely, there is a paucity of research on Aboriginal and Torres Strait Islander birth; this being overwhelmingly focused on a western biomedical worldview of health which is objective and

quantitative in design. Furthermore, the limited research on Aboriginal and Torres Strait Islander peoples birthing fails to incorporate their knowledge around birthing (Kildea, 2006). Given the Aboriginal and Torres Strait Islander concept of health, particularly with respect to birth, which comprises community, relationships, family, spirituality, land, country and culture (Kildea, 2006), it may be reasonable to conclude a more creative approach is needed to improve birth outcomes for Aboriginal and Torres Strait Islander peoples.

Clearly then, midwives and other health professionals who are committed to providing culturally competent and sensitive care, must listen to the voices of the women. This level of candour from Aboriginal and Torres Strait Islander women must reflect their concerns, primacies and knowledge, while challenging the colonising practice of healthcare professionals from the dominant society of speaking for, rather than speaking with, Indigenous women (Salmon, 2007).

The voice of women can speak loudly and effectively through research. This would seem a natural way of communicating, as stories and yarning have traditionally been the Aboriginal and Torres Strait Islander way of passing on wisdom to future generations (Robertson, et al., 2005). Yarning has been established as a legitimate method of research (Bessarab & Ng'andu, 2010; Dean, 2010) and as such, can be utilised to gain understanding about issues that affect Aboriginal and Torres Strait Islander women. Culturally inclusive qualitative research that explores birth experiences places the Aboriginal or Torres Strait Islander woman at the centre of her care, thereby informing health practice and optimising holistic care (Dietsch & Davies, 2007). Consequently, the voice of Aboriginal and Torres Strait Islander women will both inform and shape culturally sensitive practice facilitating a paradigm of empowerment, through culturally centred control and self-determination.

Conclusion

Current available research about childbearing Aboriginal and Torres Strait Islander women explores and identifies the negatively disproportionate maternal and neonatal outcomes relative to the wider Australian population. Such research identifies deficits, proposes solutions, models and strategies, thereby exemplifying

the problem. Although extremely useful as a starting point, the available research, by virtue of its approach, could be seen to perpetuate the colonised dominant discourse that continues to direct rather than be directed. The voice of Aboriginal and Torres Strait Island women is all but absent in the maternity healthcare debate. The literature reviewed and presented in this chapter identifies a knowledge gap that this study aims to address by exploring Noongar women's lived experience of childbirth.

The current study adds the voice of Aboriginal women to maternity debate. Acknowledging that Aboriginal and Torres Strait Islander women in Australia comprise many diverse and different groups and peoples with unique cultures, aspirations, challenges and constraints, the present study focuses on a single Aboriginal people; the Noongar people. From this standpoint the lived experience of Noongar women in childbirth is explored.

The following chapter presents the methodological approach this research study will take. The philosophical underpinnings of interpretive phenomenology are presented and the applicability of this approach to the phenomenon of interest is discussed extensively.

CHAPTER 3: METHODOLOGY

Introduction

The purpose of this chapter is to present an account of the philosophical underpinnings of the study. Initially a description of research paradigms, how they differ from each other and the way in which new paradigms have emerged over time is offered. An in-depth exploration of hermeneutical phenomenology is then presented. Justification of the choice of research design follows and a transparent demonstration of the methodological fit of the chosen approach to the study of the phenomenon of interest is offered. Importantly, the non-Indigenous researcher's positioning within the study is examined, leading to discussion of cross cultural challenges inherent within the study and the formation of an Aboriginal Women's Reference Group as a strategy to address this. This chapter, therefore presents the overarching methodological intent of researching the birthing experiences of Noongar women, which is to identify, analyse and describe the unique meaning or essence of the lived experience.

Differing Research Paradigms

A paradigm is a worldview; a scientific perspective from which the researcher can build a bridge between the aims of the study and the methods to achieve those aims (Houghton, Hunter, & Meskell, 2012). When research is considered, it is generally the philosophical persuasion of the researcher that initially determines how the study is conducted (Richardson-Trench, Taylor, Kermode, & Roberts, 2011). A research paradigm will reflect this perspective and inherently reflect these values and meanings assigned to knowledge. Each paradigm has its own philosophical underpinnings, uniquely linked research designs and rules that structure specific approaches to the collection and analysis of data. These associated structures guide research and are therefore essential to understanding the nature and substance of the research process itself and the findings it generates (Le May & Holmes, 2012).

Some go so far as to assert that a paradigm can represent the philosophical stance and processes of enquiry of a profession (Richardson-Trench, et al., 2011). Most however, do not ascribe to such rigidity of thought (Welford, Murphy, &

Casey, 2011). Nonetheless, it is the choice of paradigm that will aid in achieving methodological congruence to the focus of the study (Houghton, et al., 2012). Put simply, if the research is situated within the correct paradigm it will ensure the chosen methodology will best answer the research question (Welford, et al., 2011).

Given the role of nurses and midwives, it has been asserted by various authors that research in these professions can be separated out into common classifications of three key paradigms; namely positivist, naturalistic and critical theory (Le May & Holmes, 2012; Schneider & Whitehead, 2013).

Positivist

The oldest of these paradigms, positivism, a philosophy developed by French nineteenth-century sociologist August Comte, was at its genesis, seen as the final of three universal stages that all societies go through. This stage emphasized that all knowledge can be explained scientifically by observation and measurement and was a way of systematically shifting the focus of knowledge from the first two stages, the religious and metaphysical, to the measurable, repeatable and predictable (Maltby, Williams, McGarry, & Day, 2010). This new science re-emerged during the 1920s and 1930s and was the quest of a group of philosophers known as the Vienna Circle (Le May & Holmes, 2012).

As research evolved to the present day, the quantitative methodology, which assumes the logical and objective stance (Cluett & Bluff, 2006), is rooted in the philosophy of this scientific positivist approach (Maltby, et al., 2010) and reflects a broad cultural orientation to rationality (Schneider & Whitehead, 2013). Positivism provided one worldview, however it was seen to be a somewhat limited and inadequate mechanism to explore the intricacies and often “messy and complex realities” of life (Le May & Holmes, 2012, p. 66).

Naturalistic

This acknowledgement of the need for a less rigid, more subjective method of studying humanity resulted in the post-positivism movement (Schneider & Whitehead, 2013). Naturalism, as it was also known, was seen to directly oppose positivism because it is all encompassing and focused on the human person, exploring meaning and complexity (Le May & Holmes, 2012). This counter

movement is sometimes referred to as constructivism because the uniqueness of human experience is individually constructed to represent its relative, subjective, diverse and fragmented nature (Walter, 2006). The theory of constructivism, developed by Jean Piaget, is premised on the fact that new knowledge is processed by drawing on internalized past knowledge and experiences and is therefore subjective and individual (Maltby, et al., 2010). This paradigm is also often associated with French philosophers Jean-Francois Lyotard and Jean Baudrillard (Walter, 2006, p. 18). For the naturalistic enquirer, reality is not fixed; rather it is constructed by individuals participating in the research (Loiselle, Profetto-McGrath, Polit, & Beck, 2010).

Therefore, a research paradigm, which allowed study outside the 'observe and analyse' domain evolved. Methods of enquiry that value human qualities such as intentions, ideas, biases, personal experiences and emotions as a part of the research, came to be known as qualitative research (Richardson-Trench, et al., 2011).

Critical Theory

Critical theory is the newest school of thought, developed in the 1960s when a group of scholars in Frankfurt Germany, most notably Jurgen Habermas, sought to address the constraining forces within society (Van Manen, 1990). The rigidity of the positivists was seen to promote perpetuation of the status quo with respect to political issues, such as the oppression of the working classes (Le May & Holmes, 2012). A focus on society resulted in the development of a research paradigm, which allowed for departure from the absolutes of positivism moving away from the individual experience of the naturalistic, yet enabling exploration of the complexity of collective human behaviour.

One would assume, given research has a global aim of improving understandings and outcomes, that differing paradigms would complement the depth of understanding of a single problem. As Le May and Holmes (2012) explain, more often than not, different worldviews are seen as discrete, with proponents claiming superiority of their own philosophical stance to the exclusion of all others. This may however, be couched as pure intentionality; quantitative research, positioned in such a way that it does not intend to understand perspectives of participants, being

described as the “place and intention of qualitative research” (Schneider & Whitehead, 2013, p. 104).

Quantitative Research

Credited by some to have scientific superiority, quantitative research, based on an empirical method of enquiry, is systematic and logical, objective, analytical, accurate and controlled (Borbasi, Jackson, & Langford, 2005; Schneider & Whitehead, 2013). Using numbers rather than explaining the complexity of relational experience, it identifies patterns in an objective and distanced manner, claiming freedom from the distorting influences of individuals (Maltby, et al., 2010; Richardson-Trench, et al., 2011). A hypothesis is proposed and tested in a controlled manner. The research aim is to discover a truth, which is assumed to exist, requiring only to be identified, tested and quantified (Cluett & Bluff, 2006). This research asks ‘how many?’ and by using strategies such as surveying large numbers of subjects, can statistically address issues from a big picture perspective (White, 2006).

Empirical science within the health professions is regarded as advantageous for populations and planning, and attracts favourable outcomes for research funding and ethics approvals (Richardson-Trench, et al., 2011). It does not seek to understand people, their experiences and viewpoints, or how they differ due to culture and context (Schneider & Whitehead, 2013). This omission is criticized by Creswell (2013, p. 48), who purports that “to level all individuals to a statistical mean overlooks the uniqueness of individuals in our studies”.

Quantitative research, sometimes termed empirico-analytical research (Richardson-Trench, et al., 2011), deals with facts and not values, therefore distance is maintained from subjects with researchers remaining objective and impartial (Neutens & Rubinson, 2010). It is highly organized and systematic, following sets of rules to ensure accurate measurement of elements by progressing through specific levels such as description, correlation, explanation and prediction (Richardson-Trench, et al., 2011). Many projects test relationships between variables, as the focus of this method is to break down different parts of a phenomenon in order to collect information that is specific and limited to the particular event being studied (Macnee, 2003).

Qualitative Research

In contrast to quantitative research, working within a world of multiple realities comprised of complex unstructured data, qualitative research is far from linear. Understanding human action within its ambit, qualitative research design seeks to provide a greater depth of understanding as it seeks to explore reasons behind any given phenomena (Morse & Richards, 2002). It is concerned with meaning and perspectives, aiming to fully comprehend the impact of these on experiences, actions and beliefs (Maltby, et al., 2010). Reality is construed as a subjective multifaceted experience rather than a single fixed objective actuality, rendering context vital to understanding the individual or group (Creswell, 2013). Qualitative research facilitates exploration of little known subjects or human experiences (Borbasi, et al., 2005) and focuses on understanding and interpreting human experience at what might be described by some as the micro level. To this end, faithfulness to data is of utmost importance and as such, data is not manipulated or controlled (Le May & Holmes, 2012).

Reasoning

Understanding ways of thinking about, or approaching a conundrum can be vital to the choice of methodological approach for a research study. Leedy and Ormrod (2010, p. 31) make the partisan claim that the human mind is “undoubtedly the most important tool on the researcher’s workbench with unparalleled powers of comprehension, integrative reasoning and insight”.

Research is described as a tool that is used to explore the world according to Borbasi et al., (2005), who assert reasoning to be a systematic way of thinking, which is considered to be either inductive or deductive. That is, it either uses data to build theory, generate ideas, or explain phenomena, which is described as inductive in nature (Schneider & Whitehead, 2013), or conversely, theory is used to break down the big picture into smaller components, to test if empirical data supports that theory; a deductive process (Walter, 2006).

Although deductive logic begins with one or more premises, whereas inductive reasoning commences with observation and no pre-established premise (Leedy & Ormrod, 2010), it is not the view of all authors that a style of single

reasoning and logical thought process is the domain of either qualitative or quantitative paradigms. Cluett and Bluff (2006) however, state categorically that the main feature which identifies quantitative research is in its deductive approach to enquiry, while qualitative research features an inductive approach. Some researchers comment that qualitative researchers tend to use inductive reasoning to analyse their data (Neutens & Rubinson, 2010). These approaches are not necessarily mutually exclusive because researchers frequently use both inductive and deductive reasoning within the same study. Still others claim less definitively, the approach of viewing the world and its phenomena is generally interpretive and naturalistic when studied by the phenomenologist (Schneider & Whitehead, 2013).

Knowledge Generation

Historically within the health context, a paradigm tension has existed between quantitative and qualitative research communities (Schneider & Whitehead, 2013). Latterly, this has been attributed to the levels of evidence (Schneider & Whitehead, 2013) which form a basis for evidence based care, so highly regarded in healthcare (Macnee, 2003).

Positivist researchers have argued the interpretive nature of qualitative data makes it a soft science, lacking in reliability and validity and of little value in contributing to scientific knowledge (Liamputtong, 2013). Furthermore, critics assert the qualitative paradigm lacks structure, whereas its proponents assert structure is present but constructed differently (Le May & Holmes, 2012). This difference is axiomatic as explained by Creswell (2013), who describes the fit-for-purpose of qualitative research. He argues qualitative research is useful when statistical analyses do not fit the problem, or when existing theories are partial, inadequate or fail to properly capture the complexity of the issue being studied.

Qualitative methods assume that experiences are unique and that, although it is possible to increase understanding regarding a particular question, definite answers are not attainable (Macnee, 2003). A strong point of qualitative research is the potential to underscore and foreground the need for change or intervention (Schneider & Whitehead, 2013). It could be asserted the power that inheres in such a research perspective can unlock the enormous transformative potential of healthcare,

which is different yet complementary to empirical designs. Creswell (2013, p.6) makes the partisan claim that “qualitative inquiry represents a legitimate mode of social and human science exploration, without apology or comparisons to quantitative research”.

Cluett and Bluff (2006), in their text on research practice for midwives, suggest that amelioration of the argument is achieved by acknowledging that qualitative and quantitative paradigms are not completely different. They assert these differing paradigms are complementary, sharing the same aim; that of increasing knowledge and understanding of midwifery matters. Further to this, Schneider and Whitehead (2013) contend the recent emphasis on collaborative research has led to different disciplines within the healthcare arena conducting research together, resulting in paradigms that share connectedness and inter-relationships, which fulfil different purposes in the search for knowledge and understanding. A collaborative stance is taken by Creswell (2013) elucidating that qualitative research is used to follow-up quantitative research and helps explain the mechanisms or linkages in causal theories. Quantitative models, he explains, only go so far in that they provide trends and associations, but do not explore the reasons and experiences leading to participant responses.

It could be described as ineluctable that knowledge generation is often used to solve particular problems, which do not fit neatly into a qualitative or quantitative paradigm. It seems evident that both views provide different and equally valuable perspectives that are complementary and inextricably related. It is indeed “naïve and simplistic” to suggest that either research approach is better than the other (Schneider & Whitehead, 2013, p. 13). Clearly then, it is the researcher who must determine the best paradigm fit and research design to address the chosen research question.

Selecting the Most Appropriate Paradigm

A qualitative approach is seen as appropriate to this study, because qualitative research focuses on phenomena as they occur in natural settings and involves studying them in all their complexity. Creswell (2013, p.43) describes qualitative research as one that “makes the world visible”. In the process of understanding the essence of how it is to be a Noongar woman giving birth, the researcher sought to

interpret women's stories to portray an insightful, reflective and true account of this lived experience.

The theoretical foundations of qualitative enquiry have their genesis rooted in anthropology, history and sociology (Neutens & Rubinson, 2010). When limited information exists on a topic, a qualitative study can help define what is important and what needs to be studied. This research approach requires 'digging deep' to get a complete understanding of the phenomena being studied; collecting numerous forms of data and examining them from various angles to construct a rich and meaningful picture of a complex, multifaceted situation (Leedy & Ormrod, 2010). The basic philosophical stance of qualitative research is that by working with raw, complex and unstructured data, new understandings may be derived. Morse and Richards (2002, p.25) concur and further assert "the research question requires it and the data demand it". Indeed, this is a feature of the present study where data obtained from participants was primarily textual, derived directly from audio recorded interviews, which in turn provided rich descriptions of the phenomenon being investigated.

Other data sources can be used in some qualitative methodologies to develop a deep understanding of the worldview of participants, by providing additional context in the form of cultural stories and art (Creswell, 2013; Van Manen, 1990). Although this departure from the traditional approach of phenomenology may seem modern, imprudent or even a risk to methodological integrity, as far back as 1990, van Manen gave cautious encouragement of such creativity. A learned scholar in interpretive phenomenology, his writings on research context advise that as long as the principled form of enquiry is maintained, the flexibility and fluidity of qualitative research allows for divergence from traditional process, enabling richer contextualisation. Further to this, he warns against simply following predetermined and limited processes in a "mindless, slavish or mechanistic manner" (p. 172) stating that valuable work must be "animated by the desire to orient to its topic of study in a strong, original and thoughtful manner" (p.172). An example of this technique was used by Lauterbach (1992) in her phenomenological study of death of the wished for baby. Making frequent reference to van Manen (1990) in her thesis, Lauterbach used Shakespearean literature, art, mourning art and photography, and music to add to her descriptive study.

Methodological beliefs form and shape qualitative research studies (Schneider & Whitehead, 2013) and methodological congruence, which is important for all research paradigms, is achieved by ensuring a fit between research topic, method, collection and the analysis of data (Leedy & Ormrod, 2010). More than this, there exists a close tie between the philosophical stance of the individual and how the research is progressed (Creswell, 2013). This linkage of philosophy and method accentuates the need for the project to entail congruent ways of thinking. That is, the researcher working with phenomenology, for example, must learn to think phenomenologically if the fit of purpose, method and data is to work well. Morse and Richards as far back as 2002 warn a lack of 'fit' is likely unless the researcher seeks to find the method that best addresses the predetermined question. Further to this, they assert that research conducted without the benefit of a coherent method will only produce an end result of 'sorted data', which is descriptive rather than analytical. Creswell, a contemporary expert on qualitative research, concurs with Morse and Richards (2002), adding his belief that those engaged in the design of qualitative research, who tend to follow the interconnected parts of the research process, will achieve methodological congruence.

Qualitative Research Designs

Qualitative methodologies have a number of philosophies that underpin the research being conducted (Maltby, et al., 2010). Creswell (2013 p.7) describes a "baffling number of choices of approaches" in his detailed discussion of various authors' classifications, strategies for data collection, organization by human priorities, primary concern, traditions, and discipline perspectives. Clearly then, the researcher is tasked with selecting the design that best fits the area of research focus. Schneider and Whitehead (2013) advise it is the nature of the study and the type of knowledge the researcher is endeavouring to gain, which must be considered in order to select wisely from the range of available approaches in qualitative research. Further to this, Morse and Richards (2002, p.29) claim "the firming research question" will indicate the best method to use. It could be asserted therefore, that the research process for qualitative researchers is emergent. That is, the greater consideration of research focus and the more deeply various research designs are understood, the greater likelihood a design with correct fit-for-purpose will emerge.

Transparency in the choice of design for the present study is demonstrated in the brief synopsis of common qualitative designs presented below.

Grounded Theory

Grounded theory uses a precise set of procedures to analyse and construct a model or theory from data. As data are collected prior to and during theory development, the theory is said to be grounded in that data (Leedy & Ormrod, 2010). This design is therefore process driven as the researcher identifies phenomena worthy of investigation and applies grounded theory procedure to fully comprehend its variability. In other words the aim is to create a theory which will provide understanding and wisdom around the actual phenomenon being studied (Cluett & Bluff, 2006).

Ethnography

Ethnographic research has its roots in anthropology and latterly sociology. It focuses on studies of culture, describing ways of human life and how people make sense of their worlds (Liamputtong, 2013). Context is central to this design with the researcher gaining understanding through prolonged and extensive interaction with participants. In this manner the provision of rich detailed descriptions enable “the realities and subtleties of the culture” to be exposed (Le May & Holmes, 2012, p. 74). The intent of ethnography is to understand how the culture works rather than focus on a single issue or phenomenon (Creswell, 2013). Ethnographic approaches are used to obtain an insider’s view of the social phenomena under study. Researchers are required, wherever possible, to fully immerse themselves in the culture to a point of being unobtrusive, to avoid influencing its dynamic. In this manner a thick description can be gained to provide valuable insights which are derived from the culture over time (Travers, 2006).

Narrative Research

A highly context driven form of research, also known as oral history, is achieved by narrative researchers collecting stories from individuals, documents, and groups about lived and told experiences of fairly recent events (Leedy & Ormrod, 2010). Stories may be told to, or co-constructed by, the researcher. These stories are gathered through many different forms of data and are shaped by the researcher into

a chronology. The stories are analysed and turning points identified (Creswell, 2013).

Case Study

This qualitative enquiry approach is one in which the researcher explores a “real life contemporary bound system (a case) or multiple bound systems” (Creswell, 2013, p. 97). This research design is also used to study the workings of a group, or multiple groups in a collective case study (Borbasi, et al., 2005) The case is explored over time, through detailed, in-depth data collection involving multiple sources of information, after which reports are presented in the form of case description and case themes (Creswell, 2013). In this way phenomena that are relatively rare can be studied and analysed, or patterns that might carry over from one case to the next can be identified and examined (Borbasi, et al., 2005).

Phenomenology

Although there are different perspectives of phenomenology, the major emphasis is exploration of a phenomenon (Creswell 2013). This can be approached from a descriptive or interpretive stance. It is the study of human experience and how things present themselves in and through that experience (Sokolowski, 2000). Phenomenology is designed to uncover previously unnoticed phenomena in everyday life; it reveals things that remain hidden without making inferences or drawing conclusions (Schneider & Whitehead, 2013). Phenomenology explores experience as it is lived rather than how it is conceptualized (Van Manen, 1990). It explores the lived experiences of people as they understand those experiences to be (Liamputtong, 2013).

Choice of Research Design

Having considered a number of different research designs, it was decided the best fit for the purpose of the current study would be a phenomenological approach. As the focus of exploration was Noongar women’s birth experience, it was considered that the phenomenon was best studied by foregrounding the voice of these women. The desire was not to create a theory that explains the phenomenon, nor to study a culture, or describe the experience from an outsider’s point of view.

Rather, the focus was to understand how it is to be that Noongar woman who had birthed a baby within the previous two years. Accordingly, it was believed the most effective way to achieve this goal was by exploration of the phenomenon as the lived experience, in order to uncover the essence of what it meant to be that woman.

Phenomenology

Phenomenology acknowledges that “instead of there being only one truth, there can be many truths” (Maltby, et al., 2010, p. 50). Knowledge results from uncovering each individual’s perceptions, experiences and an intuitive sense of what they are thinking and feeling in different encounters with the world (Macnee, 2003). Phenomenology values the importance of measuring meanings that individuals attach to their experiences. The key to obtaining this knowledge is to fully understand how individuals perceive and make sense of the phenomena (Maltby, et al., 2010). It reveals meanings embedded in the investigated situation and uncovers possibilities from data, rather than drawing inferences from it (Schneider, et al., 2007). A pivotal cornerstone of phenomenology is that methods in which the notion or essence of the phenomenon under study is derived from data, not presupposed or assumed (Creswell, 2013; Liamputtong, 2013; Moustakas, 1994; Morse & Richards, 2002). Two major underlying assumptions of phenomenology are firstly, perceptions present evidence of the world as ‘the lived experience’ and secondly, people are understandable only within their own context. This existential perspective is expressed as ‘being in the world’ (Morse & Richards, 2002; Schneider & Whitehead, 2013).

Creswell (2013) discusses the four philosophical perspectives of phenomenology as described by Stewart and Mickunas in 1990 as follows:

- A return to the Greek conception of philosophy as a search for wisdom.
- A philosophy without presuppositions. This suspension of all judgments about what is real is called “epoche” by Husserl.
- The intentionality of consciousness. Reality of an object being inextricably related to one’s consciousness of it.
- The refusal of the subject – object dichotomy. The reality of an object is only perceived within the meaning of the experience of the individual (pp.77-78).

Phenomenological Philosophical Underpinnings

Phenomenology as a philosophical movement has its origins in Ancient Greek philosophy. It is however, the German philosopher Husserl (1859 – 1938) who is credited as the founder of the twentieth century phenomenological movement. Husserl, a mathematician who entered philosophy later in his career, was by nature logical and very much a rationalist in the style and content of his work (Sokolowski, 2000). Husserl studied human beings as subjects in a world of objects and termed phenomenology as the study of the consciousness of those objects. He developed one of the two schools of phenomenology, that of descriptive phenomenology. Husserl's descriptive phenomenology is epistemological in nature, that is, it is concerned with what it is to 'know' the experience (Schneider & Whitehead, 2013; Schneider, et al., 2007). Modern descriptive phenomenologist Giorgi (1997), has been credited with advancing the work of Husserl by describing a method of phenomenological reduction, description and a search for essences, as the specific properties associated with a phenomenon (Morse & Richards, 2002; Sokolowski, 2000).

Heidegger (1889-1976), who was a pupil and colleague of Husserl, questioned the relationship between consciousness and objects. Heidegger, an educated philosopher from the beginning, had studied Aristotle in his teenage years and displayed a deep knowledge of philosophical history. He was adept and well versed in philosophical argument (Sokolowski, 2000). Heidegger made a great impression on the philosophical world in Germany in the 1920s. According to Sokolowski (2000), Heidegger surpassed Husserl on an academic and intellectual level. He was more concerned with the practical 'situatedness' of human experience as the most important premise. He asked the question 'how is it to be?' Heidegger diverged from Husserl's philosophical stance with an ontological perspective, which is known as interpretive phenomenology (Schneider & Whitehead, 2013; Schneider, et al., 2007) and refers to a systematic account of existence, exploring how it is to be human. According to Sokolowski (2000, p. 213), "Husserl and Heidegger formed one of the great pairs of thinkers in the history of philosophy".

Laverty (2003) presents a comprehensive account of Heideggerian phenomenology incorporating several views from as far back as the 1980s. She explains that this ontological philosophy is centred on interpretation and based on the

premise that to be human is to interpret. Laverly takes care to exemplify that background and prior experiences, termed the individual's historicity, as described by Heidegger, are integral to interpretation of every individual experience. It is clear this perspective is far more than mere description, as it goes to the heart of matter in an effort to understand how it is to be, and reaches the essence of what it is that constitutes the phenomenon under examination. Albeit in recent past history, Sokolowski (2000, p. 2), speaks of the continued value of phenomenology to modern day philosophy when he states "its intellectual capital is far from spent, and its philosophical energy is still largely unexploited".

Hermeneutics

Heidegger described hermeneutic phenomenology as an approach which provides a framework and defines a person's 'being-in-the-world'. One strategy used in the interpretive process is that of questioning data by moving from parts to the whole of the text. Moustakas (1994, p.10) explains as "hermeneutic science" the examination of text to a point that exposes the intention and meaning which lies beneath the superficial exterior. Hermeneutics defines meaning and language as inextricable entities and demonstrates how knowledge of human beings in the world is subjective, temporal and historical. Temporality is described as the understanding that life, as lived now, cannot be separated from historical and future life experiences. People come to the research encounter with a history of culture that is bound by language (Schneider, et al., 2007).

Heidegger believed that consciousness was not separate from the world, but intertwined with history and the influences that history has on the formation of present reality. He called this "historicity" and emphasised the "historicity of understanding" as one's background or situatedness in the world. He believed this culturally inherited understanding provided ways that people could understand the world (Laverly, 2003). Gadamer, in conversation with Carsten Dutt in 1993, spoke about his thesis of the connectedness, bound by the history working within them, of all knowledge and understanding. Further to this, Gadamer stated unequivocally "people who believe they have freed themselves from their 'interwovenness' into their effective history are simply mistaken" (Palmer, 2001, p. 45).

Barton (2003, p. 521) explains the hermeneutic circle, a philosophy of how humans understand experience, as “a concept derived from the Greek word ‘hermeneia’ – to express, interpret and translate”. It is this illumination of taken-for-granted assumptions which are challenged by new understanding, that van Manen (1990) called a “caring act”, because, he explained, it is the search for what is most essential to being. The hermeneutic circle was described by Heidegger (1962) as comprising the historical, cultural and personal interpretations from which human understanding is developed. Gadamer described *projecting* an enquiry or concern and then returning to the project time and again (Gadamer, 2013). It was, however, more than this to Gadamer who, in conversation with Carsten Dutt in 1993, spoke of a critical interplay between the researcher and the phenomenon under study. This movement back and forward was in essence the notion of moving in and out of the hermeneutic circle (Palmer, 2001). This is not a static thing, it is essentially dynamic and ever changing, as the assumptions once challenged, become new understandings that are further challenged (Schneider & Whitehead, 2013). Given the history and culture that people bring to phenomenological research, which is bound by language, the fluidity of the process of moving in and out of the hermeneutic circle becomes evident. As different patterns emerge, these are articulated in a shared hermeneutic language (Schneider, et al., 2007).

Gadamer is credited as the person primarily associated with phenomenological hermeneutics; being both a student of Heidegger and a learned philosopher, he is noted for his erudite interpretations of Plato, Aristotle and poetic texts (Sokolowski, 2000). In 1976 he expanded on Heidegger’s concept of the hermeneutic circle by suggesting that the realisation of self occurs in the circle of understanding and is integral to the setting, blending and identification of explored horizons (Schneider & Whitehead, 2013; Schneider, et al., 2007). Hermeneutics has evolved to such a uniquely interpretive form of phenomenology that van Manen (1990), an international authority on interpretive phenomenology explains how hermeneutics is often seen to be synonymous with the interpretive, whereas phenomenology is used in relation to descriptive function.

Moustakas (1994) an expert in descriptive phenomenology and a contemporary of van Manen, described heuristic phenomenology. This form of descriptive phenomenology is autobiographical in design and unfolds as the

researcher is placed central to the study, seeking to understand the self within the lived world. As the researcher in the present study is not a Noongar woman, an autobiographical approach was not considered appropriate in which case Gadamer's approach incorporating the hermeneutic circle appeared to provide the best fit, in order to inform, contextualise and shape the present study.

Research Assumptions

Axiological assumptions are values and apriori understandings that the researcher brings to the study (Creswell, 2013). It is only through suspending ones prior knowledge, understanding and experience of the phenomenon that the lived experience can be studied (Van Manen, 1990). This includes the taken-for-granted, everyday understandings that the researcher will hold. A process of phenomenological reduction was undertaken by the researcher of the present study. A detailed description of this process is presented later in this chapter.

Ontological assumptions are based on subjective reports of multiple realities of participants, in that each participant views their experience differently (Creswell, 2013). It is by interpreting the multiple realities of participants that the researcher comes to understand how it is to be a Noongar woman experiencing birth. Further to this, experiential accounts or lived experiences 'given' to the researcher, whether oral or written, are never identical to life itself, as all data are already transformations of those experiences (Van Manen, 1990).

Epistemological assumptions are that the lived experience can only be understood in context. The researcher of the present study gathered data by interviewing women and creating memos of interpretations and observations. Interviews were conducted in the homes of participants, in homes of friends and on the premises of Aboriginal medical centres. Subjective evidence is assembled, based on individual views gathered where possible in the world of the individual participant (Creswell, 2013). By extension it is impossible to generalise findings, rather, insights may be considered by readers to have the potential to be transferable to other populations or contexts.

Methodological assumptions are of a study that is "inductive, emerging and shaped by the researcher collecting and analysing the data" (Creswell, 2013, p. 22).

The process of gathering data is responsive to unfolding avenues of enquiry gained through reflection on data collected (Van Manen, 1990). That is, the researcher proceeded in the research by analysing data to develop an increasingly detailed knowledge of the phenomenon of interest.

Methodological ‘Fit’

The present study explores the lived experience and common themes of Noongar women who have given birth within the previous 2 years. In order to provide a relatively homogenous group, without imposing constraints on the recruiting process, participants were required to have given birth to a live, singleton baby, in a public hospital, within the past two years. The researcher with an underlying philosophical stance that is ontological, as described by Heidegger, sought to discover what living this experience means to Noongar women. Historicity as described by Heidegger (1962) and Gadamer’s thesis of the connectedness of history and culture with knowledge and understanding (Palmer, 2001), are considered by the researcher to demonstrate synchronicity with Aboriginal values.

The understanding that the present and the future are absolutely bound up in the past, which cannot be separated from each other, is a fundamental value of spirit and integrity so important to Aboriginal identity (National Health and Medical Research Council [NHMRC], 2003). This compatibility of values is seen to be a fit for purpose between the focus of this study and the chosen methodology.

The Essence

The search for the essence of the experience of birthing for a Noongar woman was the purpose of this research. That is, to go further and deeper than a description of events, which is essentially achieved at arm’s length, was to understand the phenomenon from within, to grasp the essence of the experience. This could only be achieved by using an ontological paradigm, which enabled an understanding of how it is *to be that woman*. The researcher could only achieve such deep and rich knowledge by hearing the voice of Noongar women who have given birth and interpreting their stories. Insight into an essence, Sokolowski (2000) calls eidetic

intuition. He elucidates the *eidos* to be the defining quality of the phenomenon, that which sets it apart from all others and without which the phenomenon would simply cease to be.

The interpretive nature of this methodology takes the researcher from identifying similarities in participant's experiences, to identifying qualities that all participants share, to finally arriving at eidetic universals – that is to identify parts of the experience without which the experience would not be possible. This final stage of interpretation, Sokolowski (2000) describes as moving from perception to imagination. Moreover he expounds, if one could imagine a given quality being absent from the experience, the result of this absence is that the experience could never be. Without essential form or quality this experience would cease to be, because the form or quality is the essence of the experience. Sokolowski (2000, p.178) clarifies this point by explaining that "we strive to reach a feature that it would be inconceivable for the thing to be without".

In order to arrive at the essence of the phenomenon, a process of phenomenological reduction is applied to data generated from analysed text. That is, a process or "phenomenological device" is employed; enabling understanding of the essential structure of the phenomenon (Van Manen, 1990, p. 185). In this way, overcoming private inclinations toward the phenomenon, stripping away scientific conceptions and finally viewing the phenomenon in a universal way is possible, such that the essence of what makes it so, can be distilled (Van Manen, 1990). In this way, meanings of the phenomenon embedded in language, are explicated. As inherent within Heideggerian hermeneutics, this process of interpretation of data reveals meaning and when analysed with other data sources, such as researcher's field notes and journals, results in richness of data.

used artistic philological-historical works as a starting point for his hermeneutic studies. He found these provided a "shake up of fixed presuppositions", which then made scientific exploration and new lines of enquiry possible (Gadamer, 1976, p. 39). These various data sources give richness to the interpretive process, enabling the author to achieve reflexivity throughout the study, a quality described as essential by Creswell (2013). It is by bringing the researchers own interpretation and understanding to the project that Gadamer's concept of the hermeneutic circle can

facilitate the interpretive process, so that the essence of ‘how it is to be’ the women who have lived this experience is uncovered (Schneider & Whitehead, 2013; Schneider, et al., 2007).

Gadamer (1976, p.11) warns against what he terms “methodological sterility”; this being the application of a methodology to something that is of dubious value or disingenuous pursuit. This warning redoubles the importance of the development of essences of experiences, which are not merely explanation or analyses, but are faithful to the lived experience of Noongar women.

The search for the essence of the phenomenon is integral to the present research and has methodological and ideological congruence with the value statement for ethical conduct in Aboriginal and Torres Strait Islander health research, which warns against difference blindness (National Health and Medical Research Council [NHMRC], 2003). The uniqueness of the lived experience of birthing for Noongar women is honoured by the processes of hermeneutic reflection and reduction, thus preserving intercultural difference and in so doing, demonstrating respect for Aboriginal and Torres Strait Islander cultural values and principles (National Health and Medical Research Council [NHMRC], 2003).

Phenomenological Reflection

The holistic nature of this methodology is a reflection from today’s perspective and focuses on the perception of the participant being present in the world at the time of the phenomena occurring. It may be asserted that the four guides to phenomenological reflection as described by Morse and Richards (2002), could be conceptualized as ‘the what, where, when and with whom’, of the phenomena. These are integral parts of the whole and provide richness of data in the form of context, breadth and depth. The descriptors may add clarity and are indicated as additions to Morse and Richards’ (2002) work as follows. The four guides to reflection are *corporeality* (lived body) [what]; *temporality* (lived time) [when]; *spatiality* (lived space) [where] and *relationality or communality* (lived human relation) [with whom]. It may therefore be asserted that the researcher is charged with the responsibility to extract meaning from data which is faithful to participant experience and therefore goes to the heart of the matter.

Hence it becomes axiomatic, so that in order to achieve such clarity, reflection which is cognisant of bias, prejudgements and researcher historicity, is vital. In this way, the researcher is aware of how personal ideological heritage can impact the interpretive process. Only by understanding and then identifying these potential influences, is the researcher able to set aside these perceptual distortions to freely work with data. The wisdom of Gadamer (1976, p.38) is demonstrated explaining hermeneutic reflection, where he asserts it is the only manner in which “I learn to gain an understanding of what I have seen through eyes conditioned by prejudice”.

Hermeneutics was regarded as the most appropriate methodology for the present study as it assumes that a life lived cannot be separated from past history and future possibilities (Schneider & Whitehead, 2013; Schneider, et al., 2007). This sense of continuity over time is congruent with Aboriginal culture and has been described as an overarching bond that sustains the values of spirit and integrity (National Health and Medical Research Council [NHMRC], 2003). Aboriginal and Torres Strait Islander communities have been identified as having difficulties maintaining cultural markers that help maintain a sense of boundary between their community and the wider culture (de Souza & Rymarz, 2007). Further to this they cite one example of a cultural marker as the key life event of birth. In direct contrast to the majority of healthcare initiatives for Aboriginal people, which are implemented and directed from the outsiders gaze (Sonn, 2004), the current study sought to understand how it is to be that woman; to explore intricacies of the lived experience.

Rather than using a method constrained by a structured process of steps, the methodology of hermeneutics suggests a more flexible structure where the researcher is led by the participant and is responsive to unfolding directions in a search for the essence of the lived experience (Laverty, 2003). Hermeneutics therefore, was considered to be the best methodological ‘fit’ for the purpose of discovering meaning embedded in language and as a means to revealing the essence of how it is to be a Noongar woman giving birth.

Differing Phenomenological Perspectives

Diametrically opposed to hermeneutics, is descriptive phenomenology where the researcher must describe the situation at hand and place brackets around personal preconceived notions or judgements in order to suspend belief in the area being studied. Bracketing is carried out so that a more precise and truthful description of the phenomena may be developed. This process, often described as phenomenological reduction or bracketing, was developed by Husserl in an effort to successfully get to the essence of the phenomena being studied. He believed true clarity of the phenomena could not be achieved without the suspension of personal beliefs and biases through bracketing (Lavery, 2003). This epistemological paradigm could be described as “situational” and the bracketing which is required in descriptive phenomenology could be likened to “propositional reflection” as described by Sokolowski (2000 p.193).

Differences in phenomenological perspective can therefore be summarised as propositional versus philosophical (Sokolowski, 2000), an extension of what may be epistemological versus ontological and descriptive versus interpretive. The phenomenological perspective of this study is philosophical, the methodology ontological and interpretive. The aim of the present study was not to formulate a description from an outsider’s gaze, but rather to develop the meaning or essence of the experience, gained from interpretation of the stories of Noongar women about their lived experience of having a baby in the last two years.

Researcher’s Position within the Study

It is suggested that a vital part of conducting research with Aboriginal and Torres Strait Islander groups who have been subject to long term effects of colonisation, is for non-Indigenous researchers to acknowledge the power base implicit in their membership of a different cultural group. This is consistent with Morgan and Drew (2010, p. 256) who speak of “relinquishing (or at least confronting) the disabling impact of whiteness”. This recognition of an existing power differential can enable understanding of the “pervasive, transgenerational impact of colonisation on the Aboriginal and Torres Strait Islander individual, family and community health” (Walker & Sonn, 2010, p. 158). This does not suggest that

the cultural rootedness of the researcher is undermined, rather it provides a strategy for reframing and reworking socialized ways of knowing; enabling “research and change activities and processes that are vigilant to issues of power and ideologies of colonisation” (Sonn, 2004. p.311). Seeking to understand how cultural imbalances affect individual participants is no longer sufficient, as Walker and Sonn (2010 p.163) assert, “emphasis [must] be placed on understanding the self in the midst of unbalanced power relationships”.

The researcher is acutely aware of the responsibility to preserve a culturally safe space when interacting with participants. Acknowledging this need and in an effort to provide such an environment, the researcher instigated several strategies. This began with the researcher performing a ‘self interview’; a technique where biases, prejudices and personal history and connection with Aboriginal people were named and explored in a recorded ‘interview’. This was then transcribed and reflected upon, then subjected to peer review, so that the researcher was able to approach the interview process with a greater sense of cultural awareness and sensitivity.

As hermeneutics is ontological and interpretive, it positions the researcher as an instrument of analysis within the study. Therefore, the researcher will inevitably impose a part of the self on the research process. It encumbered the researcher to constantly identify attitudes and presuppositions about the phenomenon, endeavouring to suspend these feelings and beliefs, so that interpretation and analysis of data could be approached in a naïve, uncoloured and fresh manner. The hermeneutic circle remains a most powerful tool with which to exercise repeated attempts at critical understanding, in order to gain critical awareness of prejudices and correct them in effort to hear what the text has to say. This “critical self-consciousness of the interpreter provided ongoing awareness of the continuing power of effective history” throughout the research process (Linge, 1976, p. xviii).

This ‘self’ encompasses and is encompassed by the world view of the phenomenon. The ‘self-interview’, a strategy employed by the researcher served as a means of philosophical clarification, aiding the ontological interpretive process. The researcher therefore came to the study with a life lived and filled with experiences that have shaped that life. It may be asserted that such self-interview closely

resembles the philosophical reflection described by Sokolowski (2000), which is “more purely contemplative, more purely detached” than bracketing used in descriptive phenomenology (p. 190). This exploration of one’s own philosophical stance, attitudes, understandings, biases and perceptions could equally be likened to the ‘epoche’ described by Moustakas (1994, p.33), in which efforts are made to revisit phenomena “freshly, naively, in a wide open sense, from a vantage point of a pure or transcendental ego”.

Below is an excerpt from the transcription of the self-interview conducted prior to the commencement of the present study:

I don't doubt that when they have their babies, they are as delighted as anyone else, and irrespective of where they have their babies and the conditions that surround that, I think that they're just as happy and delighted to be a mother as any other mother. Being a Midwife myself and having been at the birth of many of Aboriginal women, that's my observation; but, of course, that's an observation from the outside, because it can't be an observation from the inside because I'm not an Aboriginal woman. So, I'll be really keen to hear what they say. I think they will say that, at the time of birth, they were delighted and that it was a time of great happiness.

I think after the birth, they will wish they could have lots and lots of people around and in most labour wards, the numbers [of visitors] are restricted and so, I guess, they will feel they miss out in this respect because culturally, there would be lots of people at the birth of an Aboriginal baby.

I think the women may feel embarrassed that it's not their place – this hospital -- and that maybe they feel a little bit powerless; maybe they will feel as though they can't really speak up and say what they want because it's really not their place. The power of place is huge, and the fact that they're in a white man's place, might make a difference.

Contextualising Researcher Assumptions

As mentioned previously, the axiological assumption of qualitative research is that all researchers bring personal values to a study. In phenomenology, opinions vary about precisely how the researcher can achieve a state of freshness and naivety when approaching the study and interpretation of any lived experience. In descriptive phenomenology bracketing or identification of one’s epoche is advised. These processes require the researcher to identify and set aside past held biases, opinions and tacit knowledge (Moustakas 1994). Proponents of hermeneutics use a

phenomenological device known as reduction, in which the researcher's focus is reduced by overcoming subjective inclinations and stripping away scientific theories, in order to gaze afresh in wonder at the phenomenon (Van Manen, 1990).

It is imperative therefore, that the researcher identified influences that constituted pre-knowledge and pre-understandings of the phenomenon under study. This is important because these *taken-for-granted* attitudes of everyday life can prevent understanding in an *ontic* sense; that which constitutes the meaning of the lived experience. Van Manen (1990, p.46) explains that it is this everyday knowledge which “predisposes us to interpret the nature of the phenomenon before we have even come to grips with the significance of the phenomenological question”. The aim of this reflective process was to endeavour to come to terms with, and set aside, existent assumptions accumulated by exposure to the external world that shape knowledge, experience, beliefs and values. Resolute reflection of this nature was a means by which the researcher in the present study was able to achieve an uncoloured or pure engagement with the research process.

Van Manen (1990, p. 185) describes the end point of phenomenological reduction as facilitating the researcher to “be able to return to the world as lived in an enriched and deepened fashion”. The researcher of the present study experienced as personally transformative, exposure of the shallow or concealing character of long held tacit assumptions and knowledge. This heightened awareness enabled the researcher to more ably enter the interpretive process, confident that faithfulness to data was achievable.

It should be stated that the researcher of the present study was Australian born in the mid-twentieth century. Having parents and grandparents who were Australian, the researcher is faced with the inevitability of trans-generational influence on her tacit knowledge and understandings of Aboriginal people. This is not to blame nor disrespect her forbearers, for they were people of the time when political awareness, beliefs, attitudes and ideologies of the dominant Anglo-Saxon society prevailed. In their day, politically driven initiatives were accepted and normalised by a population, it would seem, who were not as accustomed to social dissent and outcry as present day society. Policies and actions such as the *Western Australian Aborigines Act of 1905*, the *White-Australia policy* and the *Stolen*

Generation had an insidious and silent influence on the formation of future generations of non-Indigenous Australians.

The researcher is confronted with the fact that she was educated with girls who may have been 'stolen', known only as Aboriginal girls from the north that lived in the nearby mission. Forcible removal of Aboriginal children continued to occur for various reasons until the 1980's according to Dudgeon, Wright, Paradies, Garvey and Walker (2010, p. 32). The researcher had lived in close companion with shameful history in the making and was ignorant of the fact. Australia as a nation, at least on the surface it would seem, was and continues to be, in denial. It seems as unconscionable that at no time in the researcher's school years was any lesson given on the history of Australian Aboriginal people; rather history taught was English history.

For almost three decades the researcher worked as a professional nurse and midwife, for the most part, in Western Australia caring for a wide cross section of people within society, including Aboriginal people. Unidentified biases and prejudicial behaviours towards Aboriginal people, though subtle and not malicious, were normalised. In the course of this active phenomenological reflection with specific intention to explicate assumptions and understandings, the researcher was faced with her own sense of place and time within a dominant culture which oppressed the rights of Aboriginal people.

It is only in recent times that membership of the dominant society with its privilege, wealth, opportunities and advantage has been internalised by the researcher. Damaging dialogic behaviours associated with cultural hegemony, including racial positioning influenced by whiteness, resonated when studying social and cultural constructs such as *othering and de-othering* (Taylor & Guerin, 2010, p. 178). Examples of naive attitudes included 'I am-you are' categorisation focused interactions; unquestioned assumptions that white, dominant society is the group against which all others are measured; as well as the stereotypical categorisation of non-problematized Aboriginality as being a medical risk factor.

This reflection by the researcher took the form of an initial awakening followed by ongoing reflection and introspection. Attitudes and behavioural changes resulted from a process of acknowledging and reframing long held tacit knowledge

and assumptions. The experience, though formational and therefore positive, was profoundly humbling.

Encumbered, the researcher needed to set aside half a century of postcolonial attitudes and understandings that were tempered by recent exposure to literature about Aboriginal culture and history. It was important to obtain a sense of context for the present study and a fresh and open-minded perspective when engaging with gathering, analysing and synthesising research data.

Racial Positioning and Identity Awareness

It may be seen as paradoxical that identity awareness resulting from critical reflection on colonisation, could result in healthcare professionals viewing their role as a part of the problem rather than the solution. To this end Eckermann et al., (2010) posit that as healthcare professionals are generally those that define the cause of illness, they stand outside of the problem to objectively identify it, because they see themselves as part of the solution. It was therefore both enlightening and confronting for the researcher in this study, to reframe the situation by taking ownership of the power that inheres within healthcare practice, realising that professional roles can indeed be a part of the problem.

Chadderton (2012, p. 364) identifies “destabilizing white supremacy”, as a contribution to society that non-Indigenous researchers in countries that have been colonized, can make. She claims that in countries where systems of oppression and structures of supremacy prevail, all members of that society, knowingly or otherwise, are positioned within those deeply engrained pervasive and normalising structures. Wilson (2011) in her doctoral thesis entitled *Addressing Uncomfortable Issues: The role of White health professionals in Aboriginal health*, supports this concept and reports the need to identify her whiteness and the impact this had on her research with Australian Aboriginal participants. Her study, set in rural and remote South Australia, explored the practice of white health professionals from the point of view of Aboriginal and white workers.

The role of the white researcher in destabilising white supremacy in cultural groups that have experienced colonisation, has been reported in terms such as *challenging, messy and frustrating* (Chadderton, 2012). The obstacles are not always

confined to the research target group, as experienced by Chadderton in her ethnographic study of minority ethnic pupils' experiences in two secondary schools in England. She found access to participants problematic and only possible after multiple contacts with schools. These contacts often required different approaches to gain access, which often needed to be renegotiated with each subsequent visit to the same school. Indeed, arrangements were often cancelled or postponed.

Different strategies have been employed to gain access to Indigenous groups by non-Indigenous researchers. The most commonly successful method described in the literature, is to work with Indigenous researchers or communities (Kornelsen, Kotaska, Waterfall, Willie, & Wilson, 2010; Kruske, Belton, Wardaguga, & Narjic, 2012). When this is not possible, a creative approach to provide a power sharing model can be employed. Salmon (2007) studied Aboriginal women in Vancouver Canada who experienced substance use during pregnancy, resulting in adverse foetal effects. She described difficulty in locating and inviting women to participate in her study as "exceptionally challenging" (p.984). Salmon became acquainted with a well known Aboriginal community leader and activist with whom she ultimately worked and this helped to facilitate introductions to participants.

Inspiration was drawn from these examples and implemented into the present study. Drawing on the initiative employed by Salmon (2007), approaching professionals working with Aboriginal childbearing women was considered. This was achieved in two ways; health professionals working at urban health centres were approached and an Aboriginal manager of a regional Aboriginal Medical Centre was contacted. Both of these strategies were effective in recruiting participants.

Research by Kornelsen et al., (2010), provided the impetus to form an Aboriginal Women's Reference Group, which proved pivotal to the success of the present study, adding a level of cultural rigour considered by the researcher to be otherwise unachievable. This group worked with the researcher throughout the study. Greater detail of the composition and rationale for this group is addressed in the following section.

Accordingly the researcher was vigilant throughout the data collection phase of the research and conscious efforts to minimize the cultural historical power differential were implemented. Techniques such as developing rapport, heightened

awareness of body language at interview, style and structure of generating conversation and use of sensitive listening were employed. The researcher endeavoured to develop appropriate practices and intervention strategies that took into account participant's historical, cultural and environmental context.

As neither the researcher nor either of the supervisors in the present research project is an Aboriginal or Torres Strait Islander person, it was identified at the outset of the study that several layers of support were needed to provide assurance of cultural propriety. These strategies were discussed with the Aboriginal Women's Reference Group who, as cultural guides for this research, provided wise counsel and advice. Both supervisors and the researcher met with the Aboriginal Women's Reference Group regularly throughout the study. This was an ongoing process and provided a high degree of confidence for the researcher to employ critical reflexivity in the study, through informed changes that improved interaction with participants. Additionally, semi-structured self-recorded reflective memos were used to develop practices that enhanced participant's individual cultural identity and empowered and promoted individual wellbeing. See Appendix E

Aboriginal Women's Reference Group

As previously stated, in seeking cultural brokerage with professional Aboriginal women, an Aboriginal Women's Reference Group was considered an appropriate way to garner necessary cultural wisdom. At the initial meeting of the Aboriginal Women's Reference Group the researcher presented the research aims and purpose, discussed the proposed method of data collection and de-colonising strategies. Members of the Group asked questions and offered suggestions. At this meeting all members confirmed their support of the research project. Further to this, members provided a signed letter of support (Appendix A) for the project stating in part that they believed the proposed research would help protect Noongar culture and identity from erosion. The formation of this group, convened for the life of the study to ensure cultural appropriateness, was inspired by the work of previous non-Indigenous researchers both nationally and internationally. Non-Indigenous Australian researchers Vicary and Bishop (2005), who explored ways to engage Aboriginal people in culturally appropriate and respectful ways, formed an Aboriginal steering group to monitor and review cultural practices of the study.

Additionally, non-Indigenous interviewers in that study were accompanied by cultural consultants to ensure data were collected in a culturally appropriate, sensitive and relevant manner. Similarly Kornelsen et al., in (2010), whilst researching Canadian First Nations women's experiences of birthing, ensured culturally appropriate practices and procedures. The primary researcher, herself non-Indigenous, used a participatory research approach. In this way, Kornelsen was guided by a community research advisory committee, comprised largely of Indigenous Canadian members, who ensured the needs and concerns of their community were upheld.

The purpose of establishing the Aboriginal Women's Reference Group, in the present study, was to provide cultural advice and reassurance to the researcher and supervisors. This advice was especially valuable in areas requiring cultural perception such as interpretation of cultural colloquialisms. Additionally, the Aboriginal Women's Reference Group ensured cultural mores were identified and aided in developing strategies where participants felt respected with interaction that honoured their unique experiences in a culturally sensitive manner. As the researcher is non-Aboriginal, this cultural perspective was invaluable in providing strength and rigour to the study.

Honoraria of \$100 per meeting were provided to members of the group to compensate in some small way for time and travel. This acknowledgement did not in any way represent the value added to the project that member's wisdom and experience provided. All members held demanding fulltime occupations and the researcher gratefully acknowledged and appreciated members tolerating the inconvenience caused by these meetings in order to assist in knowledge generation through the present study.

Several gatherings of Aboriginal health professionals were visited in preparation for the study; these included an open meeting of Aboriginal and Torres Strait Islander Sids n Kids (Sids is an acronym for Sudden Infant Death Syndrome and Kids is a colloquialism for children often used in Australia), and a Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN). Professional contacts were accessed by the researcher of colleagues who were actively engaged in Aboriginal maternal and child health. In this way, invitations to celebrations of Aboriginal

health achievements were extended to the researcher and at these events, new contacts were established. Dialogue about the proposed study was undertaken in an attempt to gauge perceived appropriateness and value of the study to Aboriginal people. Female Aboriginal elders expressed interest in the proposed study and gave encouragement to the researcher.

Application by the researcher was made to CATSIN to present an outline of the proposed research. The researcher considered the opportunity to expose her study outline and process to an Aboriginal and Torres Strait Islander audience, to be a valuable opportunity to receive feedback and advice from professionals within the culture. This presentation was received with mixed reviews. Concerns were raised by Aboriginal and Torres Strait Islander health professionals in the audience, about the ability of the researcher to accurately interpret data given the researcher and both supervisors are non-Indigenous. These concerns resounded in accordance with Moustakas (1994) who cautions that “we must not lose sight of the fact that a person [researcher] is present in perception, someone who perceives what is given [and] enters into an encounter with it” (p.71).

Given these concerns, additional efforts and strategies to ensure correct interpretation and faithful reporting and analysis of data were implemented. This was achieved by members of the Aboriginal Women’s Reference Group participating in a review of the analysis of primary data development as codes were extracted from participant transcripts. Additional one- on- one analyses of data in later stages of the research were also undertaken with individual members of the Aboriginal Women’s Reference Group. Presentations of progress of the study and preliminary findings were presented to the Aboriginal Women’s Reference Group and round table discussions that followed provided further insight and context to data analysis. The final meeting of the Aboriginal Women’s Reference Group culminated in a presentation of research findings. This method of collaboration could be seen as synergistic to that of participant participation in data analysis viewed by Creswell (2013) as a way to further de-emphasise a power relationship (p.48).

The group comprised of three Aboriginal women who are accomplished community leaders. A brief outline of their unique attributes enabling valuable contribution to the study is presented below:

- Community representative - a mother and grandmother, also works as an economic development officer for Aboriginal Australians was able to give intergenerational advice on the Noongar woman's birth experience. Many years of work in Aboriginal and Torres Strait Islander business activities contributed to the wisdom and worldliness of this member who has been interfacing with government agencies, businesses and Aboriginal and Torres Strait Islander clients in a professional manner for many years;
- University academic in Aboriginal studies – has worked in several of the Universities in Western Australia. Having conducted her own doctoral study using an Aboriginal methodology and supervised higher degree studies, this member is acutely aware of the processes and challenges specific to research of Aboriginal and Torres Strait Islander peoples in Western Australia;
- Program Coordinator of an Aboriginal College – this member provided a deep understanding of the unique issues important to Aboriginal youth and was able to provide advice and expert knowledge of communication skills to which young Aboriginal adults respond. As the target group of the present study was Noongar women of childbearing age, advanced communication skills and knowledge of the unique concerns of this group proved most valuable. Meetings were scheduled on a regular basis and at various times, the Group consulted with other informants for advice on a need-basis.

The Aboriginal Women's Reference Group was consulted from the early preparatory phase of the study and continued to provide strong support throughout. During the proposal preparation and prior to interviewing participants, the group ensured questions were appropriate and advised the researcher on techniques that would be particularly helpful when interviewing Noongar women. It was agreed that with the consent of participants, a member of the Aboriginal Women's Reference Group would accompany the researcher during initial interviews. This practice is in line with other published research by non-Indigenous researchers who were accompanied by a cultural consultant during the interview process for various reasons, such as validation of interpretation of data (Vicary & Bishop, 2005). This,

however, proved unnecessary in the present study. The willingness of the members of the Aboriginal Women's Reference group to collaborate with, instruct and support the researcher in all phases of the study was ever present and greatly valued.

Implementation of this power-sharing model enabled the researcher to seek guidance and meaningful input from Aboriginal women who are community leaders. The researcher constantly made a concerted effort to minimize and neutralize any potential power differential that might exist between interviewer and participant in order to provide culturally secure interview environments where women felt respected and their stories honoured.

Researching the Vulnerable

Vulnerable populations have been described as those with diminished ability to protect their own interests (Grady, 2009), who have a lower degree of control over their own circumstances (Liamputtong, 2013), often being rendered mute and overshadowed by more powerful groups (Taylor & Guerin, 2010). Even though vulnerability is a social construct and thus difficult to define (Liamputtong, 2013), certain groups have an increased risk of being subjugated or harmed in research (Grady, 2009).

Aboriginal and Torres Strait Island peoples' disadvantage has been evident over approximately 200 years (Pholi, Black, & Richards, 2009). A vast amount of atrocities have been reported in that time, including massacres (Schlunke, 2001) and forcible removal of children from parents (Petchkovsky, San Roque, Napaljarri Jurra, & Butler, 2004). Given vulnerability, including current rates of family violence in Aboriginal and Torres Strait Islander society, has successfully been linked to events associated with the colonisation of their lands (Atkinson, et al., 2010), it is clear that disadvantage is not contained in the past. Persistent prejudice of mainstream society (Rickwood, et al., 2010) and inequalities of power and resource distribution (Tsey, et al., 2007) continue to perpetuate powerlessness and disenfranchisement of Aboriginal and Torres Strait Islander populations.

The crux of the problem when involving vulnerable populations in research; is a power imbalance, according to Le May and Holmes (2010), who place the researcher in a position of power over the participant. They warn that participants of

vulnerable populations may not fully understand the research, its aims, implications, their role within it or how the findings will be used. Further to this, the vulnerable participant may not be able to confidently articulate their view, or opinion, or question the research benefit. Consequently it is the responsibility of the researcher to instigate strategies affording protection against abuse, discrimination and exploitation (Le May & Holmes, 2012).

The interview method of data collection, so often used in qualitative studies aims to know and understand experiences of the participant as interpreted by them (Suarez-Ortega, 2013). This form of data collection can be extended to “research topic yarning” described by Bessarab and Ng’andu (2010, p. 40), in which the exchange is relaxed and interactive, yet purposeful; intending to obtain information relating to the research question. The gentle egalitarian “chat style” of interview has been described as positively influencing production of a rich source of information (Watson, et al., 2002, p. 155).

In stark contrast, the power differential and therefore the risk, is highlighted and termed the “asymmetrical power relation of the interview” by Kvale (2006, p. 483), as he scathingly drives home the point that “in contrast to the mutuality of dialogue, in an interview, one part seeks understanding and the other part serves as a means for the interviewer’s knowledge interest” (p.483).

It is for these reasons that research of vulnerable populations must not only be very carefully considered, but subject to ethical scrutiny of the highest order (Maltby, et al., 2010). The welfare of participants is of utmost importance and they should be treated with special sensitivity (Habibis, 2006) ensuring protection, consent and benefit to the individual.

Enormous impacts sustained over the past 200 years as a result of colonisation, have impacted upon and shaped contemporary Aboriginal and Torres Strait Islander cultures and societies. Judged from an ethnocentric viewpoint, non-Indigenous Australia, both politically and publically, supported change in the form of Aboriginal and Torres Strait Islander peoples’ disconnection from history and culture (National Health and Medical Research Council [NHMRC], 2003). By the mid 1990s however, recognition arose of the need for a fair and respectful way forward, one that acknowledges the values and cultures of Aboriginal and Torres Strait

Islander peoples (Habibis, 2006). As a result of community consultation the National Health and Medical Research Council developed a set of guidelines to ensue ethical relationships between Aboriginal and Torres Strait Islander peoples and the research community (National Health and Medical Research Council [NHMRC], 2003). These guidelines were endorsed by the Council in 2003 and provide guidance to researchers, Higher Research Ethics Committees (HRECs), including Aboriginal specific HRECs and sub committees (National Health and Medical Research Council [NHMRC], 2003). These guidelines formed a basis for construction of ethical research methodology in the present study. The six values that lie at the heart of these guidelines and the way in which these were applied to and integrated within the present study are explained in the following section.

Conclusion

In this chapter the methodological underpinnings of qualitative research, phenomenology and hermeneutics have been discussed. Transparency of methodological fit has been demonstrated and the depth of the interpretive process which leads to uncovering the essence of the experience was explored. Consideration of contemporary Aboriginal reality against the backdrop of a history of colonisation has been explored; exposing its interconnection to all aspects of the study. The researcher's position in the study has been clarified with an evolving cultural consciousness throughout the research process being shared. The following chapter addresses the methods and processes used in the study to produce data.

CHAPTER 4: METHODS

Introduction

The intent of this chapter is to provide a detailed report of the methods used in the study to produce data prior to systematic analysis. To begin with, ethical considerations and process of recruiting participants, including cultural observances, guidance and governance used when gathering data have been detailed. This is followed by an explanation of the challenges and difficulties that were experienced when accessing and recruiting participants. Interview considerations and technique are then explicated, after which data collection processes are exhaustively discussed. Finally, an overview of the sequential process that were utilised during phenomenological analysis, including discussion of rigour, robustness and cultural inclusivity, provides a platform for the findings in Chapter 5.

Ethical Considerations

Ethical considerations in any research project encapsulate the degree to which the study abides by, and is accountable to, professional, legal and social moral standards and values (Cluett & Bluff, 2006). The present study, conducted at the cultural interface, encumbered the non-Indigenous researcher to ensure no harm was caused to Noongar women in the conduct of the research procedure. To this end, every effort was made to ensure cultural propriety and conformity throughout the study. Strategies implemented to ensure culturally congruent practices in this research study, as previously explained, are discussed further within this chapter.

Conduct of the Study

Permission to conduct this study was obtained from the Western Australian Aboriginal Health Information Ethics Committee (WAAHIEC) and The University of Notre Dame Australia, Human Research Ethics Committee (HREC). Approval by the University's HREC would only be considered following full WAAHIEC ethics clearance. The Noongar community is acknowledged as a vulnerable population and consequently the research study, considered to be high risk, was required to meet strict parameters in order to gain approval. Both ethics applications were granted on initial application, following submission of a detailed research proposal.

Integration and Application of the Six Values

The researcher was guided in all matters concerning provision of safeguards to protect the rights and welfare of participants in this study, who were considered vulnerable by the Commonwealth of Australia publication: Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research (National Health and Medical Research Council [NHMRC], 2003). The six values that lie at the heart of these guidelines; Spirit and Integrity, Reciprocity, Respect, Equality, Survival and Protection and Responsibility, are the framework upon which this study sits and are referred to both implicitly and explicitly throughout this thesis. In order to demonstrate how the application of each of the six values is achieved throughout the study, an example of each of the six values in terms of how these apply to the present study has been articulated below.

The Aboriginal Women's Reference Group enabled the researcher to implement a collaborative and power sharing model of research that preserved the cultural integrity of the study, ensured continuity between past, present and future generations, and upheld the *value of spirit and integrity* of Aboriginal culture over time.

Once the essence of 'how it is to be a Noongar woman who has given birth' was captured and recorded, this knowledge formed a basis for translation into professional healthcare practice enabling midwives, doctors and policy planners to provide more appropriate care to childbearing Noongar women. This is an example of the *value of reciprocity* where the Noongar community benefits from research outcomes.

Valuable guidance from the Aboriginal Women's Reference Group enabled the researcher to demonstrate and reinforce dignity and respect to Noongar women, promoting the development of trust. Importantly this group contributed to elimination of 'difference blindness' wherein the uniqueness of Aboriginal people is celebrated. The purpose of the study was to understand and value Noongar women's experience and wisdom around birthing as authoritative knowledge. This *value of respect* for Noongar women's wisdom acknowledges the individual and collective contribution of Noongar women in this process.

The existing gap in the knowledge of Aboriginal birthing experiences severely limits the ability of healthcare professionals to establish culturally appropriate and more effective care for Aboriginal and Torres Strait Islander women throughout pregnancy and childbirth. Such *inequality* violates the fundamental dignity of humanity. Therefore the present study positively contributes to the knowledge base of Aboriginal birthing.

Participants were assured that their stories belong to them. These stories contribute to the survival and protection of Noongar cultural identity in that participants are acknowledged in this thesis as owning their stories and holding authoritative knowledge about their birth. Record of this study will be held at the University of Notre Dame Australia Research Online thesis repository and as such, is preserved for public access as an aspect of Noongar culture. The *value of survival and protection of culture* is honoured and respected throughout this study.

It is the opinion of the Aboriginal Women's Reference Group that this project will contribute to protecting Noongar culture and identity within the context of childbirth, from erosion. This statement speaks strongly to the Aboriginal value of survival and protection of culture.

Strategies implemented in this study facilitated the development of rapport and engagement with Noongar women, which was none-the-less challenging. Initial participants in the study were accessed by third party introduction and this 'lead in' method provided a pathway to gain acceptance and trust from the outset. This method of introduction and initial engagement from within the community is in keeping with the *value of responsibility* and collectivism of Aboriginal culture, in which members of the group look out for and assist each other.

Self-determination and Ownership

All participants were informed that their involvement in this study was purely voluntary and no coercion or persuasion from any person would occur. Participants were advised that they could withdraw from the study at any time and without prejudice, or any expectation to explain their decision. Assurance was given that all communication with participants would be conducted with discretion and in private.

Participants were assured that their unique stories would be honoured and their wishes with regard to the progress of the interview upheld without delay.

Consent and Confidentiality

An information letter was provided to all participants (Appendix B); this was written in plain English with no use of jargon. A signed consent form (Appendix C) was obtained from all participants. All transcriptions of interviews were de-identified to ensure confidentiality. In order ensure auditability of data, lists of codes and a list of participant names were kept in a location separate to these data. Two transcriptionists, other than the researcher, were employed; both were appropriately qualified and provided signed confidentiality declarations prior to engagement.

Storage

Data was stored away from identifying codes that linked participants with transcriptions or audio recordings of interviews. Audio recordings and transcriptions of these recordings, memos and consent forms were stored in a secure location in a locked office during the period of data collection and would be kept in this manner for five years after completion of the study. Electronic data has been stored on a password protected computer and backup kept on an external hard disk drive, also kept separately in a secure location.

Follow up

An offer to answer any questions concerning the research was provided verbally at interview and within the information letter received by all participants. Contact details of a free Aboriginal counselling service was made available to all participants at the time of interview, in the event that they experienced any feelings of distress caused by the recall of events. Individual transcriptions of interviews were offered to participants to keep as a record of their unique story and these were provided upon request. Participants were also given the opportunity to receive a written summary of the study results, following completion of the research.

Participant Inclusion Criteria

Only women who identify as Noongar and had given birth in the last two years were included in the study. Stadlmayr et al., (2006), in a study of memory

following childbirth, found that within the second year after birth, assessment and evaluation of the experience was not subject to further substantial changes. Examples of other studies of recall following childbirth, which also used a two year timeframe, include a Canadian study of First Nation Women's birth experiences (Kornelsen, et al., 2010) and an Australian study exploring bullying by midwives of women in labour (Dietsch, et al., 2010).

Participants in the study were required to speak and understand English so that the researcher could reflect upon and gain an understanding of their feelings. The participant needed to recall, reflect and articulate the experience of giving birth in the last two years, in order to ensure a richness of experiential data. To be included in the study, participants must have birthed a single live baby in a public hospital. These inclusion criteria served to focus on a relatively homogenous group and were not so limiting as to constrain recruitment of participants.

All participants in the study were Noongar women. As Noongar land extends to urban, regional and rural areas, this included women from a geographically diverse area. No requirement was made to ensure that women birthed on country, meaning that all participants had birthed on their Noongar homeland. To clarify this point the following example is offered. Due to perceived health risk to mother and / or baby, some participants were transferred to a city tertiary maternity hospital several hundred kilometres from their home in the country. Although both the city hospital and the country home are on Noongar land, the participant was geographically displaced by the requirement to birth in the tertiary hospital, which was not in the same town or area as her home. In this instance the participant did not birth on country.

It is recognised that in Aboriginal culture, land is central to social relationships and individual and collective wellbeing (Zubrick et al., 2010, p. 85). Furthermore, having birthed on country gives the baby cultural rights to be an elder on that country into the future (Nappaljari Jones, 2011). There is increased frequency of maternal and neonatal complications in childbearing Aboriginal and Torres Strait Islander women (Eades et al., 2008; Titmuss, Harris, & Comino, 2008), that necessitate transfer of the pregnant woman to a specialist maternity hospital (Kruske, 2011). In Western Australia, there is only one tertiary maternity hospital

that is situated in the city of Perth. It was therefore considered unwise to limit inclusion into the study to Noongar women who had birthed on country. It was predicted that such a limitation would severely compromise access to, and retention of participants.

No specification of the number of births each participant had experienced or the mode of delivery was imposed. Irrespective of these variables, each birth is a unique experience and understanding of the essence of this lived experience was sought. The participants were required to be at least 18 years of age in order that autonomous consent could be obtained. Although it is acknowledged that Aboriginal and Torres Strait Islander women reportedly have babies at a younger age than non-Indigenous women (Nguyen, Gee, & Le, 2008), to impose barriers to recruitment such as mandatory parental consent, was considered a factor that would place unnecessary constraints on recruitment and data collection.

Additionally, the outcome of the participant's pregnancy must have been a live child. This inclusion criterion did not diminish the value of the birth of a child who is stillborn, however, as this is such a uniquely significant life event, the researcher considered this beyond the scope of the present study.

Population

The study population is Noongar women who have given birth in the previous two years. The Noongar people, like all Aboriginal people in Australia, have areas where they historically reside and have cultural connections, typically for thousands of years before European settlement (Host & Owen, 2009). For Noongar people the south west of Western Australia is their country. While there are different subgroups of Noongar people, they are one community and "continue to observe the community's traditional laws and customs, particularly in relation to land, although with changes flowing from the existence and actions of European settlement" (Host & Owen, 2009, p. xi). In 2005 a single Noongar land claim was filed in the Federal Court. At this historic juncture 99 originating ancestors from whom the Noongar people are descended and some 200 different family names were identified in a population of around 27,000 (Host & Owen, 2009). Refer Figure 1. Map of Noongar Lands

Sample

The study sample was projected to include approximately 10 to 20 women, however it was fully understood that in qualitative studies the exact number of participants is not predetermined, as this is governed by the richness of data and is halted when a sufficiency of data is reached (Leedy & Ormrod, 2010; Maltby, et al., 2010; Schneider & Whitehead, 2013; Schneider, et al., 2007; Travers, 2006). The number of participants recruited in the present study was determined by the quality of participants' experiences and their ability to reflect and report upon these (Morse & Richards, 2002).

Sufficiency of Data

It was imperative in the data gathering phase of the study, that individuals were able to articulate their lived experience of birthing. Therefore, even though it was originally envisioned that as many as 20 participants may be included in the study; through a process of concurrent data retrieval and analysis, participant's stories were similar enough to provide a sufficiency of data. No claim was made that data saturation had been achieved, this being the notion that no new information emerged as data was collected and analysed, because the lived experience is unique to the individual and therefore will always present new data. When studying the lived experience, the truth will always remain partially hidden; a deeper level of understanding ever remaining to be heard. In the present study however, it became apparent after interviewing 10 women that a sufficiency of data had been collected to enable understanding of the lived experience. This well established process is congruent with qualitative research conducted since the mid 1990s, where sample size, rather than being too large or small, is judged for the intended purpose of the qualitative outcome (Sandelowski, 1995).

Implications of Participant Selection

Careful consideration of participant selection and recruitment posed a salient methodological concern. While the prime motivation of the researcher is to come to an understanding of how it is to be a Noongar childbearing woman, achieved by the privilege of listening to each individual woman share her story, this does not

represent the views of any women other than the participants. However, as the end point of the research process is a thematic understanding of the phenomenon, it could be construed that the individual voice is lost in the collective emergent themes. The researcher acknowledges that a risk exists where insights resulting from the present study may be seen to apply to all Noongar women in birth. It is for this reason that clarification is offered at this early juncture of the thesis.

Additionally, recruitment of women to participate in this research had limitations in that women agreeing to participate could be considered more confident, articulate, politically aware or opinionated than other Noongar women. In effect participants might be considered to be a differentiated cohort of a marginalised group. These tensions can be ameliorated however, by reflection on the tenets of qualitative research, which does not seek to generalise, but rather endeavours to produce deep rich data that resists at all times the homogenising gaze. The more appropriate concept is that of transferability of knowledge, which allows the reader to determine how transferable the findings and insights are to another context. This is one of the primary reasons that rich thick descriptions are provided throughout the thesis.

Furthermore, Aboriginal and Torres Strait Islander peoples have declared as a united body, their abhorrence of the disrespectful notion of “difference blindness”, which is the inference that all Aboriginal or Torres Strait Islander peoples are the same (National Health and Medical Research Council [NHMRC], 2003). Celebrating individuality and uniqueness, where each Noongar woman has her own story, coloured by lived experiences and history, is the basis of the present research which explores the lived experience of birth with each of the participants.

Recruitment of Participants

A combination of purposive and snowball sampling, sometimes called “chain sampling” (Creswell, 2013, p. 158) or “network sampling” (Schneider & Whitehead, 2013, p. 189) was used in the present study to access participants. These are both types of non-probability sampling and an approach that is considered appropriate for qualitative research (Schneider & Whitehead, 2013). Moreover, non-probability sampling is a typifying feature of qualitative research, as it is concerned with selecting individuals who are likely to be able to purposely inform an understanding

of the research focus and contribute to the development of the central phenomenon within the study (Creswell, 2013; Maltby, et al., 2010; Schneider & Whitehead, 2013).

Purposeful sampling was used in the present study in order to select participants who fulfilled the specific inclusion criteria and could clearly articulate the experience. In this way the researcher was able to select participants in a deliberate, subjective manner achieving a sample that specifically reflected the characteristics and commonalities required of the target group (Leedy & Ormrod, 2010; Maltby, et al., 2010; Walter, 2006). This style of sampling was used for recruitment of initial participants and for reasons explained below, it was necessary to also use snowball sampling for additional recruitment of participants. This style of sampling made use of initial participants to find additional potential participants (Walter, 2006).

As it was envisaged that recruitment from outside the culture by a non-Indigenous researcher would be challenging, it was proposed that five initial participants would be purposively selected, from which additional participants would be recruited using the snowball method of sampling. It was planned that the five participants would be subsequently asked to suggest other possible participants. As Walter (2006, p.199) asserts, a snowball sampling technique is most appropriate when “surveying a limited number of respondents from a hard-to-reach group”. Consultation with the Aboriginal Women’s Reference Group concluded that, due to the networks of Noongar women who have given birth in the past two years, this two-step purposive technique would be an appropriate and successful method of recruitment. It was reasoned that intercultural access to participants from trusted known acquaintances would be more likely. This proved to be accurate, wise and helpful counsel.

Gaining Access to Participants

As the researcher is non-Indigenous it was acknowledged that cultural barriers would be experienced when endeavouring to gain the confidence of women to tell their stories. Further to this and prior to the commencement of this research-project, a feasibility activity was carried out to assess the researcher’s ability to access participants.

Feasibility Activity

Five mutually exclusive initial contacts of the researcher that could facilitate recruitment of a participant were identified. That is, five non-Aboriginal women known separately to the researcher and who were not connected to, or acquainted with each other. These women who were professional and personal contacts of the researcher were not asked to be participants in the study, rather to facilitate an introduction to a possible participant.

A separate meeting with each of the five contacts was conducted. Of the five meetings four were in person and the remainder was by telephone. At these meetings, the aims of the research and the inclusion criteria of participants were explained. All contacts were supportive of the project and its expected outcomes, expressing confidence that they could introduce at least one possible participant. It was anticipated that this personal introduction to prospective participants would enhance researcher rapport when making contact, particularly in view of cultural differences.

Pathway to Participants

Recruitment of participants proved to be more problematic than anticipated. Five initial contacts were approached and all were confident they could provide access to a participant. One of these contacts introduced a participant directly to the researcher and the initial interview resulted from this.

Gate keeping was a characteristic common amongst those who expressed an interest in facilitating introductions to possible participants. For example, an Aboriginal grandmother was introduced to the researcher who could potentially introduce her daughter and niece as likely participants. However, it was necessary to meet with the grandmother and provide her with an overview of the study before she would consider speaking with her relatives about participating. It may be asserted that given the history of colonial domination and the reported lack of reciprocity to Aboriginal people throughout generations, this protective behaviour is both reasonable and noble.

Although many and varied assurances from the five initial contacts, that the women they introduced would be willing to participate in the study, this did not

eventuate. Many weeks of making connections that resulted in a web of third party contacts, unfortunately did not yield a single participant.

It became obvious that working within this cultural interface necessitated an understanding of the non-Indigenous researcher's positioning. Further self reflection resulted in an appreciation of the broader social and historical context of cross-cultural recruitment, which led to a repositioning of the researcher's role in the study. Clearly then, the perceived ease of engaging with Noongar women in the research process was not a given reality. Trust needed to be earned and established. An alternative approach was necessary; one which relied less on 'contacts' and more on collaboration with professionals who interfaced directly with Noongar childbearing women.

Alternative Pathway to Participants

Child health centres provide a valuable service to childbearing women in the Western Australian community. They are staffed by registered nurses and midwives with qualifications in child and family health who can assess infant and child health and development. Within their role, these nurses and midwives also provide information about many aspects of parenting, maternal and family health, and healthy lifestyles. They provide a range of services in partnership with parents and carers of babies and young children up to the age of four years (Government of Western Australia, 2013).

Given the lack of success recruiting participants in the previously described manner, the researcher implemented a different method of approaching possible participants. Meetings with managers of an urban child health centre and a regional Aboriginal Medical Centre were arranged and conducted in both venues. Information provided to the managers of these centres included a synopsis of the research proposal, copies of both ethics approvals from the University of Notre Dame Australia and the Western Australian Aboriginal Health Ethics Committee, consent form and a plain language information letter. Managers were given a briefing and information about the research, which they agreed to display on notice boards. A notice to potential participants (Appendix D) was prepared which briefly explained the research aim of the study and also included researcher contact

information. Managers of both centres agreed to provide the notice to any woman wishing to know more about the research.

The non-Indigenous manager of the urban health centre, who was approached to display the notice as advertisement of the research project, had worked with antenatal and postnatal Aboriginal women for many years. At the initial meeting between the researcher and manager it became apparent that the manager was engaging in gate-keeping behaviour. This behaviour was an indication to the researcher that the manager needed reassurance that reciprocity of process would occur, in that research outcomes could benefit the interests of her clients. Three weeks after the initial meeting the manager provided a list of seven contacts, all of whom were willing to be contacted. Of these, four of the women agreed to become participants who in turn provided introduction to further participants. It was clear to the researcher that, as Walter (2006) asserts, snowballing is the most effective way for a non-Indigenous researcher to gain access to this “hard to reach group” (p. 199).

The Aboriginal Medical Centre in the city of Bunbury was managed by an Aboriginal registered nurse manager. The researcher travelled to the centre for an initial meeting where the project was judged to be worthy of support and in particular the manager was satisfied that her clients would be treated fairly and with respect. Several weeks after this meeting, a list of names and contact details of 12 potential participants was provided by the manager. Of these, five interviews were arranged and four women became participants. No snowballing recruitment occurred in this the regional city of Bunbury.

Additionally, staff of a rural Aboriginal Medical Centre to the east of Perth city was contacted and a meeting occurred with the manager of this centre. The centre was going through accreditation at the time and it was difficult for new initiatives to be adopted. Unfortunately, no participants were able to be accessed through this avenue of enquiry.

The manager of a group of women’s refuges facilitated the introduction of a possible participant to the researcher. The woman was contacted and a meeting arranged. This meeting was to take place in the woman’s home, which is a secure location with no publically obtainable address. The meeting did not take place despite the researcher endeavouring in various ways to make follow-up contact. At

this time, as it was impossible for the researcher to have an understanding of this potential participant's worldview, nor of her competing interests or responsibilities, it was considered culturally inappropriate to persist further.

Research Technique

The significance of hearing the Noongar woman's voice cannot be overstated. While there is no doubt that research about Aboriginal women would be best conducted by Aboriginal women, due to the lack of educational equivalence in Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians (Dudgeon, et al., 2010; Gray & Beresford, 2008), the volume of research required by a limited number of Aboriginal and Torres Strait Islander researchers is not a possibility. Given this reality and considering Aboriginal and Torres Strait Islander women's voices are not being heard in the maternity debate, it could be described as unfair for Noongar women to have their voices absent due to the persistent legacy of colonisation. Salmon (2007) describes the process of speaking with marginalised groups in support of moving their situation forward on their own terms. She affirms it is the responsibility of those in positions of power, to shoulder some of the load and to find answers to problems of which they have been an inherent part. In essence Salmon is adamant that the responsibility to effect change cannot be left to Aboriginal and Torres Strait Islander peoples alone.

Efforts to preserve Aboriginal and Torres Strait Islander culture must be ongoing if gross social inequities that exist relative to non-Indigenous Australians are to be addressed. Cooper, Baturu, Warren and Doig (2004, p. 239) lend much credence to this claim when they describe the systematic degradation of Aboriginal and Torres Strait Islander culture over the past 200 years, as rendering their peoples "disavowed, disempowered and displaced". It is asserted that the present study can serve to preserve Noongar culture by underscoring the needs of Noongar women in childbirth through exploration of that lived experience. Furthermore, to recognize the Noongar experience of birth as culturally specific is to acknowledge the uniqueness of all Aboriginal groups in Australia. Sonn (2004) asserts that once culture is given primacy in research and practice, the knowledge gap becomes evident as assumptions about universality, individualism and singular reality are exposed. Watson (2007), an Aboriginal lawyer and researcher, emphasizes this

when she states “to assume the role of speaking for all Aboriginal women and our laws, would itself be a breach of our law” (p.98). In qualitative research the interviewer is the main data collection instrument. This is particularly evident in Gadamerian hermeneutics and the concept of the hermeneutic circle, where the researcher’s pre-understandings, prejudices and expectations are used to develop horizons to identify the explored phenomenon (Schneider, et al., 2007).

In the present study of Noongar women’s childbirth experience, the researcher who is a midwife with extensive breadth and depth of clinical experience, has considerable expertise and understanding of the complexities and context of pregnancy and birth. Despite being non-Indigenous, particular empathy with, and understanding of, Noongar women can be claimed by the researcher who was born on Noongar land, was educated with and later cared for Noongar people as a nurse and midwife for almost three decades. Although interfacing and engaging with Aboriginal people for over 40 years, this did not prevent the researcher in the present study from carrying forward some archaic aspects of colonialism that have derived from her own cultural conditioning over time. Exposure to the present research however, has provided a deep and valuable body of knowledge, learning and experience, enabling understanding and far greater appreciation of matters uniquely pertinent to Noongar women and culture.

Data Collection

Honoraria for Participants

Each participant in the study received a small honorarium of \$50 per interview as an acknowledgement for her contribution to the research and to compensate for any out of pocket expenses that might have been incurred. As Salmon (2007) asserts when reporting on her research of Canadian Indigenous women’s health, even a small honorarium can significantly enable a person’s participation. In the present study, costs were seen to include babysitting, transport and time which may have been used for competing priorities. It is acknowledged that a disproportionate degree of social inequalities is suffered by Aboriginal and Torres Strait Islander peoples compared to non-Indigenous Australians. This has

been described, in part, as having insufficient money to pay for basic necessities of life including food and rent (Zubrick, et al., 2010).

Provision of this honorarium also demonstrated cultural respect in the form of reciprocity, as the researcher is fully aware of the many research projects that have been reported as taking from, and not giving back to culture (National Health and Medical Research Council [NHMRC], 2003; Salmon, 2007). Further to this, the provision of an honorarium acknowledged the participant's responsible agency in the production of knowledge and was intended to reduce the risk of the perception of any coercion, co-optation or exploitation by the researcher for her own gain. That is to say the researcher has not sought to engage the services of participants in a way that serves only the researcher, for example, in order to fulfil the requirements of the present study. Rather it is to acknowledge the input of participants as described above.

Salmon (2007) insightfully and poignantly asserts that failing to provide honoraria is often viewed by Aboriginal society as suspect. The researcher became increasingly convinced of this sentiment throughout the data collection phase of the study. Immediacy of this acknowledgement ensured that women benefited from their participation in the study in a tangible and meaningful way.

Interviews

Interviews Ethics and Background

Qualitative interviews came to popularity in the 1980s and were seen as an alternative to the impersonal, objective and positivist method of knowledge generation. This new style of data collection was diametrically opposed to the alienated relations of the researcher and subject frequently associated with positivism. The narrative style was gentle, unassuming and inclusive. It was seen to promote equality and provide opportunity for populations, otherwise marginalised, to express opinions to the broader community (Kvale, 2006). It has been contested however, that accounts given by the interviewee are contextualised to the interview within a cultural reality and against a cultural background. Therefore, Tanggaard (2009, p. 1503) asserts, it would be a "mistake to regard the [subject] as the 'sole agent' of the interview". Additionally, it has been argued that a power differential

exists between the researcher and participant or interviewer and interviewee (Kvale, 2006), therefore one could reasonably assume that this could occur with non-Indigenous and Aboriginal and Torres Strait Islander relationships. The power dynamic that exists in the qualitative interview scenario is explored in some depth by Kvale (2006), who advises recognition of this, in the social construction of knowledge, as necessary to “ascertain objectivity and ethicality of interview research” (p. 480).

The researcher was cognisant of the power differential inherent in the interview process when gathering data in the present research study. Interviews were all conducted in an environment where the participant had the power of place. Seven of the 10 participants were interviewed in their own homes, two were interviewed at an Aboriginal Medical Centre and the final participant was interviewed in the home of a friend. This helped to address the perception of a power differential during interviews, enabling the researcher to present a non-dominant position to the interviewees. Prior to commencement of the interviews, the researcher reassured participants that if they became upset when recalling their stories of birth, they could pause or stop the interview at any time. Participants were reassured that emotional responses are a normal reaction of recall. In anticipation of participants needs, information leaflets from obtained from Aboriginal Medical Centres in Perth and Bunbury were offered to participants prior to commencement of interviews, informing them of free Aboriginal counselling services.

Power within the Interview

Letting go of the expert role inherent in the researcher participant relationship (Walker & Sonn, 2010) was achieved by using the reflection technique of *mindful practice* described by Johns (2005). Being aware of oneself in the unfolding moment is the basis of mindful practice, coupled with the researcher undergoing continuous reflection to ascertain if actions are empowering or disempowering (Taylor & Guerin, 2010). This activity formed a powerful tool to monitor cultural appropriateness during the data collection process.

Engaging in critically reflective practice, as described by Walker and Sonn (2010), involved the researcher in the present study letting go of certainties and being able to work outside of her personal comfort zone. These criteria were integral to

negotiating the cultural interface and gaining the trust of participants. This was an important first step in the development of relationships that enabled the researcher to appreciate the story and the storyteller (Watson, et al., 2002) within a culturally appropriate context.

Place of Interviews

Data collection was achieved by in-depth face to face interviews and these were conducted one to one in a location or place that was amenable to the individual participant. Urban participants all chose to be interviewed in their own homes. Quiet spaces in the home were sought to enable audio recording and these included participants' bedrooms, communal lounge rooms and outdoor areas. Most often children and babies were present at interview, this being the most comfortable and natural behaviour for participants. All of the participants from the city of Perth in this study had other family members present in the home at the time of interview, however none of the interviews involved adults other than the participant. Interviews were not achieved in seclusion in the home, rather, children came and went and babies were fed and tended to. The researcher employed a relaxed, adaptable and reflexive attitude during interviews, realising that such emersion in the lifeworld of the participants was a rare privilege and honour.

Although participants from the regional cities of Bunbury and Busselton were given options for interviews taking place in their home, the Aboriginal medical centre or any other venue, all chose the medical centre. The researcher arranged access to venues with managers of two Aboriginal medical centres. The managers were fully aware of the aims and purpose of the research project, having met with the researcher prior to commencement of the data collection phase. They eagerly advised on, and assisted with, the provision of culturally appropriate spaces to conduct the interviews.

Aboriginal medical centres are a health and social nexus for Aboriginal and Torres Strait Islander people living in regional areas of Western Australia and are places that participants obviously feel familiar with and comfortable to be in. It may be asserted that, as participants had a sense of cultural ownership of these centres, the interviewer interviewee power differential was minimised somewhat during interviews. Being aware of the enduring realities of the history of colonisation, it

was assumed that use of these centres contributed in some way to supporting women by addressing the relative position of power and privilege. This view is consistent with Lock and Gibb (2003) who found the power of place to directly shape experience in the form of comfort, self-agency and security.

Style of Interviews

Unstructured narrative style interviews provided the researcher with a valuable opportunity to enter the world of the Noongar woman who was asked to reflect upon her experience of having birthed a baby in the previous two years. This interview format was seen to be most appropriate for the present study because it is designed to be informal and conversational, supporting the naturally unfolding narrative (Schneider & Whitehead, 2013). This is consistent with the ‘yarning’ described by Dean (2010) as a feasible method of conducting research among Aboriginal and Torres Strait Islander peoples across Australia. As phenomenology explores the lived experience of the participant, it is not asserted that yarning was used as a methodology in this study. Although yarning is a relaxed and informal semi-structured interview, methodologically it involves researcher and participant journeying together in the exploration of the area of interest in the study (Bessarab & Ng'andu, 2010). It is asserted however, that the unstructured, relaxed and narrative style of interview used in the present study, could be likened to virtual yarning, which is a way of communication favoured in Aboriginal and Torres Strait Islander research.

Culturally Appropriate Interview Style

Stories from Aboriginal Women of the yarning circle by Robertson, Demosthenous and Demosthenous (2005) informed this research with regard to the value and appropriateness of data collection in the narrative form as culturally appropriate. Further to this, Barton (2003) asserts ethical narrative enquiry involves learning how to listen and receive stories, followed by interactions of authenticity and respect.

A good interviewer according to Creswell (2013. p. 166), is “a good listener rather than a frequent speaker” in the interview. This is especially pertinent for groups who have constantly experienced not being heard, where failure to actively listen translates to negative feelings of being diminished (Eckermann, et al., 2010).

Comfortable silence is another mechanism of effective communication with Aboriginal people and as Eckermann et al., (2010) explain, can be difficult and even stressful for those not relaxed with prolonged periods of dialogic quiet.

Taylor and Guerin (2010) also advise to “let them finish” (p. 174), imploring the non-Indigenous researcher to end the encounter with a final question eliciting the participants perspective, allowing time for the response to be voiced naturally. This advice prompted active reflection that served as a tool for improvement and growth by the researcher. Observing silences provided time and space for thought and consideration, which helped to increase the level of trust from participants and demonstrated respect for their self-agency. Additionally, non-verbal interaction such as body language played a big part in communication and awareness of the many aspects of conversation (Dudgeon, et al., 2010). This was translated, for example through head movements, posture, hand gestures and facial expressions, requiring the researcher to be ever vigilant of the participants feeling at ease or tense during the interviews.

Interviews were open ended to allow for women to express stories they felt were personally important, rather than to answer direct questions (Liamputtong, 2013). Initial open ended questions were followed with prompts to facilitate continuation, clarification and elaboration of the narrative. These prompts were simple and sensitive expansions of the participant’s expressed line of thought, as described by Morse and Richards (2002, p. 93), who instruct that the role of the interviewer is to “let the participant tell his or her story without interruption”. Clarification techniques such as probing and paraphrasing were used where appropriate and when additional questions were necessary, these were asked in a layered fashion moving from general to more specific (Schneider & Whitehead, 2013; Schneider, et al., 2007).

Reflection and Reflexivity on Interviews

It was vital to the success of the interview process that critical reflection and reflexivity were constantly employed by the researcher. Such reflexivity is explained by Taylor and Guerin (2010, pp. 172-173) in terms of “reflection-in-action” and “reflection-on-action”. Both processes were employed with increasing frequency to successive interviews. Reflection on action occurred as a two phase process;

immediately after the interview and subsequently at meetings with the Aboriginal Women's Reference Group. Recording and transcribing of these reflections became a useful tool for reflexive practice and personal growth in the research process.

Reflection on action in phase one took the form of immediate reflections, which were recorded as soon as possible after the interview and as close as possible to the interview venue. These reflections were usually audio-recorded in the researcher's car after an interview. This process enabled immediacy in the documentation of researcher feelings, insights and observed behaviour in the participant. Eckermann, et al., (2010, p. 129) assert that non-verbal communication in Aboriginal cultures "probably have the greatest impact on communication and hence, potential rapport between members of the minority and the majority". In order to ensure that accurate and faithful representations of data were recorded, non-verbal communications, noted immediately after the interview, were documented on transcriptions for use during interpretive analysis.

Reflection on action which occurred in phase two was the subsequent reflection on action that at times, transpired in the form of dynamic conversations between the researcher and the Aboriginal Women's Reference Group at regular meetings. These interactions were valuable to the researcher as they provided encouragement, critical review and practical suggestions. As a consequence of these meetings, the researcher became increasingly mindful of Aboriginal culture. Meetings with the Aboriginal Women's Reference Group were not the only time or place that subsequent reflection on action took place. A research strategy of semi-structured memo creation served as a means to assist the researcher to both interpret data and engage in phenomenological reduction in an ongoing effort to step in and out of the hermeneutic circle. This took the form of confronting ones ongoing assumptions, by identifying and contextualising these in the research process. These reflections were also used to create points of discussion between the researcher and supervisors at formal and informal meetings. Refer Appendix E Semi-structured memo

Reflection in action occurred at the time of interview. As the researcher is non-Indigenous, it was at times confronting but salutary to be faced with the Noongar women's worldview. At the time of interview a practice of self-conscious

awareness was implemented by the researcher, in order to ensure support and empathy was imparted to the participants in a culturally mindful manner, while hearing their stories. Activation of the “internal supervisor” is a technique described by Taylor and Guerin (2010, p. 172) where the interviewer “dialogues with [the] self while in conversation with another”. This strategy was naturally and automatically employed by the researcher as a means to ensure awareness of, and respect for participant’s cultural values. Monitoring personal behaviours while interviewing, constantly questioning if these were empowering or disempowering, was the method used for reflection in action. This enabled the researcher to affirm and impart to the participant that the interview process was more important than outcomes.

Cultural Advice on Interview Technique

Consultation with the Aboriginal Women’s Reference Group improved the researcher’s questioning and interview technique after the initial interview. At this point some clarity around utilization of a non-threatening and appropriate approach, paying particular attention to conventions that are culturally sensitive when interacting with Aboriginal women was provided. Although the prepared open ended questions were perceived to provide adequate cues to initiate the story of birth from participants, these questions did not include generalities needed to approach the subject of investigation. The researcher was advised to engage in conversation about other children and family for some time, to build rapport before arriving at the area of focus. This approach paid great dividends resulting in interviews in which participants were noticeably more relaxed and eager to share their stories.

The initial interview questions were:

“Please tell me about how you see yourself as a woman”

and

“Please share your story of pregnancy and birth of your baby”

Subsequent to advice from the Aboriginal Women’s Reference Group, interview questions that triggered conversation, derived from the two focal questions above, were used. In this way the researcher adopted and internalised a more relaxed approach to interviewing, allowing the participant to lead the conversation with some guidance from the researcher. General discussion about family and home led to

more focused conversation about the birth experience and matters surrounding and pertaining to it. Although initial conversational enquiries became the norm, the way in which each interview evolved was uniquely reflexive. The researcher was primarily focused on encouraging the participant to share experiences in a relaxed and uninterrupted manner. Prompting was both verbal and non-verbal, at times used to gently direct the conversation and at other times to keep the conversation flowing. With successive interviews the researcher sensed that participants were becoming more at ease and responsive due to improved technique. Additionally, the researcher experienced increased self-confidence in and comfort with the interview process.

Building Rapport

Rapport and trust was developed with all participants to varying degrees. This is desirable to yield 'rich', extensively, detailed and pertinent data (Schneider & Whitehead, 2013; Schneider, et al., 2007). As most participants were recruited by the snowball method, they had been approached by friends or known associates and had been briefed by them on some aspects of the project prior to interview. When contact was made with the researcher, conversation about the purpose of the research and practical arrangements such as times and venues were agreed upon. Resulting from the critical appraisal of earlier interview techniques, the researcher implemented a strategy to inform all subsequent participants who were interviewed, about the types of questions they would be asked. At this time the purpose of the research project was explained in a conversational manner and participants were encouraged to be as openly critical and honest as possible about all aspects of their experience of childbirth. This conversation occurred several days prior to interview, enabling participants to think about areas of importance that they would like to speak about. It was assumed by the researcher that this forewarning would engender confidence in participants when they shared their experiences at the interview. This effect was observed to occur.

Most participants confidently interacted with the researcher and interviews evolved as conversational encounters that offered useful opportunities to clarify issues, as well as probe for ever deeper insight. One participant however, seemed to be very shy or self-conscious and appeared uncomfortable with the interview process. Creswell (2013) describes the hesitant and less articulate interviewee as

challenging for the researcher and a participant most likely to provide less than adequate data. Watson et al., (2002) display a more compassionate approach by explaining such reticence as possibly a result of being shamed; this they clarify is an important concept for Aboriginal and Torres Strait Islander peoples, which reflects being singled out for special treatment. Shame they elucidate further, results from being forced to act in disharmony with the individual's cultural or social beliefs. This participant did not articulate her discomfort; nonetheless, despite the researcher endeavouring to put her at ease, the interview was of noticeably short duration.

All interviews however, offered unique data where outcomes were never exactly the same between participants. The conduct of culturally competent engagement with participants was of prime importance to the researcher and endeavours to provide this was continuous throughout the entire project.

Language Use in Interviews

Particular note was taken of a Northern Territory study by Watson, Hodson and Johnson (2002), relating to appropriate information gathering strategies in Aboriginal and Torres Strait Islander research. They advise that when communicating with Aboriginal and Torres Strait Islander peoples, researchers must be aware of different cultural and communication styles and avoid using medical jargon and long technical words. Vicary and Bishop (2005) concur, underscoring this point by asserting that "language use can potentially pose a problem if polysyllabics are used"; this style of speaking being negatively termed "high language" by many Aboriginal people (p.14). Eckermann et al., (2010) warn against speaking too quickly as to confuse the listener, too slowly as to appear patronising, too softly as to be difficult to hear, or too loudly as to offend. Further to this they advise that differing communication styles can be a major stressor because they frequently block interaction when people from different cultures meet.

Sustained systematic questioning of Aboriginal and Torres Strait Islander peoples is often viewed as intrusive and hostile and may even be viewed as criticism (Watson, et al., 2002). Given this assertion, only two focal questions were prepared prior to commencement of data collection. However, additional reflexive verbal and non-verbal prompts and cues were used to support the line of conversation and elicit further discussion with good effect. This is compatible with the informal interview

technique of phenomenology (Neutens & Rubinson, 2010) and is described by Leedy & Ormrod (2010, p. 141) as “one in which the researcher and participants work together to arrive at the heart of the matter”. Therefore, open ended questions were asked with follow-up discussion being led not so much by the researcher, as by the participant. This openness ensured the interview process remained as close to the lived experience as possible (Laverty, 2003).

Listening During Interviews

Interviews took on the informal ‘chat’ style of approach described by Watson et al., (2002). To foment transparency in the discourse however, it was important to include interpretive observation by noticing what was half said, intuiting meanings behind comments and discerning what was not said (Suarez-Ortega, 2013). “Deep listening”, a technique described by Taylor and Guerin (2010) was a strategy employed as a part of the interpretive process. This went “beyond simply hearing” the spoken word of the participant (Taylor & Guerin, 2010, p. 178), to gaining an understanding by actively listening at a level where perception and interpretation are integrated. The process enabled the researcher to demonstrate empathy; that is, showing compassion in response to various cues about how the participant was feeling when telling her story (Taylor & Guerin, 2010, p. 174).

Clearly then, the interviews had a relaxed and informal atmosphere, even though concurrent observation and reflection were essential to the interpretive process. In order to ensure interpretive accuracy, a Rogerian process of reflective listening was used intermittently, where the researcher “grasped” what the participant was feeling or meaning and then paraphrased to the participant for verification (Rautalinko, Lisper, & Ekehammar, 2007, p. 192).

Non-verbal Communication in Interviews

It cannot be assumed that a good listener is necessarily a good interviewer (Morse & Richards, 2002). Travers (2006) attributes an effective in-depth interview to good listening and reflective skills. The generation of narrative without interrupting the participant’s story, whilst using “reflection within the moment” (Taylor & Guerin, 2010, p. 172), was a learned skill implemented by the researcher by interpreting and responding congruently to the unfolding narrative. This was achieved by using non-verbal responses and encouragement in an effort to maintain

the flow of conversation, rather than to interrupt the participant's train of thought (Morse & Richards, 2002).

Participants also frequently used non-verbal communication in the usual course of interaction. Being alert to these cues is vitally important and useful because the exchange of unspoken messages in Aboriginal culture is a powerful method of communication and is therefore, potentially the most effective way to build intercultural rapport (Eckermann, et al., 2010).

Researcher Interview Techniques

Researcher technique improved and evolved with each successive interview experience. Engaging participants in conversation and establishing trust, to a point where they appeared comfortable and spoke freely, was a learned skill. Consultation with the Aboriginal Women's Reference Group after the first interview was especially important. At this meeting, advice and guidance about how to initiate conversation with Aboriginal women was given. Enquiring about family and investing a generous amount of time in general conversation before moving to specific concepts, were recommendations that radically changed and improved researcher interview technique. With successive interviews the researcher gained confidence, viewing each interview as an opportunity to reflect, learn and improve.

Length of Interviews

Prior to commencement of data collection the length of interviews was predicted to be approximately one hour. However this was a guide for participant time management only, as the researcher was flexible and attuned to encouraging the participant to take as long as they required. Length of interviews varied greatly, ranging from approximately thirty minutes to three hours.

The researcher acknowledged that flexibility and accommodation of individual needs was necessary to optimise richness in acquired data. As discussed previously, interviews were conducted in locations familiar to women and at times that suited their needs. Sonn (2004, p. 311) describes an "iterative, generative and reflexive orientation [that] has been helpful to consider multiple ways of knowing" this ably describes the interview technique used in the present research.

Recording of Interviews

Interviews were all audio-recorded. It was anticipated that participants may feel uncomfortable with this method of data recording and other techniques such as note taking was offered at the start of each interview, should this be the case. An interviewing strategy described by Dietsch et al. (2010) where Aboriginal and Torres Strait Islander participants were given control of the audio-recorder, ensuring they had the power to stop the interview at any time, was also put in place in the preparatory phase of the study. In consultation with the Aboriginal Women's Reference Group, these strategies were considered to enhance the participant's confidence, trust and acceptance of the information giving process. However, no participant expressed any discomfort with the interview being recorded, so the conceptual strategies to mitigate objection to audio recording proved unnecessary.

Reassurance of confidentiality enhanced the women's confidence in the interview and the research process. Further to this, participants were assured that their stories belonged to them and their contribution would be acknowledged. Transcriptions of interviews were offered to each participant as a keepsake of their unique story. Only four participants expressed interest in receiving their transcriptions. These were presented as a memento in a document folder and were gratefully received and appreciated.

Phenomenological Sequential Data Analysis

Phenomenological reduction is a process of identification of biases and assumptions, internalised by the researcher and used in subsequent phenomenological reflection. The methodology is cyclical rather than linear and is an insightful process constantly open to experience, which guides the research process (Lavery, 2003).

Although there is no single 'right way' to analyse qualitative data, the researcher began with a large body of information and reduced this, eventually, to a smaller set of abstract themes. In keeping with the underlying philosophy of Heideggerian hermeneutics, Creswell's (2013) data analysis spiral ensured that analysis and interpretations are interwoven. Using this approach, data was reviewed

and analysed several times. The four analytical phases of the spiral, organization, perusal, classification and synthesis are explained in brief below

Organization of data was achieved by analysis of data. The generation of a vast amount of data necessitated the researcher using a combination of filing methods. NVivo 9, a software data management platform, was used as a tool to assist with the organisation of data. This enabled sorting, segmenting and organizing transcriptions, field notes and memos. In effect, this phase reduced large units of data into smaller, more manageable units.

Perusal of data is where the researcher achieved an overall 'sense' of data and it was at this stage that preliminary interpretations were formed through the process of coding text. The transcriptions were examined several times. This increased the interpretive ability of the researcher, thereby enhancing analytical rigour as the process was repeated over and over in an effort to make sense of all information. Such was the method of initial interpretation through the process of data coding.

Classification of data is where coded data was grouped into categories that were antecedent to the identification of emergent themes and 'meanings' or 'essences'. At this point themes, once identified, were returned to the Aboriginal Women's Reference Group to ensure robustness of the study. Themes were also returned to some participants ensuring meanings drawn from their stories were truly representative. Preliminary themes were drawn from the stories of all participants and not just one woman. This concept was clarified with each participant prior to the commencement of the initial interview.

Synthesis of data is the final stage where propositions were offered. At this juncture data were integrated and summarized to produce a report of findings.

The data analysis cycle is in direct keeping with the "iterative, generative and reflexive" interview technique described by Sonn (2004 p.311). An iteration of the analysis process was specifically focused on the six values of ethical research for Aboriginal and Torres Strait Islander people. This provided an opportunity to purposefully reflect on culturally attuned analysis. A study by Kenny (2006) of Canadian Indigenous women, found that analysis of data for values to be an appropriate cultural practice.

The methodological description of data analysis provided above, serves as an introduction to the following chapter which explores the analytical process in greater depth.

Phenomenological Rigour and Robustness

Transparency

Reliability and validity are discussed in the tradition of hermeneutics as issues of rigor (Lavery, 2003). The multiple stages of interpretation that allow patterns to emerge and the process of arriving at those interpretations are crucial to the robustness of the study. Although memo generation is not a defining characteristic of the methodology of hermeneutic phenomenology, it was considered by the researcher to be helpful to the interpretive process and ongoing engagement with the hermeneutic circle.

Critical reflexivity was enabled in this way by self-reflective semi-structured memos being audio-recorded immediately after interviews. Recording of interpretations of participant's non-verbal communication and behaviours was also achieved in this way. This activity, which positioned the researcher within the study, enabled ongoing acknowledgment and reflection of preconceptions and assumptions, resulting in an evolving awareness of the interpretive process. Ongoing cultural awareness, sensitivity and appropriateness were attained in part by a process of critical reflection of "combing through assumptions and values in the light of cultural safety" (Eckermann, et al., 2010, p. 189).

Credibility

Credibility was assured by construction of texts that were faithful to the descriptions of the experience and could be understood by people within and outside the study. The researcher acknowledges personal responsibility to reflect the complexity of the phenomenon without omission or deception. In-depth recording of these experiences and interactions are embedded in data and the final text. The methodical and sequential manner of data analysis provides auditability and thus transparency of process in the construction of texts. This credibility or 'truth' of data

was assured by returning interpretations to participants in order to confirm that meanings extracted from stories were accurately portrayed.

Collaborative Power Sharing

The collaborative and power sharing model of this study ensured continual surveillance of process and assured cultural appropriateness. A study by Kornelsen et al. (2010) of participatory research conducted at the cultural interface, inspired the researcher of the present study. In their Canadian study, Kornelsen et al. used an approach that utilised community participation in research design, methods, data collection and analysis, as well as shared power and a culturally responsive framework. They formed a community consultative group that was integral to the power-sharing methodology of the study's design.

In the formative stages of the present study, the researcher convened an Aboriginal Women's Reference Group that enhanced research rigour by providing cultural advice, advocacy and support. The Group also participated in moulding the research design and assisted with confirmation of interpretations of analysed texts. Analytical rigour will be discussed in depth in the following chapter.

Conclusion

In this chapter ethical considerations of the study are discussed in detail, considering not only conventional research standards and protocols, but also exploring Aboriginal and Torres Strait Islander peoples' values and principles as they apply to research. Following this, strategies used to recruit participants are detailed. A comprehensive explanation of the process of data collection is then presented. Finally, an overview of the process of analysis prepares the reader for chapter 5 in which methodical and sequential processes of interpretation and analysis of data are presented.

CHAPTER 5: ANALYSIS

Introduction

The purpose of this chapter is to provide a detailed description of the processes used in analysing and interpreting data in a transparent and auditable manner. Discussion of robustness and rigour of phenomenological reflection includes cultural collaboration and guidance in the form of co-analysis and shared analysis. A detailed explanation of the process associated with working the text to reduce data to themes, which faithfully represent participant's experiences is provided. Five themes, each essential to the phenomenon, collectively represent the essence of how it is to be a Noongar woman who has experienced childbirth. Finally, the method of structuring the written account of findings presented in Chapter 6 is outlined.

Process of Analysis

As this interpretive study was conducted by a non-Indigenous researcher, vigilance of and adherence to empirical process was paramount. Multiple strategies were employed to ensure that transparency occurred during analytical and reporting phenomenological process. The following account demonstrates the high degree of analytical rigour utilised by the researcher in describing the logic; interpretive considerations and processes to ensure credibility, trustworthiness and auditability of analysis.

Guided by van Manen (1990), the researcher in the present study began the analytical process during the data production phase of the study. Use of formative data sets and preliminary analyses helped to guide and shape ongoing data collection and systematic analysis. This sequential approach enabled successive interviews to yield data based on emerging insights pertinent to the research enquiry (Pope, Ziebland, & Mays, 2000).

A total of 10 Noongar women were interviewed. The researcher assessed that a sufficiency of data was reached after the tenth participant was recruited. At this point no new information emerged from phenomenological reflection and analysis and data were amply aligned to establish meaningful units or themes. Moreover, at

this juncture, the researcher considered a clearer understanding of the phenomenon would not be achieved through continued data retrieval and analysis.

A coding system of P1 to P10 was used to ensure participant confidentiality and when referring to babies of the women, an ‘a’ was added to the mother’s code. For example the first participant would be identified as P1 and her baby as P1a. Noongar women, who were all at least 18 years of age, comprised a mix of four first time mothers, the remainder having between two and five children. Six of the women interviewed either lived away from, or did not have a partner. Each woman shared her story of the birth of her most recent child, a single live baby, born in a public hospital on Noongar land in Western Australia within the previous two years.

Six participants of the study were residents of Perth metropolitan area and the remaining four located in two regional cities in Western Australia. Noongar land lies within the south west region of Western Australia, extending from the city of Geraldton, around the south west corner of the state to a point east of the town of Esperance. This vast geographical area comprises 194,000 square kilometres (Kormendy, 2003). Within this area, the greatest population of Noongar people live in the metropolitan area of the city of Perth (MacRae, et al., 2013).

Transcription

Transcription, often considered a ‘behind-the-scenes’ task has been lauded as a powerful act of representation (Oliver, Serovich, & Mason, 2005). Thus, to accomplish the goal of creating text that was true to data, deliberation on the process of transcription was undertaken in earnest. This reflective step was imperative. By questioning the method of transcription and the possible impact this may have on participants and research outcomes, the researcher was able to incorporate an enhanced level of transparency, which was considered necessary for transcultural research (Oliver, et al., 2005; Skukauskaite & Green, 2011). Two dominant modes of transcription, “naturalism and denaturalism” are described by Oliver et al. (2005, p. 1273). Denaturalised transcription is filtered by the transcriptionist, who removes all idiosyncratic elements of speech. This method of transcription was considered inappropriate for the present intercultural research, because a central tenet of hermeneutical phenomenology is that understanding is bound by language.

Naturalised transcription however, in which every utterance is transcribed in as much detail as possible, incorporates distinctive inflections of speech such as pauses and non-verbal utterances. Naturalised transcription was therefore judged to be particularly appropriate for the current research as it enabled the researcher to become immersed in the intention inherent within data. Such is the researcher's task of accessing the totality of the participant's "relationship to the world that finds its expression in language" (Gadamer, 1976, p. 83).

The researcher considered professional transcription services to be beneficial in the present study, reasoning that temporary detachment from the interview would enable analysis to be conducted in a measured and sequential manner. Naturalised transcriptions provided a record of all utterances on the audio recordings and were transcribed verbatim. As the primary aim of the research was to give voice to Noongar women around their childbirth experience, it seemed logical to be guarded at all times to preserve linguistic integrity.

The hermeneutic nature of this research is "to bring to light an interpretation that has revelatory power" (Gadamer, 2001, p. 42). It is within the idiomatic source of the unadulterated transcription that a search for the 'taken-for-grantedness' that human language has within it, can be located. Here certain "hidden originals" that are "sediment cultural and categorical forms" present the researcher with a cultural force within language (Sokolowski, 2000, p. 166).

Moreover Gadamer (2013, p. 407) states that "language is the universal medium in which understanding occurs. Understanding occurs in the interpreting". In order to be faithful to data and to study the participant's intended stories, every word, utterance and nuanced comment of the spoken word in each transcription was interrogated methodically by the researcher, by simultaneously reading transcriptions and listening to interview recordings.

Audio recorded interviews were transcribed by a professional transcriptionist located overseas. Interviews were emailed and non-disclosure validation was returned with each transcription. The average time for an interview to be transcribed was 48 hours. This efficient service allowed the interview transcription to be analysed while the actual interview process was in the researcher's very recent memory.

The process of interpretive analysis at the transcription stage entailed reading each transcription in its entirety, five separate times for independently defined purposes (Refer Figure 2 next page). Initially the transcription was read to gain an overall sense of the interview. Confidentiality was achieved with perusal of the transcription for a second time and at this point, the interview was de-identified with codes being applied to mother and baby. All other people were de-identified with an X and places including venues, hospitals and towns were described in a general and unrecognisable manner.

Field notes were then used to achieve a deeper level of interpretive analysis as the researcher examined the transcriptions in a methodical and systematic manner. This reading allowed the researcher to insert comments relating to occurrences and inferences that were present in the interview, but not articulated and as such, not represented in the textual data to that point, satisfying the need for full interpretation of data described by Smith and Osborn (2008). An example of this process was an instance when the researcher, having asked a participant how she felt, received the reply “yeah great”, which was not mirrored by her body language. In this case, the apparent incongruence between verbal and non-verbal behaviour was noted on the transcription. Clearly then, to generate transparency in dialogic data collection, it was important to include observation to illuminate non-verbal communication and “to capture the intentionality conveyed by facial expression, gestures and tone of voice” (Suarez-Ortega, 2013, p. 193) where appropriate.

The fourth reading was undertaken because the transcriptionist was located in another country. To ensure no misinterpretations of colloquialisms were included, the researcher listened to the audio-recording while simultaneously reading the transcription on the computer screen, enabling identification of instances where language was misconstrued. At this point the researcher, being so close to data, automatically and instinctively linked a face to the voice and was able to relive the interview with surprising clarity. Thus, the researcher was able to examine the silences in the interview “noting what was not said”, a process described by Creswell (2013, p. 186). With each reading and working of the text the researcher was able to obtain deeper insight and understanding of data. Such data immersion is described as “dwelling with the data” by Borbasi, Jackson, and Langford (2005, p. 148) who assert this level of acquaintance with data enables the “researcher to get in touch with

not only the content, but also the feeling, tone and emphasis being communicated”. The fifth reading of the transcriptions of data was conducted in order to group segments of data into folders or *nodes* within the data management system.

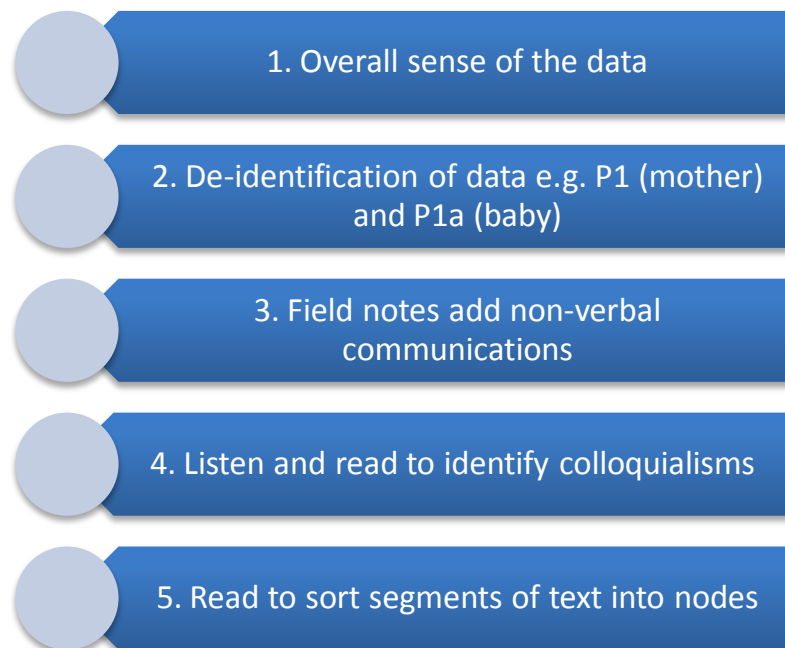


Figure 2 Five readings of transcriptions

Data Management

NVivo Version 9 software platform was used to facilitate the organisation and management of data produced by this research. It is noted however, that no computerised package is capable of “perceiving a link between data and theory or defining an appropriate structure for data analysis” (Pope, et al., 2000, p. 115). Development of analytical skills sufficient to move data toward a proposition was the journey of discovery experienced by the researcher in the present study.

The intention of the analysis was to enable data reduction by employing a method of several stages of codifying data in such a way as to represent the essence of the phenomenon. Once stated, this determined the direction of the textual process (Richardson-Trench, Taylor, Kermode, & Roberts, 2011). Several iterations of organising or grouping, categorising, and synthesising of data were integral to the process. Data were distilled and reduced in a planned methodical fashion.

As previously mentioned, NVivo 9 data management system was used to manage and store data and this was achieved by sorting, coding and categorising data and then constructing thematic statements. De-identified textual data in the form of transcriptions of interviews were stored in the data management system. Transcriptions were then analysed and segments of text were coded or assigned to meaning units called *nodes*. In total 121 nodes were created. Further to this, like nodes were grouped into nine categories called *node classifications* within the data management system. Each node classification was then analysed by a process called *working the text* in which questions were asked of all segments of text within the node classifications. The process of working the text described below resulted in the formation of thematic descriptor statements called *plausible statements*. Further data reduction and formation of successive thematic statements contributed towards the confirmation of emergent themes.

As suggested by Creswell (2013, p. 182) “data analysis is not off-the-shelf rather it is custom-built”. He further suggests that researchers “learn by doing”, which was the experience of the researcher in the present study. Qualitative research data analysis, although crafted to the unique study, does “conform to a general contour” according to Creswell (2013, p. 182). The general guide of the data analysis spiral described by Creswell was used in the first instance. Further to this, Creswell’s (2013, p. 260) declaration that “a quality hermeneutic study would by necessity use the procedures of van Manen (1990)” was heeded uncompromisingly.

Coding, Categorising and Constructing Themes

Initial coding was achieved by grouping segments of text from each interview transcription into a meaning unit folder called a node. Sifting through data, described as “winnowing the data” (Creswell, 2013, p. 184), was a process of reading each transcribed interview for a fifth and final time in order to identify significant segments of text which represented a particular description of subject matter articulated by the participant. Each description was filed into a node where future commentary on the same subject was placed. Sorting and coding of text in this manner broke up the individual transcriptions into 121 nodes, into which like comments were placed. At the conclusion of coding all data into meaning unit folders, 121 nodes were created. No data reduction had occurred at this stage and all

nodes were simply grouped on the basis of affinity as a means of managing the large number of nodes and data. Examples of these nodes were *lonely; unsupported in parenting*; and *changing future for child*. This became the first step in a long and complex analytical process which eventually resulted in the formation of five themes.

Categorising of data was achieved by grouping similar nodes together into node classifications. Nine node classifications, which included all 121 nodes, were formed. Examples of the node classifications are *self determination; culture; support; and importance of family*. It was from these node classifications that further analysis of the segments of text was achieved to produce a series of thematic statements which led to the formation of five themes.

Isolation of thematic statements was achieved by using a process called the detailed reading approach (Van Manen, 1990, pp. 87-93). This is the commencement of phenomenological interpretive analysis leading directly to data reduction. This strategy entails reading every single sentence cluster and asking questions of data to formulate one overall *plausible statement* describing each node within the node classification. Examples of plausible statements are *single mothers need extra support and consideration*; and *inadequate care increases stress on discharge from hospital*. Questions were extrapolated from writings on hermeneutic phenomenological reflection by van Manen (1990, pp. 87-93). The process of questioning data is termed working the text. Refer Figure 3 below

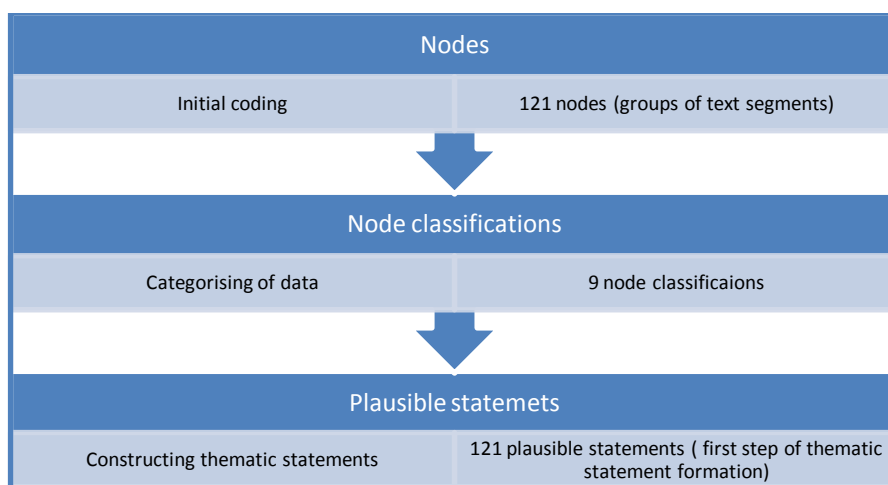


Figure 3 Coding, categorising and constructing themes

Working the Text

The method of working the text developed in the present study drew heavily from van Manen's (1990) direction. Each node classification was analysed by asking six questions of all sentence clusters contained within it. The questions were; what is the meaning of this statement or sentence cluster, what is the overall point? This was termed *overall point*; what aspect of the structure of the lived experience does this describe? This was termed *aspect of the lived experience*; what does the notion of this have to do with the lived experience? This was termed *notional impact*; how is this experienced lived? This was termed *how is experience lived*; what does this sentence cluster reveal about the phenomenon or experience being described? This was termed *reveal about lived experience*.

When each of these questions were asked of the sentence clusters within the node classifications, a single statement was created and entered in a table in the NVivo program. The five answers were then summarized into one short statement of which the sixth question was posed "is this plausible? This was entered on the table as *plausible statement*. The researcher then reviewed each of the first five questions until satisfied that the single plausible statement did in fact represent all aspects of the individual the node. Refer Figure 4 below.

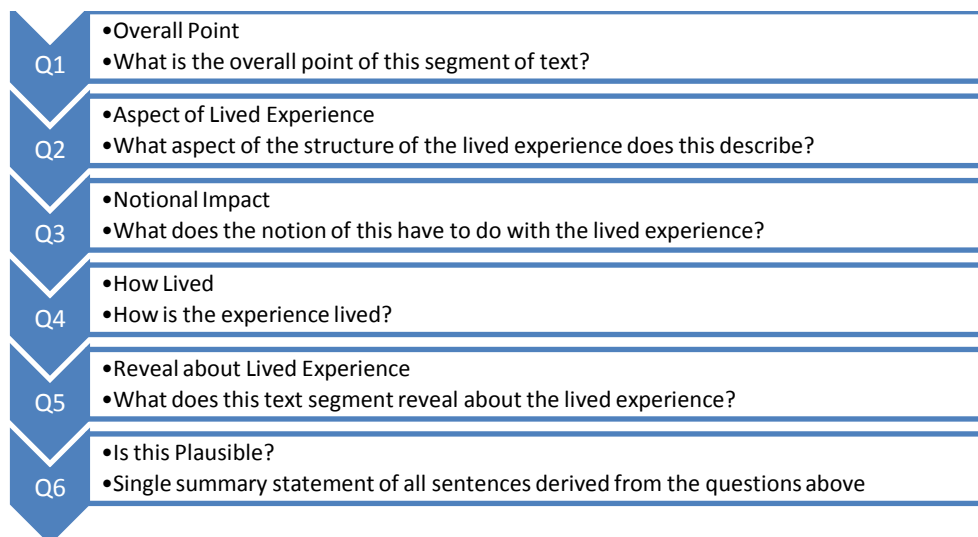


Figure 4 Construction of plausible statements - Six Questions

This procedure was completed for all 121 nodes within the nine node classifications. These 121 plausible statements were then grouped within the node classifications and

like statements were amalgamated and reduced. A screen shot of NVivo 9 program in use when working the text is presented as Figure 6 on page 102.

Further reduction of statements was achieved by creation of tables to systematically analyse data through a further four steps. Tables created enabled data to be reduced in the following four steps; plausible statements to thematic descriptors (within nodes); thematic descriptors (nodes) to thematic description (clusters); thematic descriptor clusters to primary themes (Refer Figure 7 page 103); primary themes to themes (Refer Figure 8 page 104). The process described above was the final stage in a process that resulted in approximately 250 pages of text being reduced to five short statements, which provided identity for each of the themes. The process, though complex and exhaustive, can be retraced to link any statement at any stage of the process to its genesis in the original transcribed interview. The additional and final four steps of data reduction are depicted in Figure 5 below.

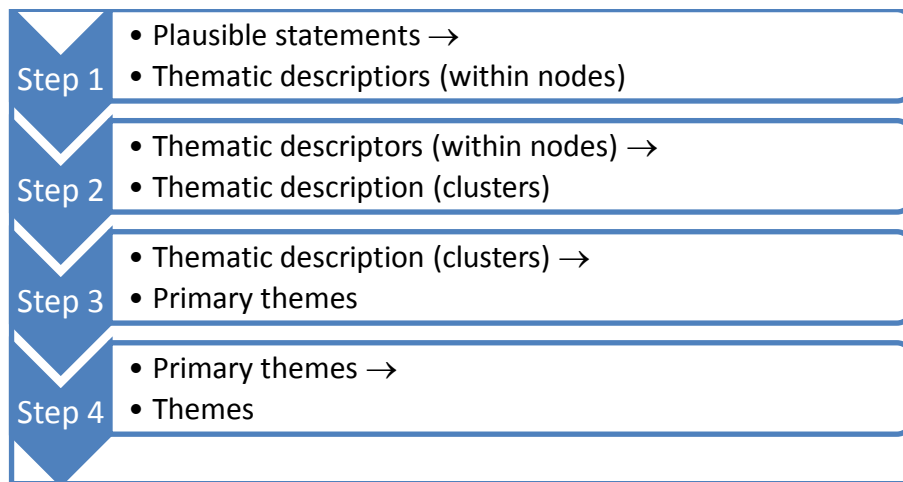


Figure 5 Four Additional Steps Data Reduction

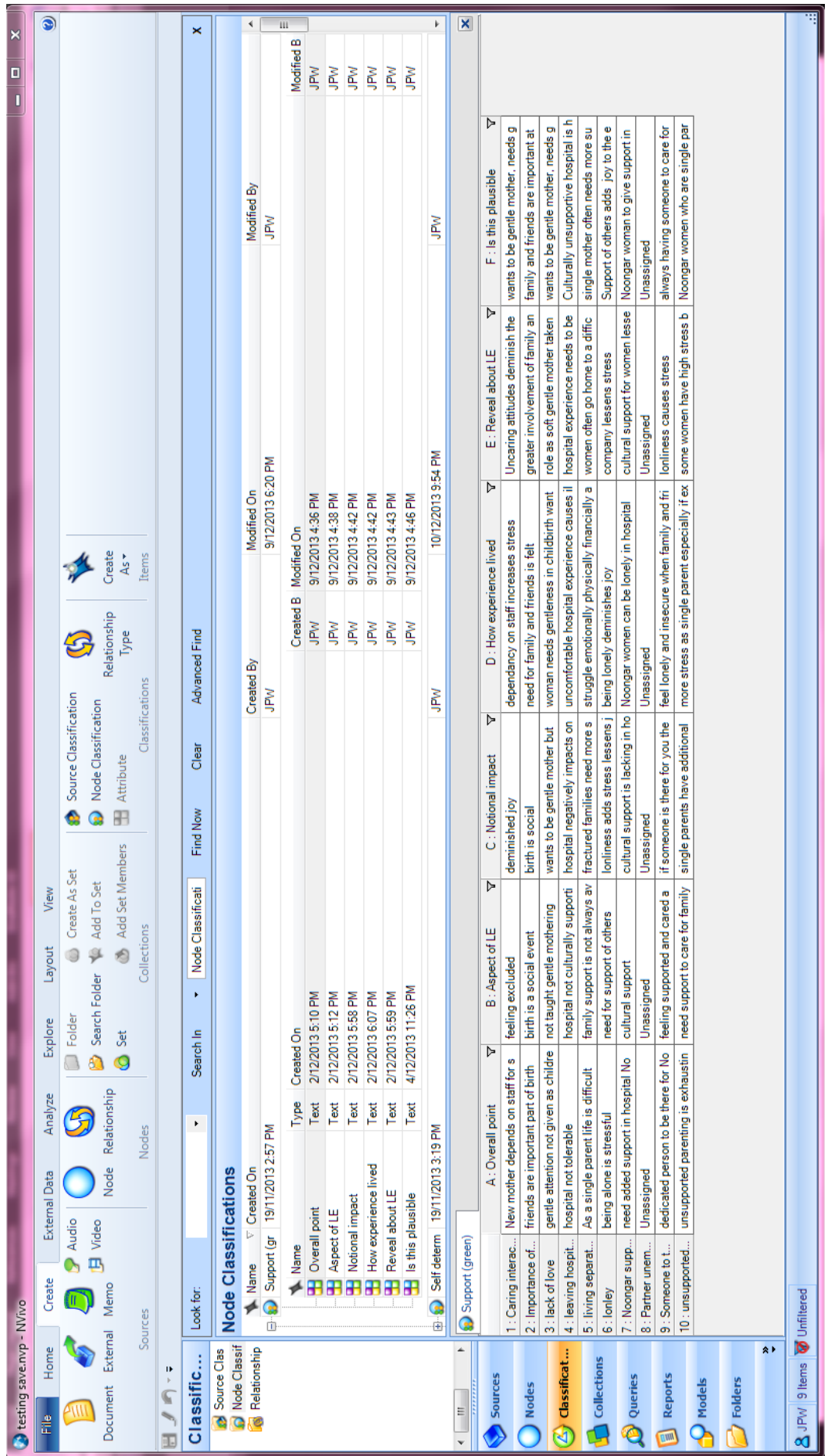


Figure 6 Working the Text

Thematic descriptor clusters	Primary themes
Those who provide care should be gentle and soft	Gentle soft care provides valuable support to vulnerable women in childbirth
Single mother needs more support	
strong determined personality decreases stress	
single mothers need extra support and consideration	
inadequate care increases stress on discharge from hospital	
Fear of loss of a child is heightened in pregnancy and early childbirth period	
depression lessens ability to love baby	
Sharing the childbirth experience is important	Family is central to the childbirth experience
limited family involvement in new baby is stressful	
Family is central to CBE	
new baby strengthens family now and into the future	
Older female family members give support in CBE especially mother	
Ongoing culturally aware support person in hospital decreases stress	Cultural support is lacking throughout the pregnancy, birth and early postnatal period
PN Cultural support needed to increase maternal / child health	
Cultural support in antenatal period is needed	
continuity of carer important	
Culturally inadequate communication and care disempowers and mutes women	
Childbirth is a time when cultural dual reality is emphasised	cultural identity is challenged
Teenage mother experiences regret stressed by dual reality	
dual reality diminishes cultural identity	
Being treated with respect by others and having self respect enhances childbirth experience	Respect for Noongar culture is necessary from Aboriginal and Torres Strait Islander and non-Indigenous peoples
Non-Indigenous Australians need to respect Noongar culture	
Insensitive disrespectful treatment disempowers women	
Pregnancy gives new direction in life enhancing maternal health behaviours	The CBE is a time of reflection on the past, recognition of its link with the present and planning the future with integrity
mother responsible for safe home	
CB time of reflection on past changes now for better future for child	
CBE a time of change, intercultural barriers to change	
Childbirth is a time of excitement joy and renewed hope for the future	
Childbirth emphasises continuity between past present and future	
Noongar women are Marginalised in CBE	To be Noongar is to experience prejudice and racism
prejudice displayed by hospital staff is easily detected	
To be Noongar is to experience prejudice and racism	

Figure 7 Phenomenological Reflection Step Three

	Primary Themes	Themes
1	Gentle soft care provides valuable support to vulnerable women in childbirth	Vulnerability
2	Family is central to the childbirth experience	Family
3	Cultural support is lacking throughout the pregnancy, birth and early postnatal period	Time of cultural challenge
4	cultural identity is challenged	Time of cultural challenge
5	Respect for Noongar culture is necessary from Aboriginal and Torres Strait Islander and non-Indigenous peoples	Time of cultural challenge
6	The CBE is a time of reflection on the past, recognition of its link with the present and planning the future with integrity	Connection over time
7	To be Noongar is to experience prejudice and racism	Prejudice and racism

Figure 8 Phenomenological Reflection Step Four

Shared Analysis and Co-analysis

Hermeneutic phenomenology explores the contextualised lived experience of a person or group of people experiencing a defined phenomenon (Wonjar & Swanson, 2007). This is realised as a shared experience of researcher and participant in which the researcher is the primary instrument of data collection. The shared experience of interaction and interpretation resulted in a cogeneration of formulating an understanding of the essence of the phenomenon (Wonjar & Swanson, 2007).

In the present study, given that the researcher is non-Indigenous, verification and advice on cultural matters was viewed as an ethical responsibility to ensure that no aspect of the analysis of data was misinterpreted or misrepresented. Cogeneration of understanding with Aboriginal women was the strategy employed to ensure cultural accuracy of interpretation and analysis of data. This was achieved using four separate strategies. Firstly, the researcher met regularly with the Aboriginal Women's Reference Group, at which times support and advice were sought and given. Extraordinary meetings were also held either by telephone or face to face meetings with available members of the group. Simply meeting with the Aboriginal Women's Reference Group to discuss general aspects of the research and challenges or opportunities experienced by the researcher enabled "interpretation through conversation" as described by van Manen (1990, p. 99).

Secondly, one member of the Aboriginal Women's Reference Group was engaged by the researcher to assist verification through the process of co-analysis.

On three separate occasions shared analysis was undertaken in this way. Furthermore, at each meeting, the researcher gained reassurance on culturally specific matters regarding analysis already performed. Such cultural support was invaluable to the authenticity of the process of analysis.

The third method of cultural verification occurred when the Aboriginal Women's Reference Group, together with both research supervisors participated in peer scrutiny of analysed data. As a single interviewer collected and analysed data, a checking system of small data sets was deemed necessary to help confirm and verify researcher coding. On these occasions de-identified excerpts of texts were presented to each person present at the meeting. They were asked to read these excerpts with a view to attributing a meaning to what they perceived within these data sets. Corresponding codes previously assigned to these data by the researcher were prepared in sealed envelopes and were subsequently verified against the member's blind interpretations. This parallel coding was impressively similar to researcher coding and these exercises helped to confirm soundness of the researcher's own interpretation of data and thus strength of the analytical process.

Once the five themes had emerged from data, these were returned to three of the ten participants who were able to be contacted, for member checking as a fourth means of analysis verification. The researcher shared the final two tables (Figure 7 & Figure 8) with the participants asking if these themes described their experience and if there were aspects of their experience either omitted or misrepresented. Each participant of the member checking group was satisfied that the themes encapsulated their experience. This validation of process provided assurance to the researcher that the process of analysis was rigorous, transparent, faithful to data and credible. To complete the analytical process the researcher returned to the Aboriginal Women's Reference Group to present the final themes and explain the full process of analysis. Feedback from the group confirmed that they were also satisfied that the process was thorough and rigorous.

These specific cultural ethical activities of co-operative inquiry, underpinned by the values of equality, transparency and democracy, ensured benefit to the individual members of the Aboriginal Women's Reference Group and their community, which honoured the Aboriginal and Torres Strait Islander cultural value

of reciprocity (National Health and Medical Research Council [NHMRC], 2003; Tee & Lathlean, 2004).

The analytical process employed in the current study, although complex, was considered to be logical, clear and auditable, enabling the researcher to confidently trace interpretation of phenomena to original data. Additionally, trustworthiness of data and emergent themes have been established by member checking, together with two separate power sharing processes, that of shared analysis and co-analysis with members of the Aboriginal Women's Reference Group.

Dasein

The phenomenon of being human in the world is known as dasein; a concept of being that has been described in terms of elements of existence (Gadamer, 2001). These elements of being human were existentials such as the lived space and the lived time (Van Manen, 1990). They differ from the 'lifeworld' which can be understood as "our overall natural and cultural environing world" (Moran, 2011, p. 92). As dasein is the concept of how it is to be human in the world (Panneeraselvam, 2003) and lifeworld is all that makes up the individual's world, one might say that to be human is to live a life that is unique and lived within context.

Thus, and by extension, each human person experiences life in a different way. This is influenced by the world that surrounds them, the world that they live in, their beliefs and their values. Further, the lifeworld is influenced by history; each generation incorporating the influences of past generations in their present lives (Moran, 2011). Such sentiments give credence to Kruske, Belton, Wardaguga and Narjic (2012) who, in their ethnographic study of Aboriginal families, found that Australian Aboriginal people hold different worldviews and knowledge systems to other Australian populations. Pattel (2007, p. 1) concurs, explicating that "Aboriginal worldview provides for the unity and coherence of people, nature, land and time, thus seeing themselves as part of the natural order, rather than apart from it and having control over it".

Consideration of the fact that Aboriginal people hold a different worldview to other Australians provided the impetus to search for a way of presenting an account of the phenomenon that explicitly returned time and again to the lived experience of

the women. Describing the phenomenon against given existentials proved a particularly useful means of giving structure to the description of the findings, whilst concurrently providing context, enabling the reader to gain a sense of connection with the women.

Methodological Fit for Description of the Essence

The description of the essence of the phenomenon in the current study is informed by van Manen (1990), who encourages the interpretive researcher to orient writing to the topic in a “strong, original and thoughtful manner” (p.172). Thus the researcher presents an account of hermeneutic phenomenology, using existentialism to shape a rich and thick description of the experience. Such departure from hermeneutics to the field of psychological phenomenology in existentialism, has been demonstrated as far back as the early 1980’s by Bergum (1986) and more recently by Moene, Bergbom and Skott (2006).

Although van Manen (1990) offers existentialism as one of five different approaches that may be used when textually organising phenomenological writing, he emphasises emphatically that these are neither exhaustive nor mutually exclusive. His final suggestion supports a combination of the five approaches or by selecting key elements, as this is likely to provide an inventive orientation best suited to the study of the phenomenon of interest.

After careful consideration, the use of existentialism was considered to be the most appropriate framework to interpret the phenomenon of Noongar women’s birth experience. Existentials of spatiality, corporeality, temporality and relationality, often described as the “lifeworld existentials” (Eggenberger & Nelms, 2007; Hyde, 2005; Merrill & Grassley, 2008; Moene, et al., 2006; Pettersson, Berndtsson, Appelros, & Ahlstrom, 2005), belong to the fundamental lifeworld and as such, questions of any life experience can be levelled against these. Interpretation of the phenomenon in this way enables the researcher to present a holistic, comprehensive and thorough description of Noongar women’s experience of childbirth by using four uniquely different lifeworld perspectives.

Lifeworld Existentials

An explanation of each lifeworld existential is offered below in order to demonstrate the level of textual depth that can be achieved, particularly when using this framework as a structure to present an account of the essence of the experience. Various research studies are used in this example to provide a substantial, credible and diverse insight into the value of utilising the lifeworld existentials. It is posited that such an approach will promote an additional and deepened perspective of the phenomenon by foregrounding with sufficient complexity, an account that is credible, truthful and faithful to data.

Spatiality or the lived space has been interpreted in various ways. This can refer to a physical space as described by Eggenberger and Nelms (2007) in their research study of families with an adult member, hospitalized with a critical illness. They found that relatives experienced the lived space of the intensive care unit as frightening, confusing, technological and overwhelming.

Others interpreted the lived space as a felt space. Merrill and Grassley (2008) for example, in their hermeneutic phenomenological research, found overweight female patients struggled to fit in, due to the way they felt about the space they were in. This felt space was experienced in the medical clinic, where women immediately looked for a couch, bench or chair with no arms, to sit on. According to Merrill and Grassley (2008), participants expressed their anxiety, dread of being examined and difficulty fitting in to examination gowns and blood pressure cuffs because of their size.

Another illustration of the lived space, experienced as a felt space, was described as the space of mistrust of others. Hyde (2006), who studied factors that inhibit children's expression of spirituality, found children experienced a type of lived space in which the inhibiting factor of trivializing emerged. An earlier study by Hyde (2005) described the lived space as a felt space; a space of mystery. In that study a ten year old child, when analysing an Aboriginal Dreamtime story, contrary to other children in the class who attempted to rationalise the story, assessed that it was beyond logic. Hyde suggests this is the child's perception of the mystical space where "some experiences allow people to enter the realm of mystery" (Hyde, 2005, p. 32).

Corporeality, often described as the lived body “refers to the phenomenological fact that we are always bodily in the world” (Van Manen, 1990, p. 103). The lived body, being subject to the gaze of others, can be a source of vulnerability for those who do not conform to the cultural physical ideal (Merrill & Grassley, 2008). In addition to being bodily constrained due to illness, the lived body of the spouse or carer is challenged, with increased physicality required to provide care and comfort (Pettersson et al., 2005). Alternatively the lived body can be expressed as the felt body when emotion, fear and anxiousness are felt bodily in response to a critically ill loved one (Eggenberger & Nelms, 2007). The experience of handing one’s body over to a healthcare team when undergoing an operation and trusting in the body’s ability to repair and heal, are also examples of the lived body (Moene et al., 2006).

Temporality is a subjective state of lived time as opposed to an objective time or clock time (Van Manen, 1990). One’s temporal way of being in the world can be viewed in terms of how time passes for the individual (Merrill & Grassley, 2008). Lived time can pass slowly when situations are difficult and conversely, quickly when life is fun filled and exciting (Hyde, 2005). Lived time has been described as shifting when one moves away from a certain time (Hyde, 2006). Such shifting of time is felt when living towards a future that is taking shape, while concurrently reflecting on, and reinventing the past as viewed from the present context (Hyde, 2005).

Temporality can also take the form of suspended time, when for example, the families of a critically ill loved one are so totally consumed with concern that all other aspects of their lives are seen as less important and thus suspended (Eggenberger & Nelms, 2007). The notion of putting life on hold was described in a research study of preoperative patients by Moene et al., (2006), who found that some patients put all thoughts of the imminent operation “in brackets”, using the period of waiting as a time of reflection.

Another expression of lived time is that of time as situated in history. Pettersson et al., (2005, p. 164) found in their study of the lifeworld perspectives on assistive devices, that spouses of persons who had suffered stroke “feel glad that they are living at a time when such devices are available”.

Relationality or the lived other, constitutes the shared lifeworld. Such are the changes that spouses experience when living with and caring for a loved one with stroke. Existence becomes more intertwined where the caring spouse negotiates assistive devices, pushes a wheel chair, arranges the home, protects the loved one from stigmatising experiences and consoles the loved one when they are exposed to condescending experiences (Pettersson et al., 2005).

Lived others in the lifeworld can be those who provide healthcare treatment. Merrill and Grassley (2008), in their study with overweight women, found relationality in this context were experienced as feelings of being dismissed and judged. Conversely, when participants in the same study felt respected by the lived other, this was found to engender respect in return. Hyde (2005), in his study which reflected on children's spirituality, described the lived other as a spiritual being.

Further research with children by Hyde (2006) found that participants, who feared ridicule and trivialization, interacted with the lived other by adopting a facade such as nonchalance or bravado, in order to protect the self from potential ridicule and teasing.

The lifeworld existentials that provided a framework upon which to weave the interpretive description of the account of the phenomenon in the present study is presented in Figure 9 below.

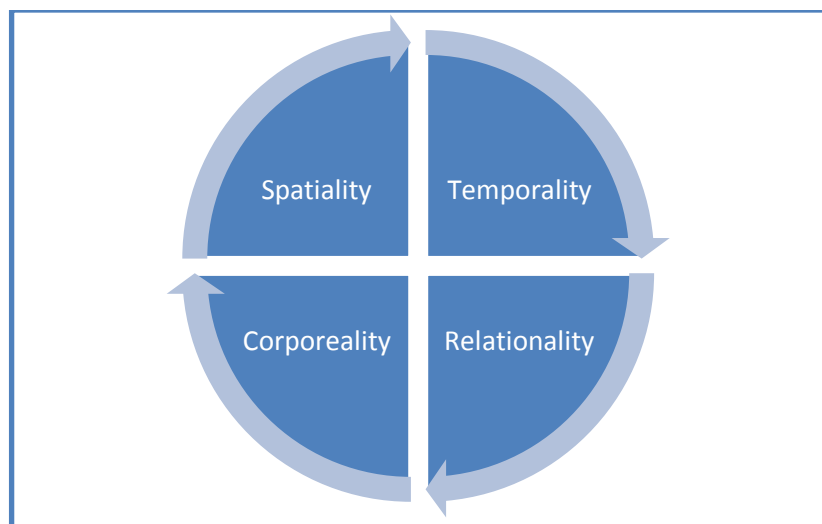


Figure 9 Lifeworld Existentials

Hermeneutic Phenomenology and the Lifeworld

Hermeneutic phenomenological research always begins in the lifeworld, the world of natural attitude, the everyday and unremarkable ordinariness of life. It is in bringing to reflective awareness the nature of experience of this natural state that uncovers and illuminates the uniqueness of human experience (Van Manen, 1990). Hermeneutic phenomenological research is essentially an iterative, generative writing activity. Research and reflective writing are one process of textual deconstruction ultimately followed by reintegration of parts to a whole. In this process the researcher is constantly “thoughtfully aware of the consequential in the inconsequential, the significant in the taken-for-granted” (Van Manen, 1990, p. 8). Clearly then, the use of lifeworld existentials provides the researcher with a platform on which to edify personal insight, enabling the presentation of a valuable and meaningful account of the phenomenon.

Voice of the Women

In an effort to orient the written account of the essence in a strong and convincing manner, further consideration was given to the early writing of Bergum (1986). In a critique of her, as yet unpublished dissertation, Bergum defied tradition by “courageously and sensitively breaking the silence” of participants (Grumet, 1987, p. 189). She did this by inserting direct quotations from the transcribed interviews such that the reader could connect to the participants. Further to this, the use of unedited, verbatim text provides the voice of the participant, itself vital to accurately convey meaning. This aligns well with Gadamer’s central hermeneutic claim that “language is the universal medium in which understanding occurs” (Gadamer, 2001; 2013 p. 407).

Bergum, took the unprecedented step of concurrently presenting three different voices in her thesis; that of the researcher, the participants and the “theoretical voice”. This creative study was applauded as one that “gives us the world” of the participants, while “at no point turning from their voices in order to amplify the superior, summarizing voice of their scribe” (Grumet, 1987, p. 190). Inspired by this creative method of conveying the essence of the phenomenon, the researcher has endeavoured to emulate this presentation of multiple perspectives.

To this end, the current study is similarly interspersed with verbatim extracts from interviews, which support and add credence to the narrative, ensuring the voices of women resonate from their stories. Intersession of a theoretical voice provides an avenue for reference and a means by which the researcher can remain somewhat anonymous; honouring the epoche, whilst interpreting and faithfully working the text with impunity.

As the researcher is non-Indigenous, constant vigilance has been employed to ensure cultural inclusion in preparation, conduct, interpretation and presentation of the findings within the study. Therefore, the final presence in the description of the essence of the phenomenon is the addition of the cultural voice. See Figure 10 below, which is a visual representation of the voices that inform and contextualise the findings of the study.

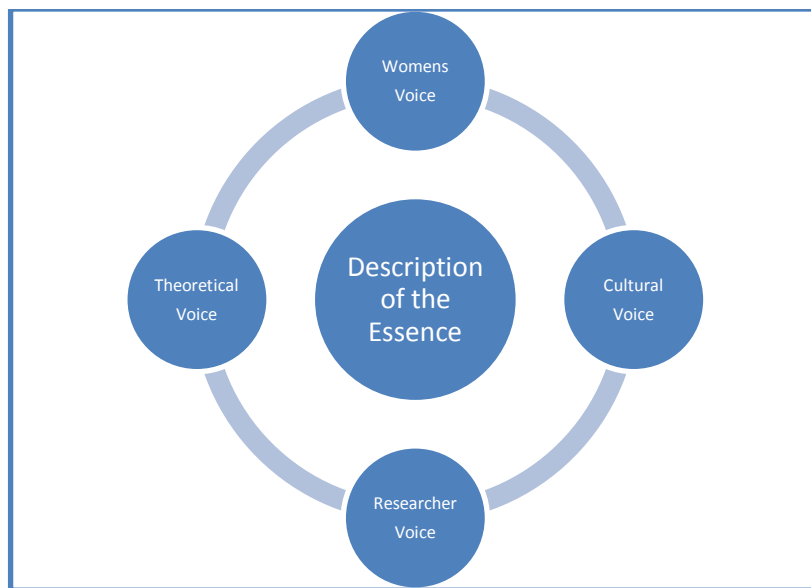


Figure 10 Voices present in account of findings

Cultural Voice

The six values that lie at the heart of Aboriginal and Torres Strait Islander culture (National Health and Medical Research Council [NHMRC], 2003) infuse the description of the phenomenon of being a Noongar woman experiencing childbirth. The six values are; *spirit and integrity, reciprocity, responsibility, respect, equality and survival and protection*. These values and principles, explained in detail below,

are related to all dimensions of the experience and punctuate the description, constantly drawing the reader to the cultural core of the phenomenon.

The cultural voice is present throughout the account which explicitly and implicitly demonstrates linkages with and pays deference to the six values of Aboriginal and Torres Strait Islander culture (National Health and Medical Research Council [NHMRC], 2003), in order to remain faithful and true to data. Full engagement with the implications of difference and values specific to Aboriginal and Torres Strait Islander peoples, means more than meeting requirements mandated for research. It is about acknowledgement of the trust that ten Noongar women placed in the researcher to faithfully and truthfully use their stories to bring the Noongar woman's voice into the wider community. The cultural presence infused throughout all aspects of the present study confirms the researcher's recognition of and commitment to respect for Aboriginal and Torres Strait Islander peoples.

Values and Principles of Aboriginal and Torres Strait Islander Culture

The indubitable and shameful truth is that, despite the advancement of contemporary Australian research, the historical preponderance of research conducted in ways that do not support the ultimate good of Aboriginal and Torres Strait Islander peoples, continues today. As a consequence "concerns persist in the Aboriginal and Torres Strait Islander communities about the ethical qualities of the research enterprise" (National Health and Medical Research Council [NHMRC], 2003, p. 5). Paramount importance has been placed on implementing every effort to mitigate the potential for misrepresentation of the women's stories. It is to this end that values, held so dear to Aboriginal and Torres Strait Islander peoples, form an integral part of the method of presentation of findings.

Examples of the way these values are applied within this study are offered as follows. *Spirit and integrity* is a quality of the culture which connects the past with the present and acknowledges its indisputable and formative role in the future.

Reciprocity is about giving and taking in equal and fair measure, both within culture and at the intercultural interface. The principle of reciprocity is described by Eckermann et al., (2010, p. 102) as "a pattern of sharing based on clear rules and regulations, which in turn define individuals' rights, duties and obligations within the

structure of their kinship network”. This value also ensures that research demonstrates cultural inclusivity and returns benefit to the Aboriginal and Torres Strait Islander community.

Responsibility is the recognition that central to the culture of Aboriginal and Torres Strait Islander peoples is a responsibility to kinship bonds, country, caring for others and maintaining a spiritual and physical balance in life. Another responsibility is to do no harm, especially not by preventing others to fulfil their cultural responsibilities. Additionally, one person’s responsibilities may be shared with others so that both become accountable.

Respect is highlighted within the culture, particularly with reference to elders, and also of the culture by Aboriginal and Torres Strait Islander and non-Indigenous people. Such respectful relationships reinforce and strengthen trust and co-operation both within culture and at the cultural interface.

Equality refers to Aboriginal and Torres Strait Islander people’s right to culture; the right to be different, the equal value of people.

Survival and protection of the Aboriginal and Torres Strait Islander cultures is primarily concerned with ensuring the continuation of the culture and importantly, the prevention of erosion of culture by colonisation and marginalisation. The right to celebrate and ensure the survival of both community life and distinctiveness of culture, ensures Aboriginal and Torres Strait Islander peoples can continue to maintain a values based and socially cohesive culture for future generations. The researcher acknowledges responsibility to do no harm and is accountable for the research process such that it is culturally respectful. Within the Aboriginal and Torres Strait Islander cultures is recognition of responsibility to country, family, land and spirit. A pictorial representation of the six values and principles of Aboriginal and Torres Strait Islander culture is provided in Figure 11 on the following page.

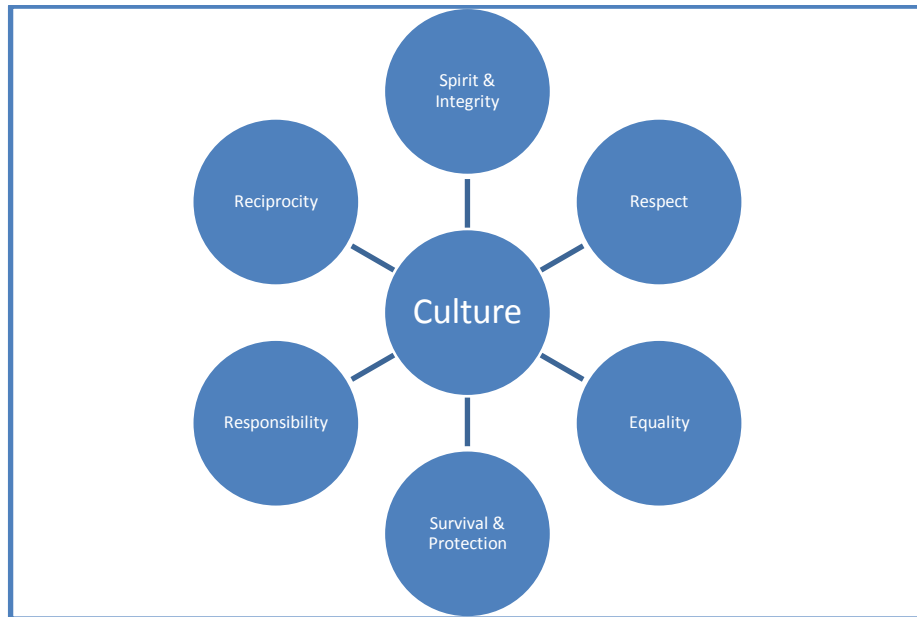


Figure 11 Six Values of Aboriginal and Torres Strait Islander culture

Themes

This study gave voice to a small group of Noongar women who would otherwise have no platform from which to share their birth experience with the wider community. Participant's accounts clustered around five themes without which this experience could not have occurred. It was discovered that being a Noongar woman who has experienced childbirth is to experience increased vulnerability; centrality of family; a time of cultural challenge; connection over time; and ubiquitous prejudice and racism. Therefore, the essence of the experience is an aggregate of these five themes that derive from multifaceted accounts of participants' childbirth experience. The quality of the theme is described by van Manen (1990, p.87) as "intransitive"; that is to say the theme is not a point in the text, but a means by which to seek meaning of the phenomenon as it moves or transits through the text. The sum of the themes therefore, provides a description of various aspects of the lived experience, such that all of the experience is drawn together by the identified emergent themes. A pictorial representation of the emergent themes is presented in Figure 12 on the following page.

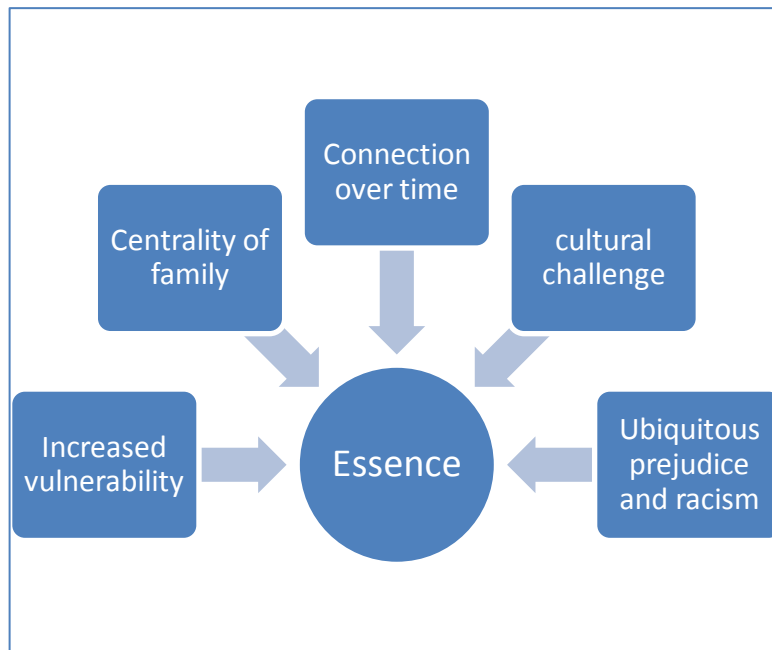


Figure 12 Emergent Themes

The researcher remains humbled however and prudently observed the caution of Sokolowski (2008) that, while discussing the human person, one can never unlock the full mystery of another’s experience. At best, light can be shed on dimensions of the experience such that it is seen as unique, aspiring to “provide glimpses that clarify [rather than] mechanisms that explain” (Sokolowski, 2008 p. 8). Explication of themes resulted in the development of a rich and deep description of the universal experience. This goes beyond the experience of the individual participant to arrive at the essence which “lies at the other side of the concreteness of lived meaning” (Van Manen 1990, p. 185).

Basis for the Account

The basis for the account of participants’ stories that takes the form of a phenomenological description, is informed by the emergent themes woven against four previously mentioned existential, as described by van Manen (1990). This is presented through an interchangeable and fluid narrative of, and articulation between, the voices of participants and the researcher, which is further supported by the theoretical voice that aims to “educate the reader” (Creswell, 2013, p. 228). Finally, the intersection of the cultural voice connects the reader to the values of

Aboriginal and Torres Strait Islander peoples. A pictorial representation of the basis of the account and its structure is presented in Figure 13 below.

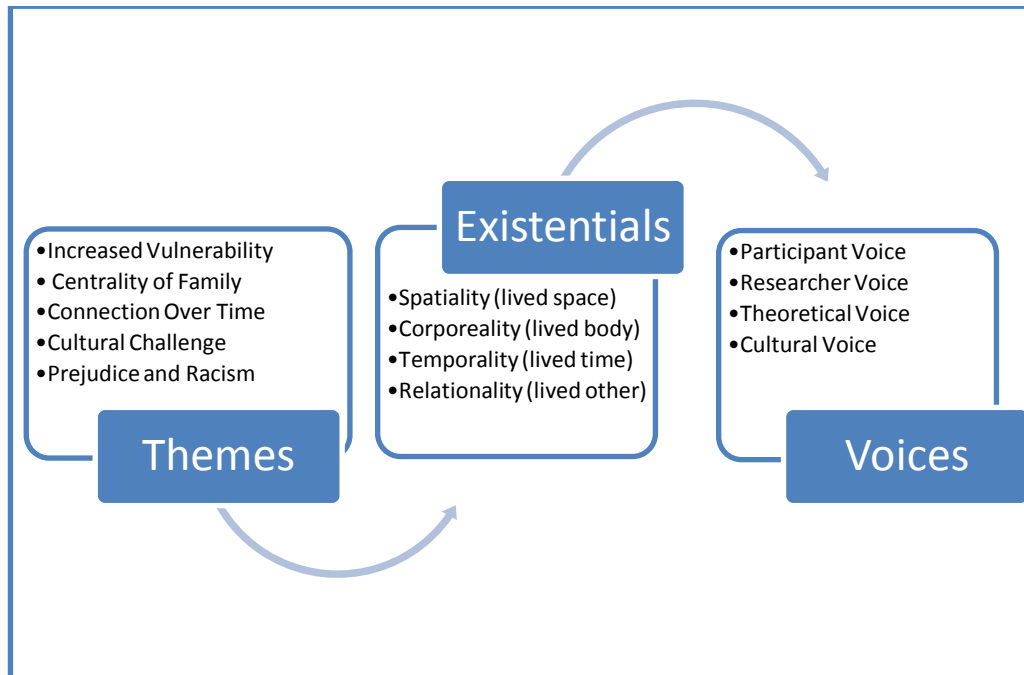


Figure 13 Basis for Account

Van Manen (1990, p. 176) asserts that in the process of “working the text”, a particular style of writing oriented to the unique study emerges. He claims “the research process itself is practically inseparable from the writing process”. This evolving of process was evident in the present study. Consistent with this, discussion of the five inter-related themes are presented separately, because of the variable emphasis participants placed on their actual lived experiences. Other aspects inherent in the description, as described above, are presented subtly and seamlessly in an effort to optimise readability and to limit compartmentalisation of the account, thus engaging the reader to connect with the women and their experiences of the phenomenon. The holistic nature of all interrelated aspects of the account of the phenomenon is depicted in Figure 14 on the following page.

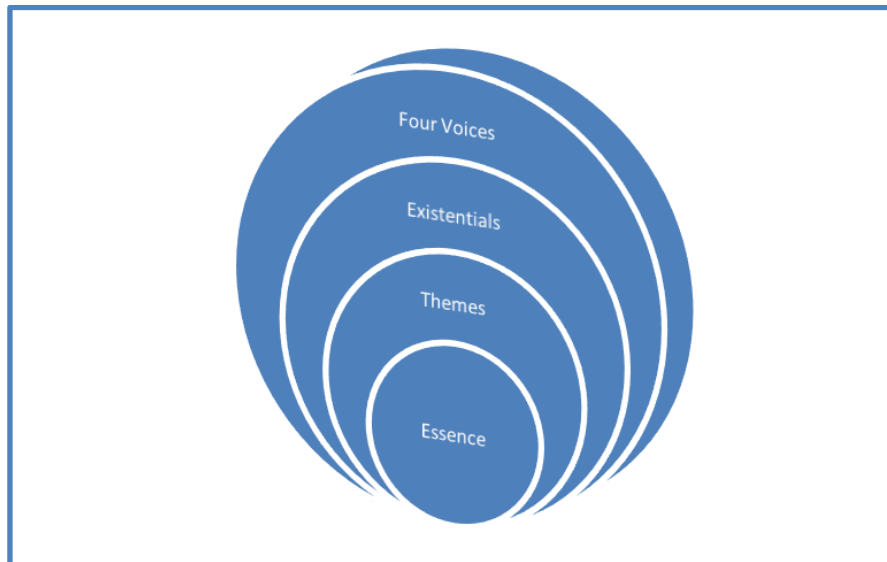


Figure 14 Presentation of Account of the Findings

Conclusion

In this chapter an extensive description of the process of methodical and sequential interpretive phenomenological data analysis has been presented, demonstrating heightened awareness of cultural vigilance and inclusivity by the researcher. Rigor and robustness of the interpretive design of the study has been confirmed by demonstrating a transparent process that is sequential, credible and auditable. In particular, a strength of the power-sharing model implemented in the present study is illuminated in the shared and co-analysis of data with individual and collective members of the Aboriginal Women's Reference Group. Finally, a detailed explanation of a unique process for presentation of findings is outlined to prepare the reader for the following chapter, in which a discursive narrative account of the findings is presented.

CHAPTER 6: FINDINGS

Introduction

The purpose of this chapter is to provide a detailed description of the findings that have resulted from the process of analysing and interpreting data described previously. The following presentation of findings combines an interchangeable and fluid narrative between the researcher and participants, supported by, and interspersed with, theoretical and cultural guidance. In this way anecdotal narrative, theoretically and culturally contextualised, provides an account of experiential examples that illuminate the deeper significance of the lived experience it describes.

The findings are presented by addressing each theme separately. These meaning structures are woven against the lifeworld existentials of temporality, spatiality, corporeality and relationality. In this way the deeper significance of the lived experience is made visible.

The following account of findings was constructed by expanding on the five emergent themes of increased vulnerability; centrality of family; connection over time; cultural challenge; and ubiquitous prejudice and racism; to produce a thick and rich description of the essence of the phenomenon. As a preface to the account of the findings below, a profile of participants is reiterated to facilitate contextualisation for the reader followed by an explanation of the system of participant identification used throughout the study.

Profile of Participants

Inclusion criteria of the study required that all participants identify as Noongar women, were 18 years of age or older, spoke and understood English language, and had birthed a single live baby within two years prior to the interview. A detailed description of participant inclusion criteria is provided in the Methods Chapter. The non-Indigenous researcher of the present study was constantly aware that the primary goal of the interview, conducted at the cultural interface, was to create a relaxed atmosphere conducive to participants sharing their stories. Interview technique was improved by wise counsel from members of the Aboriginal Women's Reference Group, who cautioned the researcher against asking too many direct

questions. The researcher considered as prudent, refraining from interrupting both by interjecting verbally and commencing the next line of conversation prematurely. By respecting silences and not appearing to force the conversation, most of the interviews took on the form of a story supported by conversation. Therefore, women were not asked to complete demographic information prior to beginning the interview, nor were they asked direct questions such as their age, marital status, educational achievement or employment position. Direct questions about how many times a participant attended an antenatal clinic for example, were avoided as the researcher anticipated that Aboriginal women may experience 'shame' and as a consequence, terminate the conversation and hence the interview. Such direct questions were not considered to make any perceptible difference to the research which, as a phenomenology, explored the lived experience as told by the participants. Information provided below which is additional to inclusion criteria, emerged in the natural course of the interview conversation.

All participants birthed their babies in public hospitals, four in regional hospitals and six in city hospitals. Although it was confirmed that all women were at least 18 years of age at the time of interview and signed a consent form to affirm this, eight of the ten participants chose not to reveal any further information regarding their ages. Four women had only one child, another had two children, a further three had three children, one woman had four children and another had five children. Eight of the ten women had not planned their pregnancy and two of the women had their babies by Caesarean Section. Four of the ten women lived with the father of their baby. Babies ranged from 4 months to 2 years of age.

Participant Identification

All women were assured of anonymity and confidentiality when they agreed to participate in the present study. Interviews were audio recorded and transcribed verbatim, after which they were de-identified. Participant details were kept separately to de-identified data as a means of ensuring confidentiality. For purposes of auditability and traceability, participants were assigned a number from 1 to 10. Further to this, identification of the baby whose birth the participant reflected upon was assigned a letter "a". The first participant was therefore assigned P1 and her

baby P1a. This system is used throughout so as to identify the variable source of participant quotes in the following account of the findings.

Findings of the Study

As previously mentioned, five themes emerged from data following a methodical and sequential process of phenomenological interpretive analysis. The resultant five themes of increased vulnerability, centrality of family, connection over time, cultural challenge and ubiquitous prejudice and racism are presented and discussed in detail below. Themes were not totally discrete in that there was some inevitable overlap in their meaning and content. For example, a participant may have described an event associated with a felt sense of increased vulnerability that had also resulted from an experience of prejudice and racism. The interpretive analytical process, as described in the previous chapter, followed multiple levels of reduction of data, reaching an end point of five themes and as such, no subthemes were nominated. The order in which themes are presented below is not indicative of importance or prominence.

Increased Vulnerability

Women who were interviewed all recounted incidents that demonstrated feelings of increased vulnerability in some way. Although it may seem obvious that childbearing women are a vulnerable group within the wider population, Aboriginal women have additional vulnerabilities (Commissioner for Children and Young People, 2009). Issues of poorer general health than the wider population, higher rates of teenage pregnancy and greater risk taking behaviours in pregnancy, are just some of the additional burdens that face Noongar women in the childbearing experience (Ferguson-Hill, 2010; MacRae, et al., 2013).

All participants birthed their babies in public hospitals. Due to the location of Noongar land and the density of population within it, all participants were cared for in hospitals where they were members of the minority race. Most women attended antenatal care appointments either at a doctors' surgery or the hospital in which they planned to birth. For various reasons, some participants found attending medical appointments for their pregnancy difficult and consequently attended less often than

was optimum. One participant said *'Well, I actually got diabetes with that pregnancy...because it my fifth...didn't really go to the doctor much...didn't really go to the ultrasounds much...when I did go...baby was really big'* (P1). Another woman without a partner said *'It would have been so much easier if he'd been here...going to the doctor's appointments...it felt really no good'* (P9). Having recently relocated back to her country from the north west of the state another woman said *'because I'm new to this area ... wasn't too sure where I had to go, ... doctor ...referred me to Maternity hospital... just over four months I started going there'* (P10).

One participant described staff in the hospital as *'friendly...they were good'* (P9). Another woman described feeling supported when she was in labour. She said *'I was just gripping the nurses, holding them tight'* (P3). However the hospital experience left some women feeling uncomfortable; one woman could not identify the reason but simply said *'I just couldn't wait to get home for some reason'* (P4). Women did not describe feeling relaxed, comfortable or at home in the hospital environment.

Many of the women interviewed felt out of place and uncomfortable in the hospital setting. One participant, alone when transferred to the city to have her baby, felt particularly vulnerable when separated and so far away from her family. She said *'the nurses and doctors were really lovely'* however she felt it *'was a bit horrible, you know, being so far away'* (P1). Home when considered in terms of the lived space, holds special significance. It has to do with the "fundamental sense of our being" (Van Manen, 1990 p. 102). One participant said *'the day before I was having her, I was getting contractions and I drove from City to Country town. ...I was born here so I wanted her to be born here, too'* (P7). In this space, being alone is not the same as being lonely. No mask is necessary to conform to the expectations of another world as there is a certain protection and power inherent in the notion of 'being at home'. One woman, who was hospitalised and away far from her home town, found the *'hospital accommodation...claustrophobic in there...summertime...horrible...those little rooms'* (P6). Thus, crossing intercultural boundaries can engender a state of vulnerability and powerlessness, with resultant feelings of being out of place and outside the comfort zone (Walker & Sonn, 2010). A lack of hospitality, respect and cultural awareness affected one woman in the following way:

Well, it was okay, but some of the nurses – not the nurse, but the doctors – yeah, that was a bit like, they didn't really want to say what was wrong with me and all that. Yeah, they just wanted to get me in and then get me out. It made me feel out of place, so I just stopped going there. When I came back home, I got my own house back. I was staying with my Nana at the time because I've got no car and she's got the car and she's close to the hospital, so I just stayed there for the night. (P7)

Four of the ten participants lived with the father of their baby, while others were single parents or had separated from their partners. One woman trying to cope with two small children and a new baby on her own felt '*really depressed...really depressed...emotionally, physically...so worn out...wasn't getting help that I should have from their dad*' (P2). As participants shared their unique experiences, they reflected on the many facets of life that impacted on the experience of having a baby at that point in time. One woman fled many thousands of kilometres from the north of the state, returning to her home country with two small children, in order to have a third child away from a violent domestic environment. For this woman a sense of the shifting lived time was influenced by immediate past events connected and influencing the childbirth experience. The following excerpt poignantly describes how one woman moved away from a destructive time in her life:

I never want her [newborn baby] to be in that situation [domestic violence]. So if I could take anything from my situation, I'd like to protect her from that. I know she's got two big brothers that will do that, anyway. It's a bit unfortunate that my oldest, he's kind of witnessed a little bit of it until I chose to get away, which is good. It's the best thing I ever did. Yeah. After that, I found out, when I did get pregnant, I could enjoy it more, whereas in a domestic [violence] relationship you don't have that energy to focus on just you and the child. You're trying to be safe and look after your kids. (P 10)

Many of the women felt that, as single mothers, they were particularly vulnerable and in need of care, which they described as gentle or '*softer*' (P5) care, to '*support them through it, and not judge them*' (P7). Often being the central care givers in the family and community, Aboriginal women have been described as the "doers within their community" (Pattel, 2007, p. 6). Many of the pregnant and childbearing women interviewed however, experienced a unique lived time, when

they were in need of a 'more softer' (P5) type of caring. One woman describes how dismissive practices affected her:

It's just like they [healthcare staff] need to be a little bit more softer. I mean, you've just had a baby. You need to be a bit more sort of caring. And if you can't be that, then you shouldn't be a midwife, because having a baby is something that's special. It's a new addition to the world. You're the person that's just brang [sic] that baby in the world. They should be a bit more attentive, a bit more softer. (P5)

Despite feeling vulnerable for various reasons, the joy of childbirth was evident throughout the participant's stories, for example one woman said 'I felt like relieved, and when I first held her, I just started crying...tears of joy' (P7). However some women shared their feelings about craving gentleness within the childbirth experience suggesting this was related to an upbringing devoid of overt displays of love. One woman linked this to the effects of the Stolen Generation; her forbearer's lives spent on the missions, where, as she explained if they 'did something wrong, you got a flogging for it' (P2) they experienced no love and affection, simply hardship and survival. Such intergenerational trauma aligns with Gadamer's conceptualisation of the connectedness of time, as being in the horizon of time, such that the present carries with it the heritage of the past (Gadamer, 2001). This indubitable truth is consistent with the Aboriginal and Torres Strait Islander cultural value of spirit and integrity that recognises the inextricable connection of past, present and future (National Health and Medical Research Council [NHMRC], 2003). The following dialogue is a participant's account of oral history passed by her mother:

And then having to eat weevils in your porridge, stale bread, yucky water and a piece of fruit. That was all you had. And they had their steaks, potatoes, and their carrots. They were Germans. German nuns. And that's where my mum learned the law of survival. Survival of the fittest. That's how she learned to be so hard. If you're going to be strong, you've got to be hard. If you're going to be weak, you're going to break. You can't let them break you, so you've got to be strong. And that's how she came out so strong and so hard. And why it was so hard to communicate. Do you know what I mean? Yeah. But how can you blame her for it? You can't, really. As much I get angry and I just can't stand her some days, then I think how can you communicate when you never had that? (P2)

Being alone and unsupported as mothers also contributed to some participants feeling vulnerable. Conscious that they had sole responsibility for children was difficult and lonely. One woman said *'I just felt so depressed...I'm on my own...just me and the kids'* (P9). Social infrastructure including formal and informal social networks provides support, trust and reciprocity. Ziersch, Baum, Darmawan, Kavanagy and Bentley (2009) found in their research that higher levels of social capital were significantly associated with better mental health for both urban and rural participants. When family relationships fracture the raising of children, so often the responsibility of extended family members and friends (Passey, Gale, & Sanson-Fisher, 2011), becomes very challenging. With responsibility to family and community so important to Aboriginal and Torres Strait peoples (National Health and Medical Research Council [NHMRC], 2003) this deficit was particularly difficult, as expressed by the following participant:

And then one day we had the smallest, smallest argument. Just like that, he said he wasn't coming back. It didn't make any sense. And he never come back. I just felt so depressed. I'm on my own. I knew I was on my own. It's just me and the kids. And I've got my mum here, but she works full-time, and no other sort of family support. But it was really hard. (P10)

At times most participants felt a lack of respect to some degree when engaging with the healthcare system; as one woman explained, *'I'd just given birth...horrible...22 hours of labour plus they were all treating me as if I was a child'* (P5). Respect, a fundamental value for human dignity, when absent from interactions, especially those conducted in a place where the woman was in a dependant relationship, caused increased vulnerability. Two of the participants were positive about their culturally oriented pregnancy care saying *'I went to ...Aboriginal medical service ...yeah it was good'* (P7) and *'I had shared care with Aboriginal and Torres Strait Islander medical centre'* (P8). It may be trite to assert that birth must happen somewhere, in some place, however it must "inevitably occur in someone's territory" (Lock & Gibb, 2003, p. 132) and the hospital was not the participants territory. Being in a familiar place inherently provides connection to the individual's lifeworld; providing a sense of empowerment, security, calm and confidence. Contrary to this, most women expressed discontent and increased vulnerability in the hospital setting. One woman said *'give them support...if they don't know...support...not judge them'*

(P7). As van Manen (1990) elucidates, the fundamental need to connect with others is a basic element of existence. Lack of connection was expressed by one participant at the time of birth who said ‘well, it was away from the family, so I didn’t have anyone to come to visit’ (P1). This need was clearly expressed in various ways by participants, where some women felt an undercurrent of prejudice levelled towards them because of their race. Another felt ‘it was really lonely’ (P5) bereft of the comfort of loved ones, while others perceived a power differential such that self-confidence was undermined. The description that follows is charged with interpersonal significance. Here a woman, deprived of this fundamental support of another, is filled with a sense of loss:

Sometimes I wasn't even strong....I was afraid to say I'm not happy with that. But I would give them a look like I don't like that, but there was nothing done. Sometimes I felt they know what they're doing. I would feel like I didn't have the right sometimes to say how I really felt and what they should or shouldn't do. I think she was a midwife, yeah, she was a midwife. A young sort of a girl, probably mid-thirties also, mid to late thirties, I think she might have been. But I did walk away that day thinking I'm so stupid, I should have really told her how I felt, told her to stop, you're hurting me or something. But it's like I didn't sort of feel like I had much of a right because she was the professional and I thought, is it worth saying anything? I just left it at that, then. But it ended up sort of being all right. (P9)

Extreme vulnerability was demonstrated by many of the women who left hospital before recommended medical discharge, because they felt uncomfortable, unsettled or out of place. As one woman explained ‘they just wanted to get me in ...out....made me feel out of place...so I just stopped going there’ (P7). These feelings that were experienced to such a degree as to result in discharging oneself from hospital against medical advice, may be perceived to have occurred as a result of implicit racism, in that due consideration of the effect of hospitalisation on the Aboriginal woman was not given. There is strong evidence that “systematic racism, [however subtle], leads to reduced opportunities to access societal resources required for health” (Zubrick et al., 2010, p. 78). Leaving hospital prematurely was a risk to health and potentially dangerous, not only for the woman and her newborn baby, but also other small children in the family. In the following story one mother shares her dilemma:

And the lady who had the C-section, there was a lot of blood in the bathroom when I went in there, and I just felt a bit awkward in there, so I kind of, instead of staying, I stayed overnight and I left the next day at twelve because I just thought maybe I'd feel more comfortable in my own home. And, because I know, that when I came out, having the diabetes as well, there was no follow-up on it. When I went shopping with the kids a couple of days after, I felt so dizzy I wanted to faint. And I knew it was because of the diabetes. And then the thing was I didn't get checked again at the hospital at all. It wasn't monitored. (P10)

Participants shared examples of how their physical appearance as simply looking like an Aboriginal, resulted in feelings of increased vulnerability. They felt judged by healthcare staff on this superficial level. One woman who experienced subtle judgement in the hospital said ‘*some of the ladies...they'd have family over... they were loud as anything...nobody asked them to stop*’ (P9). Another woman who had made the decision to discontinue breast feeding explained ‘*from then on, they just sort of went a bit cold towards me, sort of like a bad mother*’ (P5).

Van Manen (1990, p. 103) asserts that despite who we are, “in our physical or bodily presence we reveal something about ourselves” to others at the first encounter. Each of the women interviewed, experienced negative prejudgements based purely on their appearance as Aboriginal women. One woman said ‘*judgment from other people, the way they look at Noongars*’ (P3), whilst another participant expressed hopes that her child would ‘*never, ever feel ashamed by saying, “Yes, I’m part Aboriginal.”*’ (P5). Such anathema borne of preconceived societal ideology and marginalisation, displays colonising behaviours so abhorrent to Aboriginal culture and values (National Health and Medical Research Council [NHMRC], 2003). The following story highlights how one woman’s bodily presence both revealed preconceptions of others and concealed aspects of her individual identity:

In a way it does, because if someone asks you, are you of Aboriginal descent and you say yes, and then it's...just like we're sort all brushed with the same brush. I think in society we're all brushed with the same brush. So if I do say yes, I'm Aboriginal, then automatically I'm one of those ones that hang around in town, smoking cigarettes at 10 years old, getting drunk and all that sort of stuff. Whereas not being Aboriginal, and missing out that detail and saying no, I'm not Aboriginal, oh, okay then. They know automatically that everything's fine. (P5)

Most participants identified feelings of hurt and frustration when they experienced personal judgement based on stereotypes. Aboriginal and Torres Strait Islander peoples have declared through their representatives that “cultural distinctiveness is highly valued by them” (National Health and Medical Research Council [NHMRC], 2003, p. 18). Cultural difference is in the first instance identified by the way someone looks. This initial presentation of one person to another, being a superficial and objective observation, if taken no further, is a racial assessment (Flemming, et al., 2006). The following woman recounts how, based solely on her bodily existence in the world, strong sentiments of disrespect and unkindness were levelled at her:

It's good being black, but if a black person did something wrong to someone, they will paint you with the same brush. Like the taxi man. I think he must have been Aboriginals who bashed him because the police reckoned it was one of "your mob". It can't be. If you tell me a name, a last name --Because we always [get] a lift with the taxi man and the policeman reckoned, as soon as the taxi man seen me and my sister, X, [both heavily pregnant and requiring a lift to the hospital] he's like no straight out. He don't want to give us a lift. So the police dropped us off. (P3)

Most mothers in the study experienced fear for the safety of their baby. Feelings of hyper vigilance and fear of the foetus or newborn baby becoming harmed in some way were common. Participants described ‘*being a very stressful mum*’ (P2) and ‘*can't even sleep light...always waking up checking*’ (P3). One may assert, given that “half the Aboriginal and Torres Strait Islander population [is] affected by forcible removal either directly or indirectly through their family” (Zubrick, et al., 2010, p. 83), an intergenerational and innate fear of loss of a child is understandable. Consequently a cultural value of protection of family, heightened by the tragedy of the Stolen Generation, links this past event to manifest as present fears, resulting in attitudes which protect the future generation. Such an example of cultural spirit and integrity (National Health and Medical Research Council [NHMRC], 2003), is movingly revealed in the following account:

But I was just really, really paranoid. I don't know why. I was so scared that she would suffocate in her bed. I was thinking, all these horrible thoughts were going through my head, so I would sort of prop all my pillows up in my bed and she'd be in her bassinet on the side and I would sort of just watch

her. It was really, really bad. Mum said sometimes I'd walk in the room and you'd be sort of asleep like an Army man or something like that. So I just was too scared to lay down. I was scared if I did and then I didn't keep watch, then something would happen. (P5)

Some participants described a fear of their children being harmed, which extended for many years. The following participant described a need to ensure the safety of her children when they were at school:

Even now, I still rock up at my kids' school just randomly to make sure that they're okay and being treated well. I'll ask the kids, sort of thing, so I'm on to it there sort of thing. (P9)

Many of the women interviewed felt a strong desire to be with their children constantly. All experienced a fear of their baby being harmed. One woman said 'we're very overprotective of our children' (P10). Although one may assert that most mothers have the primordial need to protect their infants, given the history of loss of children within the culture, it could be fair to claim that Aboriginal women are especially vulnerable to such fears. Taylor and Guerin (2010) provide a powerful case in point in their discussion of the Australian Northern Territory Emergency Response. The Intervention as it came to be known occurred in 2007, resulting in the "arrival of a convoy of army trucks in a number of remote communities evoking considerable fear among some who remembered members of their family being removed under previous policies" (p.40). Additionally, since colonisation, Aboriginal people have experienced a higher rate of loss and death compared with that of mainstream Australia (Pattel, 2007). These factors add weight to the concerns of the following participant:

Yeah. I've got trust issues bad. With all my kids, I never let them leave my side. If they had to go somewhere for anything, I'd be there. Otherwise, they never left my side. I've heard too many stories of weird things happening and stuff and I just thought no. But then it might be because they were in me for so long. (P9)

Some women reframed their lived past as the impetus to change what they perceived to be the root cause of personal vulnerability. One woman explains that 'I used a lot of drugs before I had my kids...totally turned my back on it since' (P2) Having a sense of time lived, as far back as their childhood, it was clear that

encounters from the past remained as memories, which in some ways shaped the women as they moved into adulthood. Some of the women interviewed remembered negative elements of childhood, articulating this as a consequence of their parent's family experiences. A participant explained that all she wanted for her baby was '*to have everything that I never had*' (P3). This is more widely recognised as endemic trans-generational trauma, associated with forced removal of children that contributes adversely to health and social situations in Aboriginal communities today (Morgan, 2010). Many women identified a resolve to gain control over their lives and situations and to implement strategies to enhance and sustain social and emotional wellbeing for themselves and their children. Affirming personal strength was demonstrated as women shared how they would improve life for the next generation. Such resilience reflects a strong sense of responsibility being poignantly evident in the following story:

Well, I grew up around my parents and my parents drank and partied and all that. They had fights. And I didn't like it. I used to just take off and go and stay at my Nana's and take it away from them, but sometimes I couldn't do that because my Nana wasn't home. And, yeah. People used to come around and they ate all our food and then we had nothing to go to school with, so we had to go with like just bread and vegemite or something like that, and a bottle of cordial. We never, ever had like lunch from the canteen or anything. So I want her to get a proper education than what I did, because my parents split up and that's what gave me – I had a breakdown. And I don't want to see my daughter go through the same thing, what I went through. Yeah. (P.7)

Centrality of Family

All women in the study described how important family was to them. One woman felt '*it's just good to be around family a lot in your life*' (P4). Family is so important to Noongar women because it denotes who they are and where they fit in to the scheme of life (Pattel, 2007). It is an integral part of their being. One participant explained that '*to have a big family...I don't have to worry about anyone else*' (P3). When meeting new Aboriginal people, the first part of the conversation is always to establish where that person comes from, who their family is and how they are connected to the new acquaintance. The researcher in the current project was advised by the Aboriginal Women's Reference Group to speak about family and country as a way to begin conversation with new participants. Interest in the

participant's family and how they are connected to country and community shows cultural respect, because it reflects interest in who that person is at their very core. Pattel (2007, p.4), an Aboriginal researcher, academic and therapist asserts "the importance of family relationships is intensified by the difficulty that Aboriginal people experience in gaining validation from mainstream society and the role that family members play in promoting one another's wellbeing".

The importance of family featured strongly in all participants' stories. One woman said '*we're very family orientated and we do like our family to be around*' (P5). Caring and protecting, promoting self-esteem and wellbeing and providing support in many different ways, are some of the reasons why Noongar women in the study indicated that family relationships are their greatest asset. Another participant commented '*even the extended...third ... cousins ...we still consider them like brothers and sisters*' (P6). Women clarified that family consisted of immediate and extended family members of multiple generations, often living together for long periods of time. As Pattel (2007, p. 3) elucidates, "whilst some traditions have been lost due to forced colonisation, the family structure has been strongly maintained", consisting of not only biological and affinal kin, but classified family members being those who have earned the right to be considered family. Such a person, who is not a blood relative, may assume the role of grandparent or aunty with equal status in the family. The importance of family is particularly understandable for Noongar women of childbearing age, who all live as citizens of a marginalised minority. The role of extended family was clearly important to the following participant:

I'm not much of a talker. I try to be, but I'm not much of a talker. But I try to be, but no. Yeah. See, I've always had my older sister to talk to. She's not around at the moment. And now I've got my cousin. She's there to listen. So there is someone, you know what I mean? But I'm not a person just to pick anybody out of the crowd. To me they're a special person; they are very special to me. (P 2)

Mothers in the study expressed a strong desire to be physically close to family members on the day the baby was born. One new mother when interviewed said '*they're sort of just in there to support you and just encourage you to keep going, see you're doing well*' (P5). Often, many relatives and friends attended the birth to support the mother and share in the joy of welcoming a new life into the

community. One participant said *'I had my brothers there and my dad...but my mum, I wanted her there but she wasn't there'* (P7). Presence of significant family members who nurture and guide the woman in birth, normalise the process and rhythm of birth (Adermann & Campbell, 2010). One woman reflected on the moments immediately after birth and said *'I was petting him, I said "no he's fine...he's asleep" and mum was right there with me'* (P4). Participants explained that these family members had a cultural responsibility to family and community (National Health and Medical Research Council [NHMRC], 2003) and would play a key role in the life of the new baby. When life returned to normal for family and friends however, one new mother was left alone pining for her family. The lived space of the hospital was one in which this woman experienced loneliness and anxiety. Feeling a deep need to be with her sick new baby in hospital, she told the following story:

That was okay for the first two nights, because I was staying for a week, because my temperature went high and my daughter got an infection or something, so she had to be on a drip and so did I. And they discharged me a few days after that, but I didn't want to leave my daughter there so I stayed with her. And in the hospital, it did get to me. I just wanted to get out there and go home. They [family] come like the first few days, but then not after that. No one came. I felt relaxed in there for a while, but then I started getting worried. I wanted my family around me and I wanted to go home. Yeah. (P7)

Mothers in the present study described dislocation from their family and home town extremely distressing. Another participant, separated from her parents found it *'just really hard'* and *'kind of horrible'* (P6) when she had to move to a city hospital for medical monitoring. She described the stress of separation from her family was exacerbated by a confined and unfamiliar living space. As the complex notion of community is key to Aboriginal culture (National Health and Medical Research Council [NHMRC], 2003) birthing away from country and the support of family and friends can be very stressful (Adermann & Campbell, 2010). The following woman relates her story of dislocation:

Yeah. About a month before P6a was born, I went to [large public maternity hospital] because she was a bit too small when I had an ultrasound done here [country town], so they sent me to [the city] and I was staying in the hospital and also in the – what's that little building? [Inpatient accommodation

attached to hospital] Yeah. Because I knew that she was going to be born soon and that was kind of a draining sort of thing. Especially because my mum and dad were down in [country town] and I was up in [city] on my own, just me and my partner, and yeah Being away from parents is scary when you are pregnant. (P6)

Birth is an important cultural event which most often involves the whole family, including the children. One participant said ‘*I just had one of my first cousins there, and then my dad ...his other partner, and my sister, and my two brothers, and my other sister*’ (P7). The Secretariat of the National Aboriginal and Islander Child Care Incorporation reportedly defines the identity of an Aboriginal and Torres Strait Islander child as “being intrinsically connected to their family and their relationship with the land” (Commissioner for Children and Young People, 2009). Geographically disadvantaged families that are separated at the time of birth, for whatever reason, are negatively affected as the following story demonstrates:

Well, it [hospital 250K from home] was away from the family, so I didn't have anyone to come to visit. My auntie did come and then she was picking up my auntie from South Australia, so they came, and I have a friend in Perth. But, yeah, it was a bit horrible, you know, being so far away. Not having all the other kids come too, because...they were just on the phone, wanting to know what she looked like and wanting. (P1)

When interviewed, women who were separated from their homes, communities and families in order to labour and birth in another location recalled time passing slowly. It has been suggested that the woman's self-esteem, mental health and wellbeing and accordingly, her physical, cultural and spiritual health are negatively affected by such disconnection (Hancock, 2007). The following story exemplifies the stresses incurred when childbirth is technological, medical and lonely:

She [participant's mother] came up the day before P6a was born, because I was booked in to have a Caesarean the week after. But because I was – it was really draining, and I was getting a bit upset, because those women that, came into [the accommodation] long before me, weeks, they was just coming in, having their babies and going out, and I'm still sitting in the hospital listening to them with all their dramas and that every night. It was just really hard. With P6a I went all the way up to 38 weeks and then, I don't know. Because I was on the – what are they called, the CTG machines? – all the

time. She was like always asleep [intra-uterine] during the day when I'm supposed to get them done, so then I had to go at night time. And that was sort of draining a lot of me as well. So that was kind of horrible, just getting that done every night, every night. (P6)

In the present study, the close bond between mother and child was evident throughout the women's stories. One woman said 'yeah...as soon as I had her, they gave her to me and I had her on my chest' (P10), yet another participant recalled 'I got to experience like straight after and got to hold her and got to have her in the room with me and everything' (P6). This close bond extended far beyond babies and young children to include the relationship with adults and their mothers. One typical comment was from a participant who said 'yeah, mum was there, all the way ... just my mum. I just wanted mum' (P4). The mother provided advice, direction and a place of refuge to many of the women interviewed. The maternal role is highly valued by Aboriginal women, often more so than the marital role according to Pattel (2007). As Aboriginal women tend to be younger when they have their first child than women in the wider Australian community (Ferguson-Hill, 2010), many participants had not left the mother's home. For others who lived elsewhere, the family home was often used as a safe haven. The following young mother shares her experience of a lived time of security when, despite having made her own home, she returned to the place where she felt supported in familiar surroundings with family and friends close at hand:

I eventually did move back home, because I wasn't living at home, pretty much so Mum could help me. And I was going to stay here until she was at least six weeks old, just to get the gist of things and so Mum could help me out with stuff. And then I eventually moved into my place, which is the one in (metropolitan suburb). It just got too far away and I broke up with my boyfriend so I was really quite isolated and lonely out there, so I just didn't want to live there anymore. My mum's lived here for 10 years, so it was a bit of a shock when I moved. I hadn't really been away from home for more than two or three weeks, so it was a bit weird moving out for good, out of my area. It was really hard difficult to be away from friends and family. I have a friend that lives just at the beginning of [mother's home suburb] then I have a friend that lives just five houses down, so everything's sort of close, and the shops are just there. You know everyone at the shops and the neighbours and everything's just so close. Everyone knows everyone sort of thing. It's like 'Summer Bay' or 'Home and Away' or something (laughs). (P5)

Some women in the study described feeling protected by their families in the normal course of their lives. One woman explained *'I'd like to have a big family...I don't have to worry about anyone else'* (P3). So integral to the Aboriginal self is the experience of "containment" where the individual is surrounded by "territories of family, community and the ecological system" (Pattel, 2007, p. 7). This provides a protective layer within the broader non-Indigenous society. Pattel (2007) elucidates further by explaining the "Aboriginal self is contained within the centre of one's family, to identify where one belongs, [one's] role, function and commitment to family and community" (p.7). Belonging to this cultural order could be described as being a part of a body of members. Such belonging means fitting comfortably into a community; a cohesive group that affords identity and support (Flemming, et al., 2006). The following woman explained that a child would provide protection and support to her as a mother so that each would look after the other. She said *'we didn't want to mingle with people. It would take a while before we got used to them. Yeah. But me, my sisters and brothers, we were like little dingoes growing up'* (P 3).

Many women expressed feelings of disrespect and judgement from others, simply because they looked like an Aboriginal person. Although most claimed that they were proud to be Noongar, their physical appearance caused them difficulty during the childbirth experience. All had endured these colonising behaviours since childhood. The following woman explains how her sense of responsibility to family outweighed her own need for support from family and friends while in hospital:

I think you'd get funny looks when your family would visit you, or if family was sitting around you. People, I don't know if they're feeling intimidated because there's a group of Aboriginals sitting together, or if they're talking a bit louder than most might. I don't know. I think maybe that sort of thing. I was a bit afraid to have people come in and see me because I was thinking... just save the looks and save people being mean to them ... whatever. Sometimes it was like that. (P9)

Although most of the women who were interviewed had strong family support, for various reasons *'some Noongar women don't have family support'* (P 10). The majority of women interviewed expressed concern that Noongar family ties were not as strong as other Aboriginal groups. One woman compared Noongar culture with Aboriginal groups in the north and said *'down here, it's like we're a lost*

culture' (P9). Some attributed this to the lighter skin colour of Noongar people due primarily to the formation of interracial families over the generations. Family is usually viewed as a complex interrelated group that derives meaning through interactions within and between the family and the outside world, which in turn is a matrix of interrelationships (Eggenberger & Nelms, 2007). However, when appearance is the key point of difference, cultural values of Aboriginal people markedly contrast with western understandings of family. This complex notion is demonstrated in the following participant's story:

Like I have aunties and uncles that are white as well, and then I have some that got their partners as Noongar. Like with my auntie, my uncle and his wife, who's white, and then my other auntie, who's Noongar, so my cousins from the Noongar ones, they're a lot more closer sort of thing, whereas my other ones, they're sort of like – I don't know. They sort of like stick to themselves sort of thing. Like, I don't know. I don't mind being with the Noongar ones, whereas like the other ones are sort of like, I don't know if they're like scared of us or something, but no. But even though their dad's Noongar, yeah. I don't really know. Because they don't even call my mum – they don't even really speak to her, really, even though that's their dad's only sister. (P6)

Although family is central to the experience of childbirth for all women interviewed, each individual came to a relationship with her new baby differently. For most women interviewed, pregnancy '*wasn't exactly planned*' (P6). One woman said '*had car accident...I was 15...really thought I'd never get pregnant... never went to the doctor's to see if I could...it shocked me*' (P4) whilst another woman explained '*I smoked marijuana ... didn't know...pregnancy never even crossed my mind*' (P2). Some women seemed not to understand fully the process of conception. One woman remarked '*I thought you've got to have orgasm and all that stuff working before you could have a baby*' (P3). Another participant said '*I had the implanon out after a year...don't know why... didn't think I could get pregnant...There was a six-year gap*' (P10).

Even though nine of the ten participants did not plan their pregnancy, this did not seem to detract from the excitement and joy of pregnancy and childbirth. It could be construed that family is so culturally significant that it overrides control, convenience or timing. One woman recalled '*hearing her cry...is that*

her...looked...that's all I wanted to see...she's fine...it was good' (P5). Most women had one or more stressors in their lives during this time including financial concerns, distance from family and separation from their partner. A cultural acumen seemed to prevail, however, as all women recounted the pregnancy and childbirth experience to be a source of happiness and joy. Recalling the moments after her birth one participant said *'this beautiful little boy, now look at him...I shed tears of joy' (P4).* As with all Noongar women, participants were different from each other, each describing their unique relationship with the new baby. The following new mother described how she came to relate to her baby with a degree of reciprocity:

Well, the first few days didn't really get to me, didn't really feel like I was a mother. But I knew I had a daughter. It didn't really get to me, but then as the days went by she started getting attached to me and I started getting happier. Nine months [old now]. I feel great knowing there's someone there I could turn. (P7)

Each woman interviewed described her family in a unique and different way, yet each of these families was as different as any family. However, the notion of family and shared values that bind Noongar families together is different from non-Indigenous families (Cuthbert, 2001). Aboriginal perceptions of community are primarily based on family relationships, as these produce a sense of belonging to family and country (Dudgeon & Ugle, 2010). One woman expressed the sentiment, imbued with a love of family, when she said *'You know, you'd think having the fifth one would make your house more crazy or something, but she brought us more closer together' (P1).*

Connection over Time

As the women in this study spoke about their childbirth experience, each reflected on an immediate or long-ago past, they acknowledged their present reality and shared plans for the future. One woman said *'well, I know I'm not going to get her to grow up the way I grew up' (P7).* Another woman who had a difficult relationship with her mother said *'I would like to have a really, really good, open relationship with my children' (P2).* Conversation centred primarily on their babies, however reflections drew the past into the present so skilfully and sensitively that the

connectedness of life over time was not only felt, but rendered the researcher truly conversant with the phenomenon.

When reflecting on their babies women expressed the joy and love childbirth had added to their lives. One woman said *'I'm loving this, so I'm glad I had a baby... because I just felt real loved and shared baby love...I thought, yeah, I can do this'* (P4). The Aboriginal and Torres Strait Islander peoples' cultural value of spirit and integrity represents the continuity between past, current and future generations (National Health and Medical Research Council [NHMRC], 2003, p. 19) and as such, has often been the "touchstone for action" that protects cultural identity. Pattel (2007, p. 9) describes this connectedness as wholeness, asserting "it is only possible to understand the Aboriginal being if we understand how all is connected". Such oneness with the world and over time is confluent with Gadamer's general structure of *understanding*; being only possible when bound in history while concurrently offering future possibilities (Gadamer, 2013).

Women within the study were diverse and unique, with each describing their own life circumstances that impacted on the childbirth experience. Several women created a different lived space for this time in their lives. One woman wanted her baby to have a *'home that she feels safe in ...feels stable ...a good relationship ...talk to me about anything'* (P5). All mothers interviewed felt a strong responsibility and need to provide a safe space for their children, often without, or indeed moving away from their partners. Decisions made were based on a deep desire to move away from the past, to create a safe life for themselves and their children and importantly, move towards a healthy and hopeful future. The following woman shares her story of creating a new lived space away from the destruction of domestic violence:

Yeah. He was six, but we weren't together, it was on and off, and I'm so thankful for women's refuges. Even though it took me a while, it's good to know there was that support. Yeah, a few, several times. Yeah. And they always say, it will take you a while then you'll realize. It wasn't about me. It was about them. No. And I had no family up there, and there was that thing where it felt that there was a lot of blame on me for leaving, and I'm doing wrong, my kids won't have a dad. But it's better to have one parent than being in a relationship where there's not two functioning parents. Yeah, my son got Citizen of the Year last year. Yeah, I know. It just reassured me that I'm doing a good job. Because a lot of people tell me how good they both are.

My youngest one, he goes to the Language Development Centre. I didn't realize he had dyspraxia so that got picked up, which is great. At one stage, I couldn't understand him. Now I can't stop him from talking, and it's so good. There's no more frustration from us both. I'm very happy with them and they're so good to their sister. I'm so glad that even though I don't have their dads for them, it's good to know that they're going to be looking after each other. (P 10)

Unhappy childhood experiences left some participants determined that they would create a better life for their children. Some of the participants had missed educational opportunities for various reasons, such as becoming pregnant or lack of family support to attend school. One woman said she '*never really went to high school (P7)*', whilst another participant who wanted her life to be different for her baby said she '*want her to go through school...get a good job ... succeed in what she wants to do when she's older*' (P8). Resilience demonstrated by bouncing back from adversity (Taylor & Guerin, 2010) shows great personal strength and tenacity. Although extremely difficult and acknowledging that there are differences within any group, the prevailing cultural attitude is that "Aboriginal people place a great value on being strong; one is expected to manage life's stressors without buckling under pressure" (Pattel, 2007, p. 9). The following woman demonstrates such strength as she shares her story:

And then I come and I'm with them and I can't be myself. Do you know what I mean? I just can't be who I am. It is. It's really hard. But it's been like that my whole life. See, that's where I would like to have a really, really good, open relationship with my children. Like they could sit down and tell me anything, and I'm not going to flog them because they've done something wrong. I'm not going to sit there and judge them and point the finger at them and start calling them names. You don't do that. You'd push them away. I know what it feels like to be pushed away and I could never do that to my children. Never, ever. (P2)

Time was often experienced by the participants as shifting time (Hyde, 2005) and *felt* as though on a continuum connecting the past, present and future. Having experienced an extremely challenging past, many women found the pregnancy and childbirth time to be one of reflection, assessment and action towards a brighter and more peaceful future. Like Noongar women over past decades, participants wanted to live the cultural value of spirit and integrity (National Health and Medical

Research Council [NHMRC], 2003), protecting and uplifting their own people by claiming respect and the right to live with dignity and self-determination (Malin, et al., 1996). Excitement is palpable in the following woman's story as she embarks on a new chapter of life:

It was a surprise, but this time around – I was happy when I was pregnant with my other kids, but for this one it was a little bit different. I think it was because the father and I broke up. It just brought a lot of happiness to me. I was excited. I couldn't wait for him to come. So I done the pregnancy on my own. He went back up north and we're still not together. I don't know. It's changed, my life, again. So it's really good. It's really good. (P 9)

Many mothers in the study had very clear plans for the future of their children. Often based on deficits in their own childhood, aspirations for the child's future were unequivocal. This time of change, one of heightened responsibility to family, seemed to be born of limited personal opportunities. These women possessed an intrinsic strength that, far from becoming disconnected from Aboriginal mainstream as is often the case (Pattel, 2007), enabled them to gain “exceptional strength, flexibility and tolerance for adversity” (p. 12). The following story, steeped in wisdom, displays carefully edified thoughtfulness:

I don't want her to have the sort of responsibilities I had when I was 12 sort of thing, 11. I don't want her to have to worry about things. I want her to be a kid. I don't want her to not – miss out on being a kid the way that I did. I want her to be able to just be a happy kid. And if she wants to do something then she can come to me and ask if, you know, Mum, I really want to do this, and if we can do it, we can do it. I just want to make sure that she goes to a good school, she gets an education, and if she wants to do anything other, leisure or hobbies or whatever, then I'll make sure she's able to do it, and that's why I want to make sure that I eventually get a job and do something with myself rather than just sitting home. I don't want to do that whatsoever. I mean, the first year, I want to enjoy her, and then hopefully get back to study a couple of days a week, and then maybe complete it and hopefully look for work. And then sort of move up and up and up from there. And then, yeah, get a little bit higher. (P5)

Self-perpetuated harm and abuse was the existential reality for some of the women interviewed. One participant said ‘I just blocked myself away used drugs to cope with loneliness from the whole world’ (P2). This destructive lived body

experience was especially dangerous at a time of physical and psychological vulnerability for the mother in pregnancy, childbirth and into the post natal period (Adermann & Campbell, 2010). These harmful behaviours were most often manifestations of multiple stressors occurring at personal, intergenerational, community and historical levels. Such behaviours encroach on and subjugate cultural connectedness (National Health and Medical Research Council [NHMRC], 2003) at the individual level, resulting in feelings of powerlessness. This web of trauma, so embedded in the cultural consciousness, has become normalised within some Aboriginal and Torres Strait Islander societies in Australia (Atkinson, et al., 2010). The following woman displays exceptional strength as she recalls how the responsibility of pregnancy and imminent childbirth motivated her to break the cycle:

Like I smoked marijuana, but I didn't know I was pregnant with [P3a], and it was like it wasn't agreeing with me anymore. I was thinking why am I sicking up – like, pregnancy never even crossed my mind smoked marijuana in early pregnancy before found out about pregnancy. Yeah. I was on that five years until I found out I was pregnant with [P3a] then I stopped. In that five years I was depressed until the day I found out I was pregnant and having a baby. She's changed my whole life. (P3)

For another participant, care of her body and general health took on a different dimension, influenced by her lived relationship of mother to child. The perinatal phase is crucial to the emotional and cognitive development of the child, in which parenting skills are attained and parent infant attachments are formed (Ferguson-Hill, 2010). Further to this, Aboriginal people are generally hesitant to undertake treatment, preferring to turn to older relatives or friends for help (Pattel, 2007). Diagnosed with postnatal depression the following woman discusses self-care framed within her role and responsibilities as a mother:

Yeah, I've only been once – I mean twice. So I do need to go back. I'm always the type that tries to just deal with it myself, so I don't usually go out and reach out for help. I just sort of do it myself [needs counselling for PND but is used to dealing with issues alone]. But, yeah. I guess things change once you have a baby because you have another person, so you need to do what's in the best interests of your child, which I'm trying to do, but yeah. (P5)

Mothers in the study understood the vital role they played in the unfolding future of their children. One woman who had used drugs explained 'I was on that

five years until I found out I was pregnant ...then I stopped' (P3). Another participant who was living as a sole parent with three children, was studying education support and said 'the boys are looking ...see me doing my assessments ...I've got to be their role model' (P10). This was not only a projection or imagination of the good things to come, but a responsibility to create a better life for their children than they had experienced. The way in which relationships not only affect a life, but become the lived reality of life as we share interpersonal space with others, is the concept of relationality (Van Manen, 1990). Endeavouring to change life for future generations is complex, because challenges of the present are an ever-present. One woman said 'I just want to be like every other mum... have your own house... just get everything for P4a every time I get paid... I don't smoke or drink or anything' (P4).

Each woman articulated new held hopes and dreams for her child foreshadowing an ongoing relationship with her child in the realisation of these dreams. With the busyness of "interrogating [their] own existence" mother's and children's lives entwine as they "forge onward in the current of time"(Gadamer, 2001, p. 92). Many women spoke of children living strong cultural lives, imbued with pride in cultural spirit and integrity. The following woman shares her story:

I want him to be well educated. I want him to go far. I want him to have that education and do a lot with his life. I don't want him to get into a relationship and have kids young like most Noongar boys do. I want him to live his life first. Marry later on and settle down. I want him to know his culture. I want him to be a proud, strong Noongar boy, Noongar man one day. Sensible. I want his head screwed on. I want the best for him. (P9)

Participants who were mothers of boys seemed particularly aware of the variety and increased risk of life stressors for Aboriginal and Torres Strait Islander youth. Adding to this, a history of long term oppression has given rise to feelings of hopelessness, powerlessness, anxiety and despair with many Aboriginal people according to Pattel (2007). The following mother displays a responsibility to guide her son away from destructive influences she has observed:

Yeah. I will, yeah. I don't want him doing all naughty stuff and that. I want him to be smart, not swearing around and stuff like that and real clean little boy and yeah. I want him just to be a worker and stuff and pretty much be

real smart about it and do the right things and that. But I will help him in that, because – doing the savings account and that stuff when he gets older, like 21. (P4)

Teenage mothers who were interviewed faced additional pressures in life. One young teenage mother commented ‘*sometimes I think gee whiz, this is not going to end...she’s mine now...I have to look after her for 18 years*’ (P5). Some felt overwhelmed by the responsibility of a child, while others described the enormity of the impact of motherhood on their teenage life; having been abruptly limited to some extent.

Aboriginal women have a disproportionately high rate of teenage pregnancy when compared with the wider Australian population (MacRae, et al., 2013), which could be said to be a normalising factor within the community. Given this, most young mothers purported to have a high level of support from their mothers and wider family. This cultural practice of community responsibility and support (National Health and Medical Research Council [NHMRC], 2003), though appreciated, did not detract from young mothers feeling as though they lived two separate states of relationality. While participants moved to a new highly responsible role of mother, they were simultaneously bereft of the freedom of youth. A profound sense of loss is conveyed in the following participant’s story:

Sometimes I think gee whiz, this is not going to end. She’s going to be – she’s mine now. I have to look after her for 18 years. You know what I mean? It’s not something I can just quit at. I’ve had enough, I want to quit this job. I’ve got this now and I’m going to have to take care of her. So I’m just trying my best, but sometimes it does get me down, especially when I haven’t seen my friends, or see them driving around. They’ve got their licence. They’re working and they’re going out on weekends and being young. It does kill me. I should be doing that as well, instead of staying home with a baby. And I was always the one in the group that said, “I’m not having a baby. Stuff that.” And I was the first one in the group to have a baby. So it does hurt a lot and I do get quite jealous, seeing my friends having sleepovers and just hanging out and stuff like that. Them just being able to go for a drive and I’m having to organize a babysitter, make the bottles before I leave, and give her a bath, and things like that before I go anywhere. I have to organize all these things just to walk outside the door without her in my arms. So it does get a bit hard sometimes. (P 5)

Cultural Challenge

One of the critical concerns women in the present study identified when reflecting on their childbirth experience was that of culture. As each woman recounted instances which challenged her cultural distinctiveness in some way, it was clear that culture and spirit, though highly important to all women, was considered from widely differing perspectives. One participant said *'being an Aboriginal woman...quite hard...ways of looking at things, ways of seeing life, ways of doing things....very different'* (P2).

Maintaining cultural identity of children was especially concerning for Noongar women given that they live in a pluralistic society as members of the marginalised minority. One participant compared her partner's country in the north to Noongar country in the south saying *'majority of the population is all Aboriginal...all Aboriginal run up there...shops that are owned and run by Aboriginals...down here it's like we're a lost culture'* (P9).

Cultural identity has been described as the degree to which an individual owns and implements the beliefs, practices, values and way of life of their group within society (de Souza & Rymarz, 2007). Another participant explained the aspirations she held for her baby girl to be *'a strong, independent woman ...lot of respect for her culture and other cultures ... people around her...be very independent... never, ever to let anybody make her feel like she's not a strong woman... proud of who she is'* (P10).

The distinctive cultures and community life of Aboriginal and Torres Strait Islander peoples are fundamental to the mitigation of colonising practices (National Health and Medical Research Council [NHMRC], 2003) and as such are guarded and valued by Noongar women in the present study. Although overarching values apply at a cultural level, Noongar people are not a single homogenous group and unique perspectives permeate the women's stories that follow.

Several women interviewed described feeling so out of place and uncomfortable whilst in hospital that they left against medical advice. Many felt *'really lonely'* (P5) and alienated, judging that being at home in a familiar place would allow them to reset and recuperate more readily. The lived space for these

women was an uncomfortable and culturally uneasy space. Feeling socially excluded in a system such as a hospital can result in poor health choices (Zubrick, et al., 2010), such as removing oneself from a therapeutic environment, despite requiring services offered by the institution. Some of the women interviewed had attended almost no high-school and as such, had somewhat restricted social negotiation abilities. Given that in 2004 fewer than 40% of Australian Aboriginal and Torres Strait Islander children attended secondary school (Adermann & Campbell, 2010, p. 108), it is not surprising that ill-advised discharge from hospital is so often observed. One woman shares her culturally challenging and potentially dangerous experience as follows:

I appreciate what they'd done but it wasn't a pleasant, it wasn't the best experience, but it wasn't the worst, but it wasn't, it didn't make me feel overly comfortable. If I had a choice to go back and have another baby, if I did, I might not go there again. Because of the lonely feeling. I mean, my concern was after I got out and had the dizzy spell and she was a newborn. And my boys, and I'm at the register, and the lady's looking at me and I'm, honestly, I was so dizzy, I felt like I was going to drop. I didn't know what to do. And I felt queasy, and it just made me feel that having the gestational diabetes, I should have gotten checked up. I didn't want to put any more burden on the hospital because they obviously were too busy to cope. I think the girl was looking at me thinking, what's going on? (P 10)

Many participants experienced the hospital as a lonely and culturally insensitive space, some staff '*they weren't very friendly*' (P5). Feelings of loneliness prompted one woman to suggest how an Aboriginal woman staff member could help to ensure Aboriginal women are not left feeling lonely or isolated. She said '*maybe somebodyeven ...five minutes, just to see how everyone's feeling*' (P5). This sentiment was raised by several women, some of whom in previous pregnancies had experienced the input of an Aboriginal liaison healthcare professional employed by larger public hospitals. The following excerpt conveys a lack of hospitality, inclusion and care:

I understand, hospitals get busy, of course they do, but they need to obviously maybe employ more staff or something like that to make sure that women feel comfortable after they have a baby and stuff like that. Maybe it's too much to ask, but I just think it's something that's needed so women don't leave the hospital feeling like crap, because that's how I felt. Just leaving the hospital

feeling like crap. Like I'd just been through a tumble dryer. I'd just given birth. It was horrible. It was 22 hours of labour and then I was in pain, plus they were all treating me as if I was a child and I didn't know what I was doing, not having any support. I mean, I had my mum and sisters coming in, but they'd go [away], if you know what I mean. So maybe somebody that can come in after hours and maybe just have a chat with everybody, go from room to room, even if it's for five minutes, just to see how everyone's feeling. When family and friends leave it can be lonely. (P 5)

Ineffective communication was the root of discontent for many women in the present study, creating a lived space of insensitive communication. One participant explained '*sometimes I wasn't even strong....I was afraid to say I'm not happy with that. I would give them a look like I don't like that, but there was nothing done*' (P9). The aim of safe motherhood has often been mooted as having in its foundation the empowerment of women (Hancock, 2007). Given that Aboriginal people have a different concept of health and wellness, and the ineluctable fact of considerably poorer maternal and neonatal outcomes, it follows that Aboriginal and Torres Strait Islander women need different and more culturally congruent maternity services (Hancock, 2007). One could assert that the persistent marginalisation of Aboriginal and Torres Strait Islander women, reinforces the barriers to full realisation of healthcare equality in contemporary Australia (National Health and Medical Research Council [NHMRC], 2003). The following woman shares her distress at a level of authority which directs her actions to such a degree that she cannot hold her child as she walks:

Yeah, my sister brought them a couple of times, and that was horrible. Horrible not seeing them. I was in there for I think five days and I'd only seen them probably maybe three times, and then it was only for a few minutes because they were rowdy and wanted to run about. And I wanted to go downstairs with them but I was in pain because of the stitches, but I did go. I did go at one point. Who was it? I think my sister was holding my son. I think she was holding him and the nurses said, "No, no, you can't hold him. You have to put him in the cot." We were walking around. I sort of understood the safety was for them and stuff, and I suppose insurance maybe or whatever, but I didn't like being told what I could and couldn't do with him Yeah, I didn't like that feeling at all. Even if I held him, they'd be like you can't hold him, or whatever. I don't know if it had anything to do with insurance you know. Even though, but I'd only take real slow steps. He was safe as anything. (P 9)

Some women interviewed described feeling ignored or invisible to healthcare workers in the hospital settings, stating she felt *'left out and pushed aside a bit'* (P10), *'it was like I wasn't there and they were all busy'* (P1), at times staff did not *'even ask'* (P3) and at other times staff were overly friendly, which was reportedly, sometimes perceived as condescending and patronising. One woman described this treatment as *'she's a poor girl, we'll treat her extra special'* (P7). Noongar women are mostly urban Aboriginals and as such, are more diverse and are less visible than other Aboriginal groups, simply by virtue of their small number respective to the non-Indigenous population. They also have a "more intense history of colonisation that has had a detrimental impact on their urban identity" (Dudgeon & Ugle, 2010, p. 186). All of these factors presented cultural challenges for the following participant who lived a time of confusion, frustration and communication breakdown in the following way:

There was one part when he was a baby, when he was a newborn, that he would have breast milk and he wasn't seeming to fill up. He would just be crying and screaming and I knew he was hungry and I'd be trying to feed him, but it just wasn't doing it. I sort of was a little bit disappointed that people didn't make suggestions to me, about feeding the baby because I knew he was hungry but I didn't know that I could give him a bottle as well as breast when he was a newborn. And then a couple of days of him going through that, my sister said, "We can't do this anymore. We've got to go and give him a bottle and some milk." And so I gave her some money to go and get some for me and she come back and he had the best sleep he'd had. And then the nurses said, "Oh, well, why didn't you just say? We could have given you a bottle." I thought, "Well, why didn't you say? I didn't know that." But everything ended up working out. It was good to stay in there. (P 9)

Although the majority of women in the present study expressed a strong desire to live with, and around their family and community, this was not the case for everyone. The childbirth experience for the following woman was lived as a time of independence:

Yeah, I've got an older brother. I'm the second eldest. Then I've got a younger brother, sister, brother. Five of us. We're rebuilding a relationship after I moved away. I used to live up north in [Remote country town]. I'm originally from [City], though, and I went up there when I finished high school, and then we kind of grew apart. I had my two oldest boys and then I moved back down here three years ago and they live north of the river. I get

to see them every now and again on the weekends. No, I think I like my independence. And the local school feels a bit like the country, because it's so small. I like that community feel. (P 10)

Cultural challenge was described in some way by most of the participants. A time of diminished cultural identity and confusion is movingly explained by the following woman. As a Noongar woman, she feels culturally bereft, grappling with her notion of a diluted culture:

It's funny, though, because I feel like there's not much culture any more. Sometimes it's like I don't know where I'm at with things in life. Well, this is it. I don't know. I mean, sort of I don't know if it's just me but the kids' father would always tell me I've got funny ways. I've sort of had white friends all my life and when I look at him and his family, it's like they're so much more, I don't know, cultural than what me and my family are. They can all live together, and I can't. But I don't think there's anything wrong with that, because my kids need their space. There's just too much conflict when you're in the same house as somebody else. I can't handle it for more than a couple of days. So I do feel a bit sad. And they'll have a joke with us and say "all you Noongar mob have lost your culture". But it's like they can still have their culture. They've still got, where their family all live and come from, the majority of the population is all Aboriginal. It's like all Aboriginal run up there. There's shops that are owned and run by Aboriginals. Down here, it's like we're a lost culture. It's very different. I do feel sad about it because, like I said, sometimes it's like I don't know who I am and what little bit of thing I've got left. It's like sometimes I'm made to feel like it's the wrong sort of way. It's like going to have babies, you don't feel like you can be yourself. It's like that kind of thing. That's not a good feeling. Yeah. That's what I sort of said to the kids' father. Because then they say oh, you Noongars are the same. You are all troublemakers and this and that. Noongars are a bit hostile. They...especially compared to them people up there. The ones down here are a lot more hostile. It seems like we've lost a lot. To the white community we're not white, even though we've got the mixed bloods and whatever, but to them we're not Aboriginals because we're that mixed race and we've lost a lot of the culture. There are some Noongars that still have it, but it's rare feels culture is watered down, mixed with white culture and blood. I want them to have it. I just don't really know how to give it to them. I sort of said to their father, I don't know a lot about a lot anymore. Not anymore, but especially since my grandmothers and grandfathers have passed on. My grandmother passed away I think it was three years ago. We used to talk a lot about the old days and how things were and things like that, but it's like when they go, it goes with them. Not many people have got it. I just said to him you need to have the kids more involved with your family

[Aboriginal family from far north WA town] so that it can go on, some sort of culture. Our culture might be sort of almost gone, but you guys have still got it. But he's sort of got no interest, so they'll end up like me, I suppose. (P 9)

Cultural challenge was experienced through the lifeworld existential of the lived body for some women in the study. This manifested as both psychological and physical ill-health. One woman left hospital early 'because of the lonely feeling' even though she 'felt so dizzy I wanted to faint...knew it was because of the diabetes...wasn't monitored... didn't get checked again at the hospital at all' (10). Given that social and economic disadvantage are disproportionately skewed to the Aboriginal population in Western Australia, it follows that they pose a barrier to attainment of social, physical and emotional wellbeing (Zubrick, et al., 2010). Perinatal ill-health is a significant major public health issue, which affects mothers, their children and families (Ferguson-Hill, 2010). Additionally, Aboriginal people are generally hesitant about involvement in therapeutic interventions, preferring to turn to older members of the family or community or help (Pattel, 2007). These facts provide context for the following story:

Yeah, I've seen a counsellor, but it's just been really hard because I don't drive, so it's been really hard to sort of get to and fro and stuff like that, because I haven't really had a lot of motivation since I've had [P5a]. I've put on so much extra weight and I was just eating so much after I had her. I was just full-on eating all sorts of crap. I don't know if I'm eating just because I'm bored or for the fun of it, or she's asleep now, what will I do? I'll go figure out something to eat or whatever, instead of going for a walk or whatever, and I just gained so much weight and I lost all motivation. I couldn't do anything. I didn't want to go anywhere. I was sort of just in my own little shell. And things with my partner were getting rocky. He had to quit his job because I couldn't handle it anymore. It was all over the place. It sort of went downhill a little bit. And then when I moved home, things sort of looked up, but I definitely needed my mum in the beginning. I don't know what I would I'd do if I didn't have my mum. (P5)

Many women interviewed described a sense of cultural disconnection, experienced as caution, wariness and guardedness, when exposed to the western biomedical healthcare system. Accepted ways of coping within the Noongar culture often resulted in women suffering without professional help, or accessing that help at

a later stage, when health was deteriorating. Another woman shares her experience of coping alone with feelings of depression:

I hid my pregnancy up until I was six months, and I started to show. So my family – my mum – I didn't tell my dad until I was five months. I guess there was the little bit of shame on me because I didn't have a dad for her, and I was doing it on my own. I guess I was very emotional. I had the baby blues really trying to do it with the boys, and then thinking I don't have their dad with them, and the kids are going to have a different dad, the boys and her, but it worked out in the end because I got to see a social worker a couple of times at [Maternity] hospital and they said if you ever need, I can go and – but I guess I kind of, I did go there a couple of times, but then I kind of withdrew a bit and just tried to deal with it on my own, because there's that thing where growing up, sometimes my family said it's not always good to tell everybody everything. But then, it's not good to keep it inside, either. (P 10)

Women in the present study identified many cultural challenges that they experienced in their childbirth experience. For the most-part participants had suggestions as to why these challenges occurred and how they could negotiate their way around them. In the following two stories women have identified the need for dedicated cultural connectedness in the hospital setting. They articulated how necessary it was that the contact person be an Aboriginal woman, not necessarily a health professional of any kind, however it was assessed to be essential 'to know that there's someone there familiar with your culture' (P10). The following story gives insight into assessment of young inexperienced Noongar women who could benefit from culturally congruent support and education in the hospital:

But I think what they need down here is more support at the hospital than [for] Aboriginal women giving birth to babies. Like some girls that don't have experience with their babies, and they should have someone come in and help them. Yeah. But I notice that some Noongar girls, they have their babies and they're out, but they're neglecting their kids around, leaving their babies around and not keeping them warm and feeding them. Yeah. Like give them support, and, if they don't know anything, support them through it, and not judge them and that there yeah. Yeah, a Noongar woman would be best because Noongar girls feel more comfortable. Yeah. (P7)

Several women who were interviewed described a profound loneliness when they were in hospital. One participant said 'when my family members left, it was

really lonely' (p5). It seemed their sense of community responsibility (National Health and Medical Research Council [NHMRC], 2003) was so great that, when family and friends departed for the day, participants would feel stressed and alone. Pattel (2007, pp. 3-4) edifies the importance of family relationships is “intensified by the difficulty that Aboriginal people experience in gaining validation from mainstream society”. The following woman insightfully suggests a possible solution to provide support and comfort to Noongar women in the hospital setting:

Probably a liaison officer. An Aboriginal lady a Noongar lady or someone coming around just to reassure you that everything's all right and we're here for you. Some Noongar women don't have family support, or they're not coming from a safe background, and maybe it would be good to know that there's someone there familiar with your culture. Yeah, and just to reassure you and help give you some sort of assistance. And support. I mean, I know they're not family but it sort of feels family. (P 10)

Participants described instances where communication and interactions they experienced in the healthcare arena as embarrassing and insensitive, hurtful and ignorant. One woman explained ‘*some women might just breastfeed in public or don't mind who's in the room, but you need to be familiar with who you know*’ (P10).

Several women identified communication styles that were unique to Noongar women. Some felt shame when health professionals spoke too loudly or mentioned private body parts in public. Relationality with healthcare providers presented additional cultural challenge in the childbirth experience of participants. Effective communication is about sensitivity to culture and the gaining of trust. Development of rapport with Aboriginal and Torres Strait Islander peoples, is therefore essential to the success of any therapeutic intervention (Kruske, 2011). The following woman explains how quality relationships can be formed:

Self-pride. And there's that sometimes, it depends, we're all different Noongar women have similarities in culture but are all individuals. Some women might just breastfeed in public or don't mind who's in the room, but you need to be familiar with who you know. You've got to build a kind of a relationship. I know, if you're in a midwife, you only get to know that person, but it would be good to know them before they have baby, just a couple of visits, just being familiar with them, or a good introduction if it's your first time. Otherwise, I'll keep my guard up, right. (P 10)

Ubiquitous Prejudice and Racism

All women in the present study, either implicitly or explicitly, described an ever pervasive prejudice and racism in their lives. Participants said *'racism don't really bother me...only a word...boong, abo, that's nothing'* (P3), *'people ...feeling intimidated because there's a group of Aboriginals sitting together'* (P9), *'wish people would see the good that there is in Aboriginal people, that not everyone is the same'* (P5). This was not specific to the childbirth experience; rather it was so integral to their lives, they could not be understood in other terms. There was a general acceptance of this negativity by the women, who seemed to have developed individual personal coping strategies, enabling them to function in the wider social world. One woman said *'pretty much being Noongar, it's good, really...didn't have the support from mum or I didn't even have the family...think the worst and do the worst ...it'd be hard'* (P4). Acceptance and internalisation of prejudices levelled against them by the dominant society, has the potential to leave Noongar people with self-denigrating views about themselves and their people (Rickwood, et al., 2010). Physical, emotional, mental and spiritual health cannot be achieved or maintained while this omnipresent insult persists.

Aboriginal and Torres Strait Islander societies have sustained enormous impacts since colonisation, resulting in a contemporary solidarity with “strong and vigorous opposition to assimilation or subjugation of their values” (National Health and Medical Research Council [NHMRC], 2003, p. 18). Clearly, it is imperative that Noongar women are encouraged to identify prejudice and racism so that the healthcare community can own the responsibility to take notice and act.

Changes in perception of health and wellbeing paradigms within the western biomedical health care system are needed to benefit Aboriginal and Torres Strait Islander women in childbirth. One woman said *'I think what they need down here is more support at the hospital for Aboriginal women giving birth to babies'* (P7). Another woman suggested the need for *'an Aboriginal lady a Noongar lady or someone coming around just to reassure you that everything's all right and we're here for you'* (P10). Healthcare professionals require a “philosophical approach of empowerment and self-determination” when caring for Aboriginal and Torres Strait

Islander pregnant and childbearing women according to Rickwood et al., (2010, p. 21).

Childbirth was experienced by many women in the present study as a lived space of aloneness and marginalisation in the hospital setting. The stories shared by participants conveyed many different dimensions of prejudice and racism. In order to faithfully convey how such seclusion impacted the lived experience of Noongar women in the study at the time of childbirth, the most articulate descriptions are presented below. These descriptions represent the participants' collective experience. The following woman tells her story of feeling excluded, alone and frightened at a time when all women are highly vulnerable:

Yeah. The reason being was there was other ladies before, in at the same time, they might have got there a bit later but I kind of had to wait and that, so – then they took me down and started bringing me on at about six o'clock in the afternoon. So I was on my own in the room, in the labour room, for about four hours because my mum had my boys and there was no one with me. Because they were busy. Yeah, I felt a bit like left out and pushed aside a bit, because I didn't get in. I was there and I thought I might have had her that afternoon or whatever. But I knew the hospital was busy and it was that time of the year. Yeah. And because I stayed and when I did have her, the doctor came in and checked and then she went away, and then the midwife, and I found a lot of the times that I was left on my own, that's my fault because I didn't have family support, I guess, but when I was ready to push her there was nobody around. And when I was ready, there was nobody there, really, so I was a bit scared. I was really scared. And after six years, it was so daunting. (P 10)

Some women felt the childbirth experience was a space to create a new future for their children and they wanted them to have 'support' (P7) and to have a 'really good, open relationship' (P2). Birth is such a key marker in life, it seemed to provide a pause for thought and reflection for participants as they reviewed past difficulties they had endured and continue to endure, foreshadowing a better time of life for their children. The view that prejudice is an "individual or personal pathology" is somewhat dismissed by Rickwood, et al., (2010, p. 17), who posit the origins of prejudice involve "processes of social learning and social categorisation". Commensurate with this is the stated value of Aboriginal and Torres Strait Islander culture, which identifies that survival and protection of the culture is dependent on

protection from erosion by continued colonisation and marginalisation (National Health and Medical Research Council [NHMRC], 2003). Both wisdom and optimistic vision is expressed by the following woman as she considers the future of Noongar culture for her family:

I thought it was a really good thing with Kevin Rudd, with what he'd done with apology and stuff. He made aware to a lot of people that they probably didn't know things and the apology and whatever, but some of the things he was saying, I wasn't aware of. But then, on the other hand, I think there's still going to be the line of ignorance as well. Like "oh they're still carrying on"....this attitude...they were like this when I was younger. Now my kids are growing up and they're like that. I think it's – who knows. I hope it [racism] does die out, because it does sort of, I don't know, what's the word I'm looking for? Would it be oppress? Keep us oppressed? But then every Noongar you know can rise up above it. But like I said, everyone's got their own story. You don't know what's going on with them. The kids' father, when he was here, sometimes he was sacked from different jobs. He'd have blow-outs with different guys and they'd end up calling him a black so-and-so, and then he'd end up punching them, and then he was sacked. It's terrible that he put up with that, he had to go through it, but at the same time he reacted wrong to it. He should have maybe, if he knew it was a pointless argument, just walked away from it. It is, especially with Aboriginal men. He doesn't need to be put down like that, racism oppresses Noongar people. (P 9)

The opportunity and drive to change life for the next generation was expressed by each participant at an individual level. The childbirth experience therefore, became a lived time of change. There were no grandiose predictions of mass cultural change, rather practical, aspirations and goals that the following woman shares:

So if I could change one thing, that would probably be the thing that people would see the good that there is in Aboriginal people, that not everyone is the same, and that there is good as well, and that white people as well, Chinese, African, whatever, probably in their culture they feel the same in certain ways, that they're being brushed differently as well. And it's sad, but that's society these days, and I think that needs to change. So in a way, yeah, I'm proud to be Aboriginal, but I'm also upset and disappointed about how things are these days and hopefully it can change by the time P5a is my age, so she will never, ever feel ashamed by saying, "Yes, I'm part Aboriginal." (P 5)

The same participant elucidates further, sharing how it is to be a woman who has *lived* prejudice from a very early age:

People think, you know, they're just having a kid to have the money and things like that. I've heard so many nasty things before, so many, so many nasty things. And it's horrible just to hear it, it breaks my heart, because it's not at all like that. Like I'm telling my friends, we don't all have dirty houses. It's not like that. Not everyone's like that. "Sorry, we didn't realize you had such a nice house, for judging you". And I think I opened their eyes a little bit, not to judge. And that was when I was in year 8, so I was 13 years old. So from that point on, I think they've learned not to judge as bad. Because I did sit down, I almost cried, just explaining to them. I felt like I had to sort of reassure myself, reassure them. "I don't have a dirty house. You see my house. It's not dirty. We live really very nicely." I just can see myself as that little kid sort of pouring my heart out, telling them, "We're not all like that," and them sort of just looking at me like, "Okay, we understand now." So it needs to be sort of recognized and everyone needs to be not so judgmental to the one kind and to sort of look at everybody individually and look at the things they're doing, not just "she's doing that, so everyone's doing that." That's one thing I definitely would love to change in time. I should just make a list and run for Prime Minister. (P 5)

A lived time of preparing their new baby for a potential future of prejudice and racism is how the childbirth experience was viewed by many Noongar women interviewed in the study. Having lived with ubiquitous prejudice and racism, mothers interviewed prepared ways in which their new babies would cope with the continued discrimination present in their country. Great strength is displayed by the following woman as she outlines a personal strategy to enable her child to cope with a life of inevitable racism:

Probably. But from my own experience, it's barely ever. I've hardly ever experienced it [racism], but compared to when I was younger, there was a lot. I don't know if it's dying out or it's just because I'm not interacting a whole lot with people. I'm not sure. I think he will. I think he's going to [experience racism]. We all do. We all do, but I hope that he's going to be smart and wise enough to know how to deal with it. He's just got to be above it. That's their problem. But, yeah, he's just got to be above it and learn how to deal with it. View racism as the other persons problem - rise above it. But what would be good, I had gone through the childbirth and everything in hospitals and stuff, I think just a bit more awareness of Noongars and things

and just be a bit more understanding and things like that would go a long way. It would make it so much easier. I think it would be good. (P 9)

Some women interviewed expressed how their appearance as an Aboriginal woman had the power to invoke discrimination. One woman said '*I hope it racism does die out...keep us oppressed*' (P5). Living ubiquitous prejudice and racism as a bodily experience is to present to the world as the object of oppression and subjugation. Such objectification renders the Noongar woman defensive against discrimination, adversely affecting her everyday life, opportunities, hopes and aspirations, regardless of economic status (Pattel, 2007, p. 13). Cultural values of respect, reciprocity and equality, so important to the Aboriginal and Torres Strait Islander culture (National Health and Medical Research Council [NHMRC], 2003) are blatantly violated in the following Noongar woman's story of her lived body experiences:

It's good being black, but if a black person did something wrong to someone, they will paint you with the same brush. Like the taxi man. I think it must have been Aboriginals who bashed him because the police reckoned it was one of "your mob". It can't be. If you tell me a name, a last name -- Because we always [get] a lift with the taxi man and the policeman reckoned, as soon as the taxi man seen me and my sister, X, he's like no straight out. He don't want to give us a lift. So the police dropped us off. Mainly my sister, but, you know, racism don't really bother me. It's only a word. Even like being called boong, abo, that's nothing. It's just a word. If I was walking around on my own, people wouldn't look at me like an Aboriginal. They'd think I'm some other culture mixed with a bit of Aboriginal or something. When I was with [another community], I know, of course, this lady was [Aboriginal], but she reckoned, "You sure you're not this other kind of culture?" I was like, "No, I'm Aboriginal." But my mum's mum, her mum was Irish, like half Irish and some other culture. This is going way back. You just get, how do you say it, throwback looks or something. (P 3)

Some women in the study described prejudice and racism embedded in society. Another woman shared a heartrending story of hurt and denigration due to pervasive effects of cultural and organisational racism:

Sometimes you can be standing in line at a shop, whatever, getting something, and then the checkout person could ask someone, "Hey, how are you doing today, how has your day been," then comes your turn to be served

and not even a smile you would get. You know? Things like that. I said who cares? It's annoying, it's really annoying, but it doesn't ruin my day. I don't care. They're not my friends, so it doesn't bother me whether they talk or not. But I know a lot of Noongars, one of my sisters in particular, she's a bit out there. She would make a thing about it. Because it's rude. You say hello to the one before and after you, but not you. For my kids, I just hope that they're smart and wise when they grow up don't react to racist behaviour decide not to be upset by it. (P 9)

Women who were interviewed in the present study experienced prejudice and racism in the childbirth experience at every turn. One woman explained how *'sometimes you can be standing in line at a shop, checkout person could ask someone, "Hey, how are you doing today, how has your day been," then comes your turn ...not even a smile you would get' (P9)*. Relationships with others that imposed negative judgements and stereotypes on them were a common occurrence, as demonstrated in the preceding findings of the study. When discussing prejudice and racism, another woman said *'I don't really want to class myself as just a particular thing. I just accept everybody...you know, we're just all human' (P6)*.

In presenting how women experienced prejudice and racism in the childbirth experience through their lived relation with others, organisational relations are exemplified. It is of particularly grave concern that institutions, disciplines and professions have a culture of institutional racism (Rickwood, et al., 2010). It is suggested that all disciplines need to "examine their role within the social and political structures and systems that give rise to, and perpetuate, racism" (Rickwood, et al., 2010, p. 18). Aboriginal and Torres Strait Islander cultural values and principles assert a dignity and worthiness of their peoples that must be observed. Racial discrimination is associated with a range of adverse physical and mental health conditions, which can lead to increased risk taking behaviours resulting in real and potential destruction of life and community according to Zubrick, et al., (2010).

Participants felt racial discrimination in their interactions with healthcare staff. Such relationships occurred when the pregnant and childbearing woman was in a dependant position, needing professional assistance and care and *'didn't really have a choice' (P8)*. The following stories, told by one woman, provide insight into the many types of prejudice one woman can be exposed to by a variety of others. The multitude of incidences demonstrates prejudice in its true light and not a single

isolated event, which is an ever present destructive force that Noongar women live with on a daily basis:

The nurses there were quite nice. I must admit, they were quite nice there. When I actually had P5a, it was a bit different. Like, I don't think I would have a baby there again. Because at the antenatal classes, it was different. They were good there. They were quite nice. But the nurses that I had when I was having my baby, they weren't very friendly. (P 5)

Often women in the present study felt isolated, neglected or uncomfortable and out of place in the hospital setting. Such feelings, combined with tiredness and frustration, resulted in many women leaving the facility often too early for full recovery from the childbirth experience. This translated to a serious risk for mothers, their babies and other children. As Pattel (2007, p. 4) elucidates, "Aboriginal people vote with their feet if they do not like something or someone, they will simply walk away". The following woman continues with another example of subtle judgement and exclusion:

I said, "She's quite distressed. The baby hasn't had a proper feed. I'm going to have to try doing a bit of both." I did try to do a bit of both but it just wasn't working out for me. It was so sore and it was just quite painful. She was going to have to formula feed. But then, from then on, they just sort of went a bit cold towards me, sort of like a bad mother. I wanted to breastfeed; it's just that I can't at the moment. It's too hard. I went home and I tried again, and I kept trying and kept trying, but it just got too hard. (P 5)

The following participant expresses a level of understanding of the people who show prejudice toward her. She is cognisant of the societal level of bigotry that is bigger than one individual. Her story of denial of her Aboriginality in an effort to avoid enduring oppressive social exclusion is evocative:

I can't blame them, because that's the example that's put out there. So I used to just eventually not tell people that I was Aboriginal. I'm Cooke Islander and German I used to just say, other bits, and leave that detail out. But, of course, people could see it in me. "Are you sure? Aren't you part Aboriginal? Isn't your mum part Aboriginal?" I'm, "No, no. She just looks it. No, not Aboriginal". I actually got so ashamed of it. It shouldn't be like that. Being an Aboriginal woman, you should be proud and be happy and have all sorts of things to say, all sorts of good things to say. (P 5)

The Essence of the Experience

Interpretive phenomenology is a methodical endeavour to uncover and describe the internal meaning structures of the lived experience. Through a process of interpretive phenomenological reflection and data reduction, five themes were uncovered in the present study. These themes were then expanded with reference to particular instances as they were encountered by participants, producing a thick and rich description of the lived experience. In this way the researcher was able to grasp and intuit the universal essence of the phenomenon of Noongar women's birth experience presented below.

Noongar women have shared their lived experience of childbirth resulting in a unique and poignant contextualised truth of the cumulative physical, cultural and psychosocial aspects of their reality. Understanding the mediators between risky environments and maternal and neonatal health for Noongar women and their babies is indispensable. Discursive construction of findings from the themes enabled presentation of a multifaceted complex exposition of the reality of the experience. Each theme encapsulates a morass of highly challenging and interrelated risks and stressors that impact on the lives of Noongar women, their families and communities at a time when the focal point is the joyful experience of birth. In and of themselves, each identified element of tension and trauma adds considerable negative physical, emotional and psychological load to the health and wellbeing of the individual participant. It is however, the exponentially compounded impost on the health and wellbeing of childbearing Noongar women, which takes a silent toll on their physical and mental health. The essence of the experience, however, is that despite the cumulative load of external stressors, childbirth is a time of joy, of family, of culture; it is a time of gazing backwards to a past that lives on in the present generation who, despite many and varied challenges, look forward to a brighter future for their children.

This unique understanding is not a panacea for Aboriginal and Torres Strait Islander maternal distress; rather it is a beginning from which the ferment of chronic injustice suffered by Noongar childbearing women may proceed and change. All Noongar women do not have the choice of culturally sensitive or congruent models of maternity care available to them. Furthermore, the western biomedical health

service is geared toward the dominant non-Indigenous Anglo-Saxon society that lives on Noongar land. Each participant of the present study demonstrated ways in which the postcolonial history of Noongar people lived on in them, no participant however, lived in a way that was totally fixed on the past. The Noongar childbearing women in this study all looked forward to the future with their child.

Conclusion

This chapter has presented findings derived from the collection and interpretive analysis of data. The five emergent themes of increased vulnerability, centrality of family, connection over time, cultural challenge and ubiquitous prejudice and racism apply to each participant in a unique way. Participants are different from each other and their distinctive life experiences, situations, demands and expectations shape the stories they have shared for this study. It would be remiss of the researcher to be 'blind' to each participant's distinctiveness and difference to the other. The findings presented in this chapter are discussed further in the following chapter, where connections to existing literature are identified, providing further insight into Noongar women's birth experience.

CHAPTER 7: DISCUSSION

Introduction

The purpose of this chapter is to juxtapose a synthesis of findings within the present study together with referral to current literature, in order to discuss the relevance, usefulness and possibilities of the research findings. The study gave voice to childbearing Noongar women; a voice previously absent from contemporary maternity discourse, with the sole aim of capturing the essence of their lived experience.

Research findings have been organised around five emergent themes, culminating in a thick and rich description of the essence of Noongar women's birth experience. The participant's experiences of childbirth clustered around themes of increased vulnerability, centrality of family, connection over time, cultural challenge and ubiquitous prejudice and racism. Acknowledging that participants have authoritative knowledge about their childbirth experience was the purpose of the study, with the additional possibility that insights gained from findings may enable more accurate predictions about future challenges, or lead to interventions that will enhance the quality of life for Noongar women and their families. The following discussion focuses on identifying and establishing connections and revealing insights that can lead to more acceptable and effective maternity care for Noongar women.

Enduring

Women interviewed in the present study experienced childbirth as a time of increased vulnerability. Many elements in their lives were legacies of a history of colonisation that had enduring effects on participant's present day lives. In many instances Noongar women who were interviewed had no choice but to bear this load, so as to tolerate or endure aspects of their lives that caused them to experience increased vulnerability at the time of childbirth. This section relates to the theme of *increased vulnerability* to enduring stressors that were experienced by participants and addresses these under the headings of loneliness, harmful relationships, risk taking behaviours and limited choices.

Some participants described an extreme level of psychosocial and physical disadvantage endured across the childbirth continuum. This vulnerability related to their decreased general health, including one or more aspects of their physical emotional and social wellbeing. For example, some women suffered diabetes that increased their physical vulnerability to wound infections and the risk of having a very big baby. The need for specialist surveillance during late pregnancy and labour was the reason women in the study, who had diabetes, were transferred hundreds of kilometres from their homes in the country to birth at the only tertiary maternity hospital in Western Australia, located in Perth. This geographical dislocation was distressing for the women and their families.

Isolation

One woman in the study, separated from her only child for over a month, described feelings of isolation and ongoing concern for her son. Another woman was separated from her four children who missed the opportunity to visit their new sibling on the day of birth. More than this, being alone in an unfamiliar hospital, away from family and friends resulted in Noongar women feeling alone and sad.

Three of the ten women suffered depression that was reportedly so debilitating for one young participant she felt unable to socialise or interact with family and friends. Other participants who described suffering depression said they felt unmotivated to seek medical advice or to continue to attend appointments with doctors or counsellors. As a consequence of social compromise, some women interviewed suffered escalation of physical ill-health such as wound infections and psychological problems such as deepening depression.

Findings highlighting vulnerability for these Noongar women are consistent with recent published research in that, on all health markers, Aboriginal Australians are reported to have lower health status than the wider population (Ewen, 2011; Morgan, 2010; Nelson, et al., 2012; Ou, Chen, & Hillman, 2012; Robinson, et al., 2012). It is however, vital to acknowledge that all women interviewed are uniquely different to each other and that probability-based risk factors, related more to individual health behaviours and social determinants of health, do not reflect innate Aboriginality (Nelson, et al., 2012).

Harmful Relationships

Several women in the study described childhood experiences that contributed to their vulnerability and which continued into their adult years. One woman described living within a family where alcohol use and violence was the norm. Another woman described feeling alone and unable to communicate with her mother, who as a result of being removed from her family as a small child, was unable to communicate well or show love and affection to her children. Effects from colonisation culminated in multiple stressors, which impacted to varying degrees on the participants in their formative years.

One woman interviewed in the study, openly and candidly shared her experience as a victim of domestic violence. As Aboriginal and Torres Strait Islander women report higher levels of physical violence than non-Indigenous women (Wendt & Baker, 2013), there exists a possibility that other participants may have endured similar experiences. However, given the extremely private nature of this crime, victims are not always comfortable in sharing their experiences. One participant felt uneasy about returning to her home town in a regional town because her brother had been involved in a crime. Consequentially, she became disconnected from family and friends leading to a degree of loneliness and isolation.

Risk Taking Behaviours

Two of the participants explained that, due to their family's high risk taking behaviours and the undesirable effect this had on them as children, they had decided to distance themselves and their children from their relative's negative influences. Most of the women interviewed were affected in one or more ways by vulnerabilities such as unemployment, poverty, ill-health and violence, high risk taking behaviours, over use of alcohol and cigarettes, abuse of drugs, educational deficit, incarceration, premature death within the family group, or racism. Several of the participants endured the consequences of exposure, through family or community, to some or many of these risks in their formative years, resulting in ongoing life challenges. Increased risk taking behaviours such as cigarettes, alcohol and drug use are reflected in the wider Aboriginal and Torres Strait Islander population relative to non-Indigenous Australians (Durey et al., 2012; Freemantle et al., 2006; Hancock, 2007; Petchkovsky, San Roque, Napaljarri Jurra, & Butler, 2004; Walters, 2012).

Several participants described illicit drug use in the early phase of pregnancy. Most women either discontinued this activity when pregnancy was confirmed, or reduced their consumption, while one participant replaced heroin with marijuana, judging this to be less harmful to the foetus. Some women described drug taking as an antidote to alleviate stress or boredom. Pregnant women who use illicit drugs have been identified as a “disadvantaged and marginalized group who receive less antenatal care” (Burns, Mattick, & Cooke, 2006, p. 881), with the use of illicit drugs or the misuse of licit drugs estimated to be twice as prevalent in Aboriginal and Torres Strait Islander Australians than the broader population (Wilkes, Gray, Saggars, Casey, & Stearne, 2010). Further, a longitudinal study by Kildea, Stapleton, Murphy, Kosiak and Gibbons (2013, p. 11) found that Aboriginal and Torres Strait Islander women were statistically more at risk of “psychosocial and emotional challenges during pregnancy, including domestic violence, cannabis use and contact with the Department of Child Safety”.

Many women in the present study consumed alcohol before realising they were pregnant; most however discontinued at this point. None of the participants described smoking cigarettes while pregnant. Research by Wills and Coory (2008) nevertheless, found that 53% of Aboriginal and Torres Strait Islander mothers smoked during pregnancy compared with 16% of non-Indigenous mothers.

Limited Choices

Many participants spoke of enduring financial hardship. For some women interviewed, financial challenges prevented them from visiting family and attending medical appointments because they could not afford transport and had no access to a motor vehicle. A recent body of research suggests that coping with cumulative low socioeconomic status stressors, elicits a cascade of biological responses, which over time, damage physiological regulatory responses resulting in illness (Brody et al., 2013; Brody et al., 2013). Cumulative stressors impacting across the lifespan have been explored with specific focus on childhood (Doan, Dich, & Evans, 2013), the sensitive period around the transition to adulthood (Gustafsson, Janlert, Theorell, Westerlund, & Hammarstrom, 2012), and midlife social environment and social relationships (Brooks et al., 2014).

A plethora of literature exists on the health and social risk factors of Aboriginality for women in Australia (Boyle, Rumbold, Clarke, Hughes, & Kane, 2008; Haswell et al., 2010; Kildea, et al., 2013; McHugh & Hornbuckle, 2010), suggesting that despite awareness of the enormity of the problems faced by Aboriginal women, problems persist and by extension, health care initiatives, past and present have not changed this fact.

Participants of the study endured increased vulnerability in many and varied ways. Lack of education for example constrained activities and restricted choices for many participants to some degree, limiting their ability to make decisions and to protect their own interests. Panaretto et al., (2006) hold an extended view of vulnerable Australian Aboriginal and Torres Strait Islander peoples, suggesting they are the most socio-economically disadvantaged group in the country. While an aphoristic claim by Freemantle et al. (2006, p. 1765) offers the laudable synopsis that “being Aboriginal is overwhelmingly disadvantaging because of the history of marginalisation that such people have been subjected to for generations”.

Knowing

Women interviewed in the present study spoke of formal and informal educational compromise that they felt increased their vulnerability. This section relates to what was known by the participants and what was known by healthcare providers, both of which relate to the theme of *increased vulnerability* of participants. What was known by women impacted their opportunities in life, their ability to be assertive and to have options in maternity care.

Lack of engagement with antenatal education and limited or delayed antenatal care, decreased what was known about participants’ health by healthcare providers and therefore, increased the vulnerability of women in the study. The following section discusses how formal and non-formal education, antenatal education, antenatal care and inadequate antenatal options contributed to increased vulnerability of participants.

Formal Education

Many participants expressed a lack of education as contributing in some measure to their increased vulnerability and compromised state of health. Some had not attended or completed secondary education, while for others, an unintended pregnancy had stymied plans to complete the final year of high school, thwarting entry to vocational education or employment opportunities.

Noongar women in this study did not discuss formal education in terms of knowledge acquisition or status; rather it was valued as a pathway to secure employment, increased life opportunities and therefore a source of respect for self and others. Although most women spoke of formal education and its relevance to their lives, university level education was not evidenced to occupy a place on their horizon.

Participants referred to education as an asset that mitigated vulnerability, each sharing how important it was for their new baby to have a good education. They commented that an education was necessary to secure a good job and contributed to self-respect and the respect of family and community. Educational deficit is commensurate with reports by Adermann and Campbell (2010) of Aboriginal and Torres Strait Islander students' frequent interrupted schooling for reasons such as health, family responsibility, lack of resources, stress and marginalisation. Additionally, they report fewer than 40% of Aboriginal and Torres Strait Islander students throughout Australia attended secondary school in 2004 (Adermann & Campbell, 2010).

Kildea et al. (2013, p. 9) report a link between limited maternal education and young maternal age as positively correlating with preterm birth, which is the "leading cause of perinatal mortality, serious neonatal morbidity and moderate to severe childhood disability". Despite reports indicating that Aboriginal and Torres Strait Islander Australian women access antenatal care much less frequently than non-Indigenous Australians (Australian Institute of Health and Welfare, 2013), no direct link is established with educational level (Kildea, Kruske, & Bowell, 2006).

Diminished Informal Education

Nine of the ten women interviewed did not plan their pregnancy. Most participants described feelings of surprise or shock on discovery of their pregnancy, suggesting a lack of understanding about conception. As presented in the findings under *centrality of family*, many participants believed they were unable to become pregnant, describing obscure, inaccurate and misguided reasons for this, such as having a car accident in early teenage years or not having had a child for several years. Participants incomplete understanding of conception parallels evidence that Aboriginal and Torres Strait Islander women living in Western Australian in 2011 had more babies, at approximately 5.9 years younger in age, than their non-Indigenous counterparts (MacRae, et al., 2013).

Diminished informal education could be linked to the Stolen Generation that has been described as a social and emotional issue affecting all Aboriginal and Torres Strait Islander families (Peeters, 2010). Transferral of knowledge from one generation to the next was interrupted when families were forcibly fractured. Given the deeply connected nature of Indigenous relationships, this profoundly negative travesty impacted intergenerational wisdom, ways and knowledge (Peeters, 2010). The interruption of knowledge transfer, which results in informal education, became one of the many tragedies of the Stolen Generation, the effects of which transmitted from one generation to the next.

The consequence of diminished informal educational opportunities was expressed throughout data. One woman, who received advice from a dietician on healthy eating for control of gestational diabetes, expressed how much she valued this, revealing that despite having other children, she had limited knowledge of a healthy diet, food preparation or cooking. In concert with this fact, Dragon (2007) asserts fewer opportunities in education impact on Aboriginal and Torres Strait Islander peoples overall health.

Antenatal Education

Most women did not attend antenatal classes provided by the hospital. Even women, who had not previously given birth, described how they relied on informal knowledge sources about pregnancy such as friends, sisters, mothers or the media. Although ambivalence about mainstream antenatal education is supported in

literature of more than a decade ago (Minniecon, Parker, & Cadet-James, 2003) a paucity of more recently published research about Aboriginal and Torres Strait Islander access of antenatal education was noted.

With more Aboriginal and Torres Strait Islander women having babies in their teenage years than non-Indigenous Australians (MacRae et al., 2013), it is understandable that some participants gained information from older female relatives. Others felt a life of dealing with younger siblings and family was preparation enough, while one participant described her strategy of watching television to gain the necessary pregnancy and childbirth knowledge as sufficient.

Some participants, who attended one antenatal class, described feeling ‘out of place’ as the reason for subsequent nonattendance. Still other participants explained how they felt different to women with partners who attended the classes. This insight is understandable given that six out of the ten participants did not reside with the father of their baby. Pattel (2007) provides explication of this fact confirming that many Aboriginal women live apart from their partners.

Findings from the present study are confirmed in a report of poor attendance of Aboriginal and Torres Strait Islander childbearing women to a local health service in South Sydney. In that report women did not attend mainstream antenatal education classes because they were “not comfortable, [there were] no vacancies, [it was] not considered to be important”. Further, this non-attendance at local health service antenatal education sessions was contrasted with the Aboriginal Medical Services antenatal classes in the same area, where it was found that women were “made to feel at ease and staff [were] empathetic” (Sydney South West Area Health Service, 2010, p. 5).

Antenatal Care

Seven women interviewed in the present study attended antenatal care. Of these, two women attended from an early stage in their pregnancy. The remainder of participants attended hospitals or Aboriginal medical centres for antenatal care at a later stage of their pregnancy and therefore, did not attend the recommended amount of times discussed below. Reasons for delayed or less frequent attendance at antenatal clinics varied. One woman who had gestational diabetes, said she was less

inclined to attend medical appointments because she was having her fifth child. When she did attend the ultrasound appointment however it was found that her baby was dangerously large. Consequently, because of the increased risk associated with a large baby the participant was dislocated from her home to the city, some 250 kilometres away, to have her baby by Caesarean section. Another participant, recently separated from her partner and with other children to care for alone, was unable to attend medical appointments as frequently as needed due to added responsibilities and less available time.

Antenatal care, which is routine health advice, screening and surveillance of pregnant women by health professionals, is strongly related to positive birth outcomes and was identified by the Council of Australian Governments as a strategic area for improving the disparity between Aboriginal and Torres Strait Islander and non-Indigenous maternal and neonatal outcomes (Kildea et al., 2013). According to the National Institute for Health and Clinical Excellence (NICE) guidelines in the United Kingdom, pregnant women should attend between seven to ten antenatal care appointments, which is also the recommended frequency for attendance recommended in the Australian clinical practice guidelines for antenatal care (Australian Health Ministers' Advisory Council, 2012; National Institute for Health and Clinical Excellence, 2008). However, as in the present study, most Aboriginal and Torres Strait Islander women continue to access antenatal care later and therefore on fewer occasions than other Australian women (McHugh & Hornbuckle, 2010; Rumbold & Cunningham, 2008).

Later and thus less frequent antenatal care attendance found in the present study is aligned with a report by McHugh and Hornbuckle (2010), who endeavour to attract Aboriginal women to attend antenatal care more frequently, by offering a maternal and child health model of care proposed for the Aboriginal Community Controlled health sector. Australian clinical practice guidelines for antenatal care also state that “Aboriginal and Torres Strait Islander mothers attended fewer antenatal visits compared with non-Indigenous mothers” (Australian Health Ministers' Advisory Council, 2012, p. 31). Lower antenatal attendance than non-Indigenous women has been reported for over a decade, for example by Minniecon, Parker and Cadet-James (2003) who studied young Aboriginal and Torres Strait Islander Australian women in pregnancy, childbirth and the post-partum period.

Rumbold and Cunningham (2008) however, assert that earlier and more regular attendance for antenatal care has been demonstrated when models of care appropriate to Aboriginal and Torres Strait Islander women are provided. A recent study by Allen, Gamble, Stapleton and Kildea (2012, p. 54), found strong evidence to suggest that a “group antenatal care model increases antenatal visit attendance and breastfeeding initiation, and decreases the risk of preterm birth”.

Inadequate Antenatal Options

Given the valuable insights provided by participants of the existing unappealing model of antenatal care and education offered in mainstream healthcare, it is clear that culturally acceptable and congruent antenatal services are not available for these women, who did not appear to have any alternative choice. An extensive literature review on improving health in Aboriginal and Torres Strait Islander mothers, babies and young children by Herceg (2005) demonstrated positive outcomes in antenatal care and antenatal education as mother/baby program uptake, when these services were offered as community based, outreach, or home visiting activities. No substantiation of educational compromise directly effecting maternal and neonatal outcomes in Aboriginal and Torres Strait Islander populations was found. Additionally the researcher did not find any reported evidence that educational deficit has a direct effect on the multiple facets of vulnerability pregnant and childbearing Aboriginal and Torres Strait Islander Australians endure.

As Crabtree (2008) elucidates, many maternity services suffer from cultural inertia steering women toward processes that reinforce the status quo. Given the educational compromise endured by Aboriginal and Torres Strait Islander women discussed previously, it may be reasonable to assume that not attending classes is a less confronting protest than contesting lack of choice in the healthcare system.

Eades et al., (2008), in a Western Australian study found educational deficit correlated, but was not statistically associated with, health compromise for pregnant and childbearing Aboriginal and Torres Strait Islander women and their families. This association between education and obstetric outcomes however, was not found to be widely reported in the available research. Although antenatal education is described by Hollins Martin (2008) as an important part of gaining knowledge that enables women to make choices in the preparation for pregnancy and childbirth,

Hancock (2007, p. 79) presents the indubitable truth that Aboriginal women in Australia are “least likely to have, if any, choice and control over their pregnancy care”.

Belonging

This section relates the concept of belonging and aligns with the theme of *centrality of family*. All women shared feelings about relationships with family, friends and community. The following discussion of belonging is presented under topics of family; community and identity; mothers; families without fathers; belonging at birth and dislocation.

Family, Community and Identity

All women who were interviewed said that family was important to them. As a core and central element of the childbirth experience, each participant explained how belonging to family affected her life in a different way. Most women were surrounded by many family members of different generations in their everyday life. In this way, family consisted of more than parents and siblings of participants. Instead, it constituted relatives and often friends who participated as family members in the woman’s life. This wide network of family cared for each other and children collectively; it provided support, identity, protection and a sense of belonging for all members.

However, not all participants lived or associated with their entire extended family. One woman chose to live at a distance from her family describing a need for independence and stating that her children needed their own space too. Even though this woman focused on her children and siblings only, these members of her family remained central to her childbirth experience. Another woman, not in contact with certain members of her family, had distanced herself from her mother in the longer term, but respected and interacted with her maternal grandmother in the same way as she would a loving mother. Even though both women mentioned above decided to keep their children away from what they assessed to be undesirable family influences such as drinking and smoking, they spoke of their family members with respect and tolerance for their individuality.

Several participants described the protective function a family held in their lives. One woman spoke of family providing a social circle sufficient to exclude unwanted influences and people in the wider society. Another woman interviewed shared that she felt, without her mother and other members of the family around her, she would have taken many more risks in life.

Findings from the present study are supported by Passey, Gale, and Sanson-Fisher (2011), who reported that family generally provided Aboriginal and Torres Strait Islander participants in their study with a sense of identity, strength and empowerment. A theory of containment is proffered by Pattel (2007, p. 7), in which the Aboriginal person is 'contained' within society by territories of family, community and the ecological system. In this way the person is shielded and protected by cultural layers providing protection from western society. As a collectivist society, Aboriginal people possess a wide social network of support, providing insulation from negative stereotypical attitudes and constraints faced daily as a matter of course (Pattel, 2007). Cultural protection of this nature is particularly necessary for many Noongar women who, unlike Aboriginal women from northern or remote areas of the centre of Western Australia, are mostly urban people. Noongar people, a minority group within the larger urban population, have been exposed to a longer and more intense history of oppression throughout history than most other Aboriginal groups in Western Australia (Dudgeon & Ugle, 2010).

Mothers

Several women interviewed lived with their mothers, while others returned to the mother's home at the time of pregnancy and childbirth. This practice was described as natural, unexceptional behaviour. Almost all mothers of participants worked, excluding those with small children of their own. Mothers played a highly significant role in the family, often protecting, advising and housing adult children and their families. Mothers were also described by most Noongar women interviewed as playing a highly significant role supporting, encouraging and comforting them in labour.

Only three of the ten participants lived in horizontal and vertical family constructs; that is families that are made up of three generations and three or more families of the same generation, all living in one home. One woman who was

interviewed lived with her newborn baby in the family home with her mother, who herself had a very young child of three years of age and another daughter with her infant. In effect, there were three mothers in the home, no fathers and three small children. The participant explained that male adult children, although not living in the home, were frequently present and also participated in caring for the small children. Findings from the present study concur with the occurrence of extended family reported by Eckermann et al., (2010, p.101), as being “not nearly as common as we might think among urban/rural Aboriginal groups”.

Families without Fathers

Six of the ten women interviewed were living separately from the father of their baby. This separation resulted in increased vulnerability for women who explained that shouldering all of the parenting responsibilities for a child or children was lonely, tiring and stressful. In these situations most women had strong family support, either living with their own mother or having support from parents and siblings while living independently. There was a clear pattern among participants; most of whom ensured contact was maintained between children, the father and his own extended family. Pattel (2007) concurs with the findings of the study, when reporting that the absence of a father or husband from the family, does not necessarily mean loss of contact with the family, asserting that “it is typical for children to maintain contact with the paternal family even in the fathers absence” (p.6).

Pattel (2007, p.6) suggests the frequency of mothers as single parents results from the “role of Aboriginal men as fathers and husbands as particularly undermined”, to a point where many find it impossible to provide for their families. Severe pressures in the social structure, such as higher levels of unemployment, incarceration, substance abuse and suicide, have resulted in an increased number of Aboriginal and Torres Strait Islander families without fathers.

The majority of mothers in the present study were not teenagers, however, as the inclusion criteria of the study stipulated all participants must be at least 18 years of age, no inference can be drawn from this. Nonetheless, a disproportionately increased incidence of Aboriginal and Torres Strait Islander teenage mothers is reported relative to the mainstream Australian population (MacRae et al., 2013).

Given the increased stress that some participants experienced as a result of single parenting, the paucity of available research exploring Aboriginal and Torres Strait Islander mothers as single parents is concerning and warrants further research.

For women interviewed in the present study, their sense of belonging was inextricably tied to family, community and culture. This was evidenced poignantly by one participant who had left a relationship of domestic violence to return to her home many thousands of kilometres away. She described feeling ‘shame’ at leaving the (violent) father of her children, explaining that depriving her children of a father was especially difficult, given her own father was a supportive and loving man who had been an extremely positive influence in her life.

Explaining that Aboriginal men are so disempowered because society no longer has a role for them to play in the wider community, Roe (2010) describes a program facilitated by senior Aboriginal men, which aims to promote acceptance of some responsibility that leads to empowerment. Of note therefore, is an Aboriginal community controlled health sector program in Roebourne Western Australia, that provides health education for mothers and fathers, including education on “men’s responsibility taking” among other Aboriginal family centred issues (McHugh & Hornbuckle, 2010).

Belonging and Birth

Participants described birth as a very special time for Noongar people and how important it was to have close family and friends participate in the event. This presented problems in the hospital setting on the day of birth for most women, who commented they would like to have more of their family present at the time of birth. Paradoxically, one woman in the study chose to have only her partner with her on the day of their baby’s birth.

Most women had visitors on the day of birth. Each visitor was a friend or relative who would play a significant role in the life of the new baby. It was described as very important that close family and friends participated in the birth as a display of support for the new mother. However, the majority of women interviewed conveyed frustration at having the number of visitors restricted while they were in

labour, especially when they were in private rooms and felt they would not disturb other patients in the hospital.

Dissatisfaction of women regarding the number of family permitted in the hospital birth room was not found to be reported in the literature, however importance of family involvement in birth was found to be very important (Kruske et al., 2012). A study conducted in the Northern Territory of Australia by Kruske et al., (2012) found that relationships with family members begin when the individual is born. They reported this kind of relationship is one of responsibility, where children are encouraged to be autonomous, care for and teach others. They also reported that children are not excluded from community events such as birth, death, illness and celebration. The Aboriginal and Torres Strait Islander notion of family is described by McGrath (2008) as different to the western understanding, in that family has a much wider concept including blood relatives and significant others.

Dislocation

Women in the present study who were dislocated from their homes to give birth described feeling distressed. Some women were hundreds of kilometres away from home; others were transferred to the city from outer metropolitan suburbs for care in a large tertiary obstetric hospital. As many women did not have a car or access to a car, having to move away from their local community could mean they had to forfeit contact and support from family and friends, sometimes for weeks at a time, and most especially on the day of birth. In all instances when women were separated from family and friends, they described feeling alone and unhappy.

Separation from their children at the time of birth was distressing for Noongar women who were interviewed. Being alone and separated from family, friends, community and country was very sad and described as joyless and depressing. Of the ten participants interviewed, only four had partners that lived with them. When one of these women was displaced to the city, her partner moved to the city for many weeks to accompany her, leaving their only other child with family at home. For this woman, separation from family and friends was a very difficult situation for the entire family. Being accommodated in a city building was also experienced as confining and alien to most women.

Geographical dislocation in childbirth resulted in some women leaving hospital as soon as possible after the birth and often before medically advised. Distress experienced by participants who were dislocated from family, community and country at the time of birth is commensurate with findings in the present research and widely confirmed in the literature (Hancock, 2007; Kildea et al., 2006). Ferguson-Hill (2010, p. 226) underscores the emotion expressed by women in the present study in her description of birthing away from country. She explains dislocation from significant family members can upset the “normal processes and rhythm of birth” leading at times to interruption of bonding with the baby with possible subsequent child behaviour problems.

The significance of belonging to family and community in the birth experience has also been demonstrated by participants in the present study and confirmed by a body of research (Hancock, 2007; Kildea, et al., 2013; McHugh & Hornbuckle, 2010; Minniecon, et al., 2003). The concept of family for Aboriginal and Torres Strait Islander peoples, which differs widely from that of the dominant culture, when considered in context with past colonising behaviours, is vitally important to take into maternity health discourse in contemporary Australia.

Connecting

Participants all discussed the past with reference to the present and their predictions and aspirations for the future. The theme identified in this study of *connection over time* is discussed in this section under topics of cultural connections, connecting future generations to culture and connection to land. This section also discusses participants’ lack of connection to healthcare providers and their suggestions for ways to provide dedicated cultural connectedness in healthcare.

Cultural Connections

Childbirth was a time of reflection for all participants of the study and was reflected in the emergent theme of connection over time. Whether pregnant for the first time or mothers of other children, all women felt the need to consider their part in the future as it unfolded for the new baby. Reflection on the past led to acknowledgement of the present, in turn invoking a maternal responsibility for ensuring a positive and fruitful future for their child. Such connection over time was

particularly meaningful to participants who, by virtue of being Noongar, had disturbing long ago histories and for most, a challenging and difficult childhood and recent past.

Although the Aboriginal and Torres Strait Islander cultural values articulated by National Health and Medical Research Council [NHMRC] (2003, p. 19) clearly describes the spiritual connections between past, present and future, the manner in which participants in the current study utilised the connections over time in an historical sense with direct reference to their perceived inherent responsibilities of mothering is unique. It does however, reflect a vitality similar to that described by Taylor and Guerin (2010, p. 113) as a process where culture is “active and proactive” rather than a fixed or inert historical entity. Similar understanding of Aboriginal culture and spirituality is proffered by Eckermann et al., (2010, p. 108) who claims “culture has and will continue to change and adapt to new influences, experiences and demands”. Application of cultural mores with such flexibility enabled the Noongar women within the study to connect the past, present and future with the childbirth experience in a reflective manner.

As also noted above, under the subheading antenatal education, few women in the present study fully accessed antenatal education provided by the Western Australian healthcare system, this being commensurate with available published literature (Freemantle et al., 2006; Hancock, 2007; Herceg, 2005; McHugh & Hornbuckle, 2010). The importance of cultural connections that were not transferred into antenatal education could highlight the need for future models of antenatal education and care to incorporate the concept of connection over time with appropriate cultural emphasis.

Connecting Future Generations to Culture

Each woman interviewed described her childbirth experience as a time when she was able to reflect on her past with reference to her present reality. This was a double edged sword for most women who valued the intrinsic elements of their culture, which had persisted despite atrocities inflicted on bygone generations. They also acknowledged the trans-generational trauma that in some ways, played out in their present reality. These considerations were steeped in the strong sense of responsibility that participants had for the future of their children.

Most women interviewed expressed concern about their own cultural connectedness and how they could provide 'strong culture' for their baby. As Noongar women, given their heterogeneity in a pluralistic society where they remain the non-dominant culture, a sense of loss of culture was conveyed. It was notable that no participant voiced or suggested a lack of connection to her body or the actual experience of birth.

Several participants spoke of dilution of their culture with loss of cultural values, particularly in respect of a perceived waywardness of many teenagers and youth. This has been explained by Aboriginal researchers as a loss of self and spirit that manifests as obsessive behaviours including addiction and violence in Aboriginal society (Pattel, 2007; Roe, 2010). Such aspersions naturally flowed on to discussion of preservation of culture for their new baby, with particular reference to respect of self and others.

Some Noongar women interviewed described 'strong culture' as reflecting an Aboriginal experience of empowerment. Participants spoke of the aspiration and ability to rise above difficulties such as racism in their lives. Achieving this goal has been described by Haswell et al., (2010, p. 798) in their study of empowerment in Aboriginal and Torres Strait Islander peoples, as involving a person living in such a way that "honours their identity, values and abilities in harmony with others", thereby achieving a sense of calm even in challenging times.

Some women described the new baby as having a responsibility to look after the parent or parents throughout life. Although this is not an unusual life concept, when expressed with respect to an infant, it conveys a sense of the connectedness over time acknowledged by the Aboriginal and Torres Strait Islander people within their cultures.

Women in the study voiced an appreciation of the hardships endured by their ancestors in both distant and the more recent past. It was important to participants to understand the past, as some told stories which provided an understanding of where their family had come from and what they had endured, while others spoke in more general terms describing the past as the 'history of our people'. Cultural and spiritual beliefs that connected time were valued to varying degrees by individual participants,

many of whom lamented a loss of cultural elements in their lives and the lives of their children.

Connection to Land

Women in the study expressed connection to land and community. Aboriginal spiritual belief conceptualises land, elements, animals and people as one interconnected whole. This concept of wholeness corresponds to descriptions offered by Kickett (2011) based on awareness of family history through many generations. That is, a cultural belief of oneness and connection to country is central to the spirit and identity of Aboriginal people.

Birthing on country was not discussed explicitly by women in this study. Some participants, who were away from their home land at the time of birth for health reasons, described a desire to return home as quickly as possible to be with loved ones, family and friends. One woman told the story of driving several hundred kilometres in early labour so that she could have her baby in the same place she was born. This, she explained, was not so much about the country. Rather she wanted to be surrounded by people she had known for many years, people she felt comfortable with. This contemporary sentiment resonates strongly with stories of the grandmothers several generations ago. In an effort to gain understanding and context of Noongar birth, the researcher visited traditional birthing places where the 'women's business' of birth was practiced long ago by Noongar women. Being guided by the last woman to be born in one of the birthing places on Noongar land close to the city of Perth, was an honour for the researcher in this study.

Traditional birthing, as described by Nappaljari Jones (2011), who is a Walmadjari Traditional Owner [of the land on which she was born] and an elder of her people, was birthing on one's own country surrounded by sisters, aunties and grandmothers who provided the birthing woman with physical and psychological support. This support consisted of holding and massage and most importantly resulted in removing fear, which she attributed to good progress in the birthing process. She also explained that being born on country is highly significant as it is the only way in which an Aboriginal person can be regarded as a traditional owner.

More recently Kildea and Wagner (2012) report that birthing on country is viewed by Aboriginal and Torres Strait Islander women as a way to improve maternal and neonatal outcomes for their people. Having stated that their relationship to the land is compromised by birthing in hospitals, where they feel culturally unsafe, many Aboriginal and Torres Strait Islander women are reported to believe that relationships with new babies would be enhanced by the whole family being together at the time of birth (Kildea & Wagner, 2012).

Pattel (2007, p. 1) extends the explanation of Aboriginal worldview to provide for the “unity and coherence of people, nature, land and time, thus seeing themselves as part of the natural order, rather than apart from it and having control over it”. The holistic nature of the Aboriginal worldview, despite being reported for several decades (Malin, et al., 1996) remains relevant today.

Research by Pattel (2007) illuminating such connection to the “mother’s country” or “father’s country”, depending on whether the clan is patriarchal or matriarchal, provides an understanding of totems and sacred sites. This also resonates with studies conducted by Kornelsen, Kotaska, Waterfall, Willie, and Wilson (2010) of Canadian First Nation peoples’ sense of identity, which is bound within their connection to family, community and place.

Connecting to Healthcare Providers

Many of the women expressed a degree of satisfaction with the way in which healthcare professionals interfaced with them. Some participants spoke of the value of knowing the professional that cared for them when they were birthing. One woman, who was hospitalised for many weeks prior to the birth, explained how supportive it was to see the same midwife every day. She expressed the value of having built a relationship with the midwife, who was there on the day of her baby’s birth. Knowing the midwife before the day of birth was preferred, however, participants advised that if this was not possible, healthcare staff should spend time getting to know them.

Eckermann, et al., (2010, p. 174) elucidate that communication, although the essence of interaction, is likely to have the greatest repercussions at the cultural interface. Observing basic communication protocols is advised and described as

simply taking time to listen, avoid terminating the conversation or interrupting and importantly “investing in the beginning”. Such advice was echoed by participants who explained that spending time establishing a relationship with the Noongar woman, especially when she was in labour, was comforting and appreciated.

Some Noongar women interviewed, however, experienced a palpable cultural disconnect when interfacing with healthcare professionals. They described recoiling at midwives using loud voices and were especially ‘shamed’ by reference to body parts in a public manner, such as a midwife asking to view a postnatal woman’s stitches or breasts in the hospital ward with other people present. Women interviewed in the study also found both under attentiveness and over attentiveness to be patronising and insulting. That is to say, being ignored was equally as insulting as being singled out for demonstrable and superficial attention.

Two participants expressed that they simply wanted to be treated with the same degree of respect as other women. Such sage advice is especially useful to non-Indigenous healthcare providers, evidencing the value of participants sharing their lived experiences with candour. Durey, et al., (2012) confirm findings evident in the present study, reporting that many Aboriginal people find hospitals unwelcoming, advising respectful treatment such as openness, non-patronising conversation and service are required.

Dedicated Cultural Connectedness in Healthcare

Many women experienced feelings of loneliness when in hospital. Several participants suggested the need for an Aboriginal advocate to support Noongar women. It was clarified that the advocate must be a woman, who is not necessarily a midwife or healthcare worker, but a person who is Aboriginal and culturally aware. This person would be responsible to visit Noongar women in hospital, simply to be a friendly face who understood them. Some participants had experienced hospitalisation previously in institutions that employed Aboriginal Liaison Healthcare workers and valued the care these women provided. The role of the Aboriginal Health worker is described as critical by Boyle, et al (2008), who assert a national need for education, registration and a defined career pathway for Aboriginal and Torres Strait Islander professionals who work specifically in the area of maternal and child health. This is one way to support the maintenance of cultural integrity and

vitality (Lewis, 2011) of Noongar women, who are destined in the foreseeable future to be a minority group in maternity healthcare.

Shaping

Emergent themes of *connection over time* and *cultural challenge* are discussed in this section as means by which women shape the future for themselves and their new baby. Influences that shaped participants lives and the way in which women interviewed reshaped their lives in the present and for the future are considered in this section. Topics are discussed under headings of history shapes the present, hyper-vigilance, breaking the cycle and shaping cultural families.

History Shapes the Present

Participants of the study suffered cultural challenge and difficulty in their childhood to varying degrees. Some women interviewed described relationships with their mothers devoid of overt expressions of love and affection. When contextualised within the history of colonisation and subsequent forced removal of children of the Stolen Generation, the enormity of the severing of trans-generational love and affection is laid bare.

Women in the present study spoke of family histories with the negative effects of dispossession, forced removal of children and prevention of cultural expression, forced assimilation, denial of expression of cultural distinctiveness, social exclusion and violence. Findings of the present study are congruent with published research about colonising behaviours of previous generations (Eckermann, et al., 2010; Ou, et al., 2012; Taylor & Guerin, 2010; Wendt & Baker, 2013). For mothers of subsequent generations, the Stolen Generation had dire consequences in their ability to parent children (Petchkovsky, et al., 2004; Walters, 2012).

A graphic and shocking expose of cruelty and inhumanity levelled at the Aboriginal race of Australia from 1883-1969 is presented by Walters (2012) in her ethnographic study of a group of elders from the western suburbs of Sydney. Additionally confronting is research by Petchkovsky et al. (2004) that reveals practices of forced separation and attacks on linkages within culture of the Stolen Generation. This enforced disconnection was a practice aimed at destruction of all

that defines a culture and its people. The researcher found that reflection on evidence of this kind provided context from which enhanced appreciation developed.

One of the many dire consequences of this period in history, was that many members of future generations of the Stolen Generation experienced profound difficulty to show love to, and bond with, their children, themselves having never received emotional warmth in their formative years (Petchkovsky, et al., 2004; Walters, 2012). The consequence of this inability to express love was described by participants of the present study in their own lives. Unique insights gleaned from women interviewed in the present study and supported by the literature present an opportunity to shape and influence maternity care for Noongar women. A possibility exists to implement mandatory cultural competence education, including advanced cultural communication skills for all healthcare providers who care for Aboriginal and Torres Strait Islander childbearing women.

Hyper-vigilance

Most women described feelings of deep concern for the safety of their baby, both in the hospital setting and once they returned home. Participants with additional children explained feelings of hyper-vigilance had occurred with previous babies and this remained with them for many years.

Findings in a study by Petchkovsky, et al., (2004) revealed hyper-vigilance to be a consequence suffered by victims of the Stolen Generation. In that study participants described a terror of anything happening to their children. This description is closely aligned with findings of the present study. Hyper-vigilance of children and anxiety felt by mothers for the safety of their children, though one might assert is predictable given the well recorded history of the Stolen Generation, was not identified in the literature. Such insight to specific and intense feelings of hyper-vigilance experienced by many of the participants, speaks to the strength of the present study. It is proposed this new knowledge may form part of future cultural awareness education for maternity healthcare professionals. Further consideration of existing policies and process and their effect on Aboriginal and Torres Strait Islander women in the healthcare system, may be reviewed in light of this finding.

Breaking the Cycle

Women in the present study applied the cultural value of connection over time to their individual realities. It was by understanding the past that most participants were able to consider their present reality with an acceptance of themselves and their family. The childbirth experience was described by participants as a time of assessing the present and making plans and changes for the future. Given the increased vulnerability of participants and their existence within a dominant post-colonial society, change would require a great deal of inner strength and determination. A strong spirit and sense of connection with family, community and country, drawing together the past, present and future is the degree of resilience required to effect positive change (Kickett, 2011; Roe, 2010).

Shaping a new life for themselves and their children was described as a personal responsibility by women interviewed in the present study. They said that children needed to be protected, but also learn to cope with difficulties of life, including racism. These aspirations are congruent with published research studies of self-mastery in Aboriginal and Torres Strait Islander children (Morgan, 2010) and Aboriginal women's attitudes of determination to teach their children how to manage life's stressors (Pattel, 2007).

At times, shaping a new future for children involved participants finding, or making a safe space for their children to live fruitful and happy lives. Some women made difficult choices when they decided to distance themselves from family members, who they judged would have an unhealthy influence on their children. Other participants moved toward family for support and community. This finding is congruent with a study by Wendt and Baker (2013) who explored Aboriginal women's perception and experience of family violence and their need for transitional accommodation.

Women described feelings of warmth and security gained from family, friends and their Aboriginal social networks. Social capital or social cohesion such as this, inheres a sense of belonging, trust, reciprocity, cooperation and social harmony (Berry & Welsh, 2010). It has been described as both an indicator and determinant of happiness and wellbeing (Biddle, 2012) and is also positively

associated with mental health (Ziersch, Baum, Darmawan, Kavanagh, & Bentley, 2009).

Two teenage participants described a cultural challenge of dual reality. They were well supported by family and both lived in their respective family homes. Although the role of mother was accepted with responsibility by each of these participants, the loss of freedom and youth was difficult to bear. Even though these young Noongar women were encouraged and supported by their mothers to socialise with their friends, they found the conflicting roles of being a mother and an adolescent difficult to reconcile. This insight aligns well with de Souza and Rymarez (2007) in their discussion of the difficulties adolescents have acknowledging their cultural identities when the context is pluralistic in cultural values and modern Australian society.

Many participants interviewed indicated that they would be hesitant to seek medical help if unwell, explaining that they would usually wait to consult family and friends for advice, only seeking medical attention if the problem escalated. They spoke of their upbringing, explaining they had been raised to keep problems to themselves. This had consequences for participants who endured mounting health complications such as wound infections, unstable diabetes and post natal depression before seeking professional medical help.

Given the new responsibility of motherhood however, many women expressed a need to change past behaviours, articulating how their child depended on a mother to be healthy and able to provide care. Such a move towards increased self-care as a consequence of the childbirth experience, represented an attitude of 'breaking the cycle' of vacillating health ambivalence. It is posited therefore, that consulting and collaborating with childbearing women and their communities to gain further understanding of the perception of mothering, may be undertaken to inform a more effective approach to the development of culturally congruent care and education.

Shaping Cultural Families

All women articulated clear hopes and dreams for their new baby as they planned for the future. Without exception, participants described their aspirations for

a future in which their child was healthy. Good self-respect embodied a mindset of self-care and preservation, including high levels of personal hygiene and avoidance of alcohol, smoking or drug usage. Such minimisation of risk taking behaviours impacts positively on self-agency, resulting in heightened motivation to participate in culture and community, enhancing and strengthening family and social connections (Omari, 2008). Self-respect also encompassed dealing with stress in positive ways, avoiding violence especially fighting, and developing positive strategies to cope with the effects of racism often expressed as 'rising above it' (Kickett, 2011). All women predicted with an insuperable air of certainty that their children would live a life of prejudice and racism.

Respect for others held special significance for women in the study. They spoke of instilling in their children respectful ways of interacting with elders, which included not only grandparents, but any person that was a generation or older than the child. The use of first names for members of the older generation was particularly abhorrent, with most participants making particular reference to observance and use of culturally appropriate titles such as nana, aunty or uncle. Respect for culture included participating in meaningful ways with family and community. Responsibility to family was seen as the cultural way of life with reciprocity and autonomy accorded to children from birth (Kruske, et al., 2012).

All participants expressed a desire for their children to lead respectful and cultural lives that they explained would prevent them engaging in dangerous and risk taking behaviours. Respect featured strongly in the women's understanding of strong culture and breaking the cycle of negativity that surrounded many of them. The childbirth experience was a unique time of putting things right, or setting the scene for a better future for mother and child.

Given the participants shared philosophy of respect and responsibilities, it is proposed that local gatherings held informally and within the community may enhance peer support of childbearing Noongar women. It is possible that inclusion of older Noongar women in these events, would serve to place positive cultural role models within easy reach for the women. This could be a means of support, education and enhanced social capital for childbearing women.

Persisting

The theme of *ubiquitous prejudice and racism* is discussed in the section below as persisting and continuing in society. Persistent efforts of the women interviewed to cope with prejudice and racism for themselves and their children is also a part of this concept. Further, findings of the study are discussed with reference to changes in healthcare service and the profession of midwifery. Topics of discussion in this section are prejudice and racism, cultural safety, affirmative action for healthcare professionals, cultural awareness, non-Indigenous discourse, cultural advocacy and de-colonising concepts and strategies.

Prejudice and Racism

Pregnancy and childbirth was a time when prejudice and racism were experienced to varying degrees by all of the participants. The discrimination they endured at this time, such as being ignored or spoken to in a patronising manner, was not unusual as it had become normalised and was a common aspect of their daily existence. However, some participants verbalized experiences of discrimination in the healthcare setting as being hurtful, though such interactions were exceptional and infrequent. In that setting, they described feelings of disrespect or prejudgement, either from the actions or attitudes of staff or the general public.

When faced with racism, women in the study reacted by avoiding the hospital system which offered antenatal care and education, seeking and accessing necessary medical advice later than prudent, or as patients, leaving hospital prior to medical advice. Consistent with findings in the current research, Zubrick et al.,(2010) report strong evidence that systemic racism leads to a reduction in accessing societal healthcare resources. These findings are advanced by Parker (2010), who reports the pervasive effects of cultural and organisational racism. Van Herk, Smith, and Andrew (2011) concur, elucidating further that Aboriginal women often fail to access healthcare because of prejudice related to present day violence and discrimination, attached to their role as mothers.

Racism, the persistent companion of colonialism, played out in many ways for women in the study. Several participants felt an undercurrent of negativity when family or friends came to visit them in the hospital. This was construed to be the

result of concentrated media representations of violence or misadventure by Aboriginal people in society. Many of the women used the expression of 'all being tarred by the same brush' when lamenting the unfounded prejudgements they experienced. A group of Aboriginals, they explained, was always seen as trouble waiting to happen.

Attitudes of healthcare professionals behaving in dismissive ways, such that participants felt they were an imposition on the staff, left some Noongar women who were interviewed feeling distressed and confused. On occasions, unspoken messages were received so powerfully that women prematurely discharged themselves from hospital endangering themselves, their newborn baby and at times, other children. That selective exclusionary practices such as these continue to persist as undercurrents in health systems is confirmed in the literature (Eckermann, et al., 2010; Grant & Francis, 2008).

Some women in the study described bullying behaviours levelled at them. One woman, who was examined in a rough manner, explained feeling powerless to protest as the reason for her silence. Another participant explaining that she felt ignored and neglected, coped with the situation by simply leaving the hospital in protest. Similar situations have been described where women were disempowered by virtue of their colonised history (Varcoe, Brown, Calam, Harvey, & Tallio, 2013). As Dietsch, et al. (2010) elucidate, irrespective of the intent, the victim of bullying is always left feeling oppressed by the more powerful party.

It is acknowledged that participants' insights align closely with the nocebo effect, described by Dietsch and Davies (2007), which refers to the iatrogenic, unintended, harmful consequences suffered by women in the healthcare setting, resulting from prejudicial actions. Given the disproportionate negative outcomes for Aboriginal and Torres Strait Islander childbearing women and babies, compared with the non-Indigenous population, improving access to healthcare can only be described as a national priority (Durey, et al., 2012). Clearly then, healthcare professionals who more fully comprehend and allow for the influence that history encumbers upon present day Aboriginal and Torres Strait Islander women, are better able to interact in a sensitive and welcoming culturally aware manner (Hancock, 2007).

Cultural Safety

All women in the present study were in the minority group when being cared for in the healthcare system. While Aboriginal and Torres Strait Islander peoples only contribute to a small percentage of the overall Australian population, the greatest concentration of Aboriginal and Torres Strait Islander people is in the large cities (Pyett, Waples-Crowe, & van der Sterren, 2009). Unlike the more remote or rural populations, urban Aboriginal and Torres Strait Islander societies lack homogeneity, so are less geographically discrete and thus, more diverse and dispersed. These factors increase ignorance of the diversity and uniqueness of different cultural groups of Aboriginal people. This attitude is described as difference blindness and contributes to racial prejudice and increased marginalisation. Consequently the reality for urban Noongar women is one of being members of a minority group, who are often challenged by non-Indigenous people about the authenticity of their identity (Dudgeon & Ugle, 2010). This perceived deculturation of Noongar people increases their vulnerability and can hinder ability to negotiate the healthcare system of the dominant culture.

On the whole, women in the present study did not engage in antenatal education, most attended routine antenatal health assessments, however they did attend later and less often than optimal. All participants attended hospitals to birth their babies, however some women left before medically advised endangering themselves and their children. In the postnatal phase, some women who were interviewed delayed seeking medical advice until the problem had escalated. These behaviours may suggest that Noongar women interviewed in this study did not experience culturally appropriate woman centred education and care.

Participants in the study exposed their method of assessment and feedback in a uniquely and culturally specific manner; they voted with their feet (Pattel, 2007). That is, when women in the study felt uncomfortable, unwelcomed, out of place or discriminated against they simply walked away. Cultural safety is a concept that goes well beyond awareness and sensitivity, as it gives “people the power to comment on care leading to reinforcement of positive experiences” (Nguyen, et al., 2008, p. 991).

Women in the study described a wide range of cultural conflict at the personal, community, societal and organisational level. Such powerlessness rendered women in the study oppressed within a healthcare system that was difficult to understand, access and negotiate. Noongar women have a long and widespread history of oppression (Dudgeon & Ugle, 2010). Homogeneity of their societies may not only be disempowering, it may be perceived by participants as a cultural dilution that leaves them at the margins of society. Durey, et al., (2012) report that Aboriginal people have a persistent dislike of hospitals and this, according to Eades, et al., (2008), has implications for the continued disparity in maternal and neonatal outcomes for Noongar women and their babies.

The onus of responsibility for improved health outcomes can no longer rest on the shoulders of the Aboriginal and Torres Strait Islander populations alone. All healthcare professionals are in positions of power and thus responsible to effect change in some way. Clinicians, educators and policy makers are therefore encumbered to not only strive to find answers, but acknowledge their part in the problem (Salmon, 2007). Hancock (2007, p. 80) calls for a “reconciliation of care” for pregnant and childbearing Aboriginal and Torres Strait Islander women. Change will only be effected by an increased understanding of the experience of Noongar women in birth, followed by a persistent concerted collective effort of healthcare professionals and policy makers to transform theory and rhetoric into concrete strategies, practice and outcomes. These should enable the provision of effective culturally appropriate care (Kruske, 2011).

Affirmative Action for Healthcare Professionals

In the present study a small group of Noongar women shared their stories, providing the researcher and potentially, future healthcare workers with insights about their experiences. Listening to the voices of these participants should provide a springboard for affirmative action that will invoke change and make a difference.

The persistent trauma associated with removal of children of the Stolen Generation continues to envelop those removed and their descendants in a “pernicious interlinked set of health and social problems” (Morgan, 2010, p. 56). These multifaceted and complex sets of challenges leave the individual midwife or

clinical healthcare professional, questioning how, if at all, one individual can make a change.

A fundamental and critical healthcare problem in health provision in Australia has been identified as the poor access and uptake of services by Wendt and Baker, (2013, p. 513), who report access to services to be constrained by “the limited number of agencies with staff able to work in ways that are sensitive are culturally appropriate”. A simple and obvious starting point to a way forward, it would seem, is the identification of a common goal at individual, professional and institutional levels, to make birth a better experience for Aboriginal and Torres Strait Islander women (Hancock, 2007).

With an understanding of the damaging effects of ‘blindness’ to the difference and diversity of individual Aboriginal or Torres Strait Islander groups, it becomes obvious that no panacea for reconciliation of maternity care exists. Respectful relationships acknowledge and affirm the right of people to have different values, norms and aspirations (National Health and Medical Research Council [NHMRC], 2003, p. 12). Local efforts can therefore be contextualised to the dominant Aboriginal or Torres Strait Islander cultural group, acknowledging their uniqueness.

Cultural Awareness

Change becomes tokenistic when it fails to match process with intended outcome. Hancock (2007) describes the need to ensure the Aboriginal woman’s feelings about her pregnancy and maternity care, as being of the highest priority. Such is the bedrock of culturally inclusive strategies’ for change. From this point priorities can be identified.

Several women in the present study said they felt out of place, uncomfortable, or they simply did not fit into the hospital system. This is congruent with published research studies that promote understanding of the marginalisation that women can experience in the western biomedical healthcare system (Merrill & Grassley, 2008). A deeper understanding of the dynamic relationship between mind, body and spirit that encompasses the Aboriginal and Torres Strait Islander peoples view of health is necessary for health professionals to provide culturally sensitive and safe care

(Taylor & Guerin, 2010). Acknowledgement of personal colonising attitudes, beliefs, behaviours and actions by healthcare professionals has the potential to reveal biases which, if left dormant or ignored, will prevent or inhibit change.

Mandatory annual cultural awareness competencies are suggested as a vital and necessary starting point. Such education, if conducted thoroughly and with appropriate evidence base, has the potential to be transformative for midwifery professionals. Identified strategic goals at the organisational level must include education of members of the professions to be “part of the multiple solutions to racism and Aboriginal and Torres Strait Islander disadvantage rather than part of the problem”(Rickwood, et al., 2010, p. 22). The present research provides some insight with which to instigate conversation around education initiatives. Research by Ewen (2011) supports a need for change and suggests a reform of a more diverse healthcare system including medical education, as does the present study.

Non-Indigenous Discourse

As previously discussed some women interviewed in the study spoke of instances where they felt shamed or annoyed by healthcare professionals communication interactions. They described staff using loud voices to be insulting and demeaning. Midwives referring to body parts or functions in the public arena also distressed women who were interviewed. The interrelationship of understanding and language is well understood, being described as the “medium in and through which we exist and perceive our world” (Gadamer, 1976, p. 29). Such philosophical acumen provides educators with a clear objective to examine non-Indigenous discourse. By understanding Aboriginal and Torres Strait Islander culture, it may be possible to reframe dialogue to present a more hopeful and positive language and hence understanding (Taylor & Guerin, 2010). This reorientation of language, achieved in concert with Aboriginal and Torres Strait Islander women, may have the potential to change attitudes and so service delivery.

Much of the literature relating to Aboriginal and Torres Strait Islander health, reports systemic negativity, disenchantment and deficit. This can be justified given the healthcare disparities relative to the wider population (Ewen, 2011). Additionally, it is acknowledged that in order for improved health outcomes to be achieved, then health needs must be reported factually and in-depth. Taylor and

Guerin (2010, p. 115) however, contend that “deficits, disadvantage and lacking [have] therefore inevitably become the norm”. Further to this Nelson, et al., (2012) discuss the unproblematised use of the descriptor ‘Aboriginality’ as a health risk marker. It is the creation of an unchallenged norm, achieved by dominant discourse, which should be of concern to healthcare professionals.

De-colonising Concepts and Strategies

Colonising behaviours persist in mainstream Australia and have relevance to Noongar women’s birth experience. Women in the study endured prejudice and racism in overt and subtle forms to a degree that they were normalised. One woman spoke of being pointedly ignored in shopping centres, while another participant said that she and her pregnant sister were refused public transport, simply because they were Aboriginal. Yet another woman recounted how school friends openly admitted expecting to find her living in an unclean home.

Discrimination was often more subtle in the healthcare setting. One participant explained how she detected tension and judgement from other visitors simply because she had a group of Aboriginal people with her in the hospital. Another woman who was interviewed, decided to spare her visitors embarrassment, when, in anticipation of the prejudice in the hospital, she asked her family and friends to stay away.

The professional healthcare workforce has a responsibility to become aware of colonising attitudes and behaviours and the power such constructs have even when enacted from the subconscious. The aim of identifying and deconstructing inherent colonising ideologies and behaviours in non-Indigenous healthcare professionals is to reach a point where, through self-examination and thus identification of biases, the healthcare service is fairer and more just (Taylor & Guerin, 2010). The ultimate aim of de-colonising strategies is to empower Aboriginal and Torres Strait Islander peoples in a way that “honours their identity, values and abilities in harmony with others” (Haswell, et al., 2010, p. 798).

It is vital at the outset to endeavour to deconstruct old myths and revealing practices that serve to enable colonising behaviours and mindsets to persist. An example is the selective historical amnesia that has prevented factual accounts of the

actions of colonisers and perpetrators of the past (Walters, 2012). By extension it could be asserted the level of amnesia corresponds to the degree of cruelty and devastation endured by Aboriginal and Torres Strait Islander peoples and its persisting sequelae. Colonialism has been accorded with providing the context for “release of an individual and cultural superego”, with which a nation levelled “aggression with its hatred and punishment on the Aborigine” (Walters, 2012, p. 150). Understanding of the history of colonialism through recording of memories and lived experiences of the past, is one way to provide context from which a more enlightened and courageous healthcare community can progress and persist (Sherwood, 2013).

The history of the White Australia Policy and its effect on the mainstream Australian psyche has resulted in “whiteness” becoming the default position, or invisible position against which all other racial and ethnic identities are measured (Health Workforce Australia, 2013). The concept of “whiteness” is premised on the fact that, as the dominant skin colour in Australia is fair, white Australians have certain privileges that are often unspoken or unacknowledged (Taylor & Guerin, 2010). This sociological concept is a point for reflection implemented as a de-colonising strategy by the researcher of the present study.

An additional de-colonising concept reflected upon by the researcher in the present study is the notion of “othering”. This is the categorisation of those perceived as different from the dominant culture. Such a concept considers the way differences are accentuated by the notion of ‘our way’ and ‘your way’, or ‘I am’ and ‘you are’. Although a seemingly simplistic concept, when deeply considered and reflected upon, illuminates inherent colonising behaviours (Taylor & Guerin, 2010). It has been asserted that Aboriginal and Torres Strait Islander peoples want to actively participate in the planning and delivery of their healthcare, in partnership with non-Indigenous healthcare professionals who “listen to their clients with respect and a decolonising gaze” (Sherwood, 2013, p. 28).

Conclusion

The purpose of this chapter was to present a composite of finding of the study aligned with current research to discuss the relevance, usefulness and possibilities of

these to Noongar childbearing women. The experience, as told by the women, was found to incorporate many different interrelated aspects of their identities and realities. The insights provided by participants are an important component of advancing efforts to provide improved maternity care that is respectful, appropriate and carefully considered. The following concluding chapter will present a synopsis of the study incorporating recommendations for future practice, as well as acknowledging limitations of the present study.

CHAPTER 8: SUMMARY AND RECOMMENDATIONS

Introduction

This final chapter reaffirms the purpose of the study and summarises findings by suggesting that lived experience of Noongar women in childbirth comprises a confluence of complex, multi-layered and challenging cultural factors. Limitations of the study are then declared and the significance of the study illuminated. Further to this, implications and recommendations for practice are presented. Finally, suggestions for future research are offered.

The researcher brought to the study a phenomenon to explore, that of the childbirth experience of Noongar women, using a particular philosophical orientation to gain understanding of how it is to *be* that woman. In pursuit of such intimate and deep knowledge, hermeneutic phenomenology illuminated the invisible ‘taken for granted’. Van Manen (1990, p.130) advises that “writing is our method” and goes on to explain it is in the writing that understanding is gained. Phenomenological textual reflection does not aim for florid loquaciousness and it is not about the words. It is an attempt to achieve understanding that goes beyond language and description. Van Manen (1990, p.173) explains the textual nature of hermeneutic research, with the aphoristic reference of a philosopher, as “finding by means of language the means to express the ineffable”. To this end, in the present study, as language and words uncovered depth of meaning, it was “in and through the words” (Van Manen, p. 130) that the unique and extraordinary phenomenon of Noongar women’s birth experience was uncovered.

Research Aim and Purpose

This study sought to give voice to a small group of women, thereby obtaining a contextualised account of the most significant aspects of how it is to be a Noongar childbearing woman. Highly significant insights into this experience resulted from rare and candid sharing between participants of the study and the non-Indigenous midwife academic researcher. The purpose of the study was to both understand and value Noongar women’s experience and wisdom of their childbirth experience as authoritative knowledge. It was anticipated that findings from the study would have

the potential to provide healthcare professionals and policy makers with insight and knowledge, upon which to base decisions concerned with the planning and delivery of culturally appropriate care. In other words, it was expected that the study would enable participants to articulate and reflect on feelings, perspectives, expectations and experiences of childbirth.

The researcher was cognisant that key to facilitation of open communication and sharing by participants was the creation of a space in which each participant felt comfortable and empowered. All interviews were conducted in a place that held *cultural advantage* for the participants, that is, either in their own homes or within the premises of an Aboriginal Medical Centre. Advanced communication skills were employed such that interviews were conversational, reflexive, adaptive, minimalistic and, at all times, respectful. In order to achieve the aim of *giving voice* to the women, it was vital to mitigate any interrogative nuances while interviewing, to respect silences and prompt sensitively.

It was considered paramount that the study be conducted on Noongar land. As all Aboriginal and Torres Strait Islander groups have different socio-political ideologies, challenges and cultural mores, confining research to a single cultural group was vital. The Noongar people in Western Australia have little written history despite enduring a longer and more intense history of oppression than Aboriginal people from remote areas (Walker & Sonn, p. 157). Although Noongar land extends beyond the cities to rural areas, the population is largely urban and heterogenic resulting in a minority population who are marginalised and difficult to locate. These factors have led to many maternity care and outcome challenges that had attracted little research in the past. An additional research advantage was the variability of services provided in Noongar country that would potentially yield valuable insights about childbirth experiences, in both regional and urban, hospital and community settings.

Findings

Women in the study identified vulnerabilities which spanned the psychosocial, physical and cultural spectrum. These were enduring stresses that most had lived with throughout their lives. At some stage in the childbirth

experience, all women accessed healthcare in the dominant western biomedical system that prevails in Australia. Being a part of the minority group exemplified and exacerbated vulnerability at a juncture where women attempted to negotiate a healthcare system that was often frightening, lonely, unwelcoming and foreign. Participants described feeling disrespected, ignored and out of place in the hospital setting. In short they were culturally alienated. Further, in response to the culturally deficient choices offered in the healthcare environment, many of the participants left hospital before medically advised, posing a risk situation for themselves and their babies.

All participants described failing to reach their formal and informal educational potential. This resulted in lack of self esteem and self efficacy to a degree that impacted on their interactions in the wider society. Education was lacking for varied reasons including increased childhood family responsibilities, lack of family stability and support, and unexpected teenage pregnancy. Given that mainstream antenatal education is offered in the public healthcare setting and developed to meet the needs of the dominant society it follows that many Noongar women may find this model unacceptable. All women in the study chose not to access the full extent of childbirth related healthcare services available to them, many explaining they felt uncomfortable in these settings and simply did not fit in. Consequently many had physical and psychological ill-health, which escalated before medical assistance was obtained. Women in the study did not have the choice of culturally congruent or acceptable antenatal education available to them in their childbirth experience.

Women provided specific insights into their experiences of communication and interpersonal difficulties. Some explained that due to historical consequences of the Stolen Generation, their parents had found difficulty expressing love to children. Some participants, who described receiving tough love from their parents, identified the need for soft and gentle care in their childbirth experience. None of the women interviewed recounted receiving care that they perceived as being gentle, sensitive or soft. To the contrary, many women who were interviewed, judging the midwives were too busy to attend to them, described feeling as though they were a burden on an already overworked staff.

Many women described insensitive, ineffective or hurtful communication interactions. Often, the way in which they were spoken to was culturally offensive. Women explained how much they disliked healthcare professionals directing a loud tone of voice at them, especially when spoken from a distance. Public reference to private body parts induced feelings of shame, with mention of checking stitches being particularly demeaning in the maternity ward setting. Participants wanted ordinary respectful conversations with staff, judging overfriendly and dismissive verbal interactions as equally patronising and insulting.

Family connections were integral to identity, sense of self and wellbeing, as expressed by the women in the study. Most women described important ties to family, community and country that were made stronger through the experience of birth. Family was central to the women's childbirth experience, highlighting the importance of significant family and friends sharing in the joy of the day of birth. Women explained that each visitor, who came to pay respect to the mother and her infant, would play a part in the life of that baby. Given the protective function that family and community play in Noongar women's lives, with special consideration to present day consequences of historical events, the vital role of family involvement at birth becomes obvious. Most women expressed that a culturally sensitive birth was one shared with family and community. However, not every woman interviewed wanted or was able to have family with her on the day she birthed her baby. Significantly, no woman in the present study had the choice to decide how many family and friends could be present on the day.

Many of the women interviewed expressed distress at being distanced from family and friends when the baby was born. Several participants were required to travel hundreds of kilometres away from their home to birth in a large city hospital. In these instances women described feeling extremely lonely and isolated. Some women interviewed recounted the great difficulty they felt being separated from their children, describing feelings of fear and hypervigilance, resulting from continual concern about their children's safety. Acute and exacerbated feelings of loneliness and isolation made the childbirth experience stressful for these women.

The childbirth experience was a time when all women interviewed reflected on the past, acknowledged their present reality and planned for the future with

integrity. Such connection over time is congruent with Aboriginal spirituality in the belief that history cannot be separated from the present and both are projected into the future. All women in the study evidenced this knowledge and applied it to the childbirth experience. Each woman spoke of her past. Some recalled the immediate past while others shared knowledge of many generations past. For some the recollections were positive. For most they were disappointing and distressing. Many women reframed their past experiences to be used as reference points for lessons learned. Many articulated a strong desire to make a better life for their children than they had themselves experienced. All women who were interviewed spoke of their current reality and shared the hopes and dreams they held for their new babies' futures. The understanding of connection of past, present and future provided an impetus for discussion of self-care and care of the baby.

To varying degrees each woman interviewed described the childbirth experience as a time of cultural challenge. Some reflected on their own cultural identity expressing concern that Noongar people were a somewhat diluted cultural group. That is, many Noongar people married or had partners who were from outside the culture. Some participants said they were concerned about their ability to provide a strong cultural identity for their babies. All women spoke of the need they felt for their children to have a high degree of respect for self, others and country. Many women felt their new baby would experience prejudice and racism in the future, speaking proactively about how they planned to teach their child about how to cope with racism, while maintaining positive cultural values. All women interviewed spoke optimistically about creating a better life for their children than they had experienced.

Most participants shared specific instances of race based prejudice levelled at them in the childbirth experience. These were normalised experiences by women who lived with an ever present undercurrent of prejudice and racism in their everyday lives. Most dismissed the attitudes of bigotry in society as a mere annoyance, however, prejudice in the healthcare sector was described in more animated terms of hurt and negativity. One participant described a passive acceptance of unkind and disrespectful behaviour.

The findings of the study presented above represent many and varied additional stressors that participants endured in the childbirth experience. The women interviewed lived complex and vulnerable lives that in some way related to a history of oppression, the consequences of which continued to play out in the normal course of their existence. It is however, the cumulative load that severely impacts on the health and wellbeing of childbearing Noongar women that findings of the study make visible.

This study is unique in that women have spoken about their lived experience as a Noongar childbearing woman. Even though the participants of this study experienced the joy of a new life, they also experienced loneliness, isolation, culturally inadequate communication, difference blindness and disrespect. They were not properly supported to make culturally acceptable choices in the way they birthed their baby, nor did they experience woman centred care. Far from feeling welcomed and acquiring a sense of belonging, most participants experienced birth as an interloper on another cultures turf.

Limitations of the Study

A limitation of the present research is identified in that participants were not asked specific questions in relation to health, lifestyle or risk taking behaviours. While the nature of the present research was focused on creating a culturally safe space so that women would feel comfortable about sharing their lived experience, elements which were not discussed cannot be speculated upon. A case in point is that birthing on country was not explored within this study. This concept would relate to the Noongar woman being interviewed identifying her birth place and exploring if she birthed her baby on that land or country. To be born on country holds cultural significance with respect to future status as an elder of that country. As the researcher of the present study is non-Indigenous, it was considered an area of exploration that required deep and specific knowledge and background. It is therefore considered to be outside the scope of the study and a limitation of the study.

It is acknowledged that, as in all qualitative research, selected participants are able to articulate more compellingly than others. Selection of participants was

purposive and non-random and therefore, not representative of all childbearing Noongar women.

The researcher acknowledges a self selection bias as women who agree to participate in this research may potentially have increased general knowledge, political awareness and/or motivation to contribute the study.

Although the sample size for this study is in keeping with the depth required for qualitative research, it does not represent all Noongar women's stories, as what matters to people keeps getting told in their stories of their life. That is, Noongar people differ from each other and what is important to one is not necessarily important to another. It is contested however, that insights gained from this research may be considered transferable in part to other populations.

All participants are able to understand and speak English. This is necessary for the researcher to understand the meaning of the experience and to ascertain a richness and depth of data. Non-English speaking Noongar women are therefore not represented in this study.

Interviews were conducted up to two years after the event of childbirth and therefore relied on memory rather than being contemporaneous. Further to this, intensity of feelings and memories may increase or decrease with the passage of time. However, the two year timeframe was based on a research study of childbirth recall by Stadlmayr, et al., (2006) who found the first two years to be the time when recall was no longer subject to substantial changes. Participants in the study focused their reflections on babies that ranged from 4 months to 2 years of age.

Analgesia used in the process of birth may have caused an altered mental state and influenced the accuracy of recollected events. To exclude this group of participants, however, would be to present an unrealistic representation of the study population.

As the researcher is non-Indigenous, it is asserted that despite continual input and advice from the Aboriginal Women's Reference Group being an integral component of the research, cultural subtleties may have gone unrecognized. Subtleties such as the risk of unrecognised jargon or phraseology, was mitigated

considerably however, by the researcher conducting co-analysis and shared analyses with members of the Aboriginal Women's Reference Group.

The researcher is of Anglo-Saxon decent and given the history of colonisation, it is acknowledged a perceived power differential may have impinged on the comfort of some participants, limiting the quality of data. This is despite measures taken and described throughout this thesis in an attempt to mitigate this.

The stories of women are contextualised to the interview which, though despite being conducted in places that provided a cultural advantage, could nonetheless have disempowered participants to a degree that resulted in stories that did not fully represent the individual experience.

The provision of honorarium to participants, while demonstrating respect for culture and reciprocity, and also facilitating the snowballing recruitment process, may be deemed an inducement or perceived as possible coercion and therefore, transgress the principle of voluntary consent.

Interpretation of Noongar women's perceptions and insights cannot be undertaken outside of the non-Indigenous researcher's white colonised lens. Every effort has been made to write this thesis with the aim of prioritising Noongar women's interests, by giving voice and making space to be culturally inclusive. Therefore, individual difference in personal histories, experiences, opportunities and privileges are acknowledged.

The limitations of this study can be used to describe the legitimate boundaries within which the study was framed. Phenomenological methods require detailed investigation of the subjective, contextualised experience and typically, small numbers of participants enter the study. In accordance with phenomenological tradition, the essence of the experience of childbirth for Noongar women has been explicated. There is no claim, however, that all Noongar women will experience childbirth in the same way.

Significance of the Study

Even though available published research in the area of Aboriginal and Torres Strait Islander maternal and neonatal outcomes has increased over recent

years, exploration of the lived experience of birth for Aboriginal and Torres Strait Islander women, is rare and thus poorly understood. Aboriginal and Torres Strait Islander women remain largely mute and marginalised in the maternity debate. This study has given voice to ten childbearing Noongar women, who have shared their experiences, disappointments, hopes and dreams, and in so doing, have provided valuable insights from within the culture.

This research study used a power sharing model such that an Aboriginal Women's Reference Group provided cultural support and guidance throughout the life of the study. With co-analyses, the Aboriginal Women's Reference Group shared analysis and constant cultural vigilance, which enabled the researcher to employ de-colonising strategies throughout. The findings of the study yielded a thick and rich description of Noongar women's childbirth experience and this has provided valuable insights for practice, education and future research.

Personal Growth through Research

The researcher has experienced significant personal growth over the course of this research study. At a fundamental level, preparing, organising, actioning and writing the study has provided previously unparalleled insights to the research process adopted. On a deeper level, however, reflective skills have been enhanced to a point where continued introspection and evaluation of opinions and perspectives have illuminated how much there is yet to understand. The researcher, originally oriented to the research because of her profession of midwifery, has developed a heightened awareness of the lived reality of Noongar women in childbirth. Awareness and appreciation of the reality of Aboriginal and Torres Strait Islander peoples, so inextricably connected to past history, has been a humbling experience. The researcher's personal journey of this research study has been powerful and transformative.

Recommendations

Recommendations for Clinical Practice

- Culturally sensitive and congruent model of midwifery care to be developed and implemented for the care of childbearing Noongar women.

The culturally congruent model of childbirth must be a woman centred approach and as such, must include, but not be limited to, inclusion of family and friends in the event of birth. Noongar women must be able to choose family and friends, including children, to be present at birth.

- The role of Cultural Advocate in Maternity Care to be developed and implemented in all hospitals that care for Noongar women. Many women who were interviewed were lonely in the hospital system expressing the need for a cultural advocate to support and befriend them. It is therefore recommended that Aboriginal women with a strong cultural focus are employed as cultural advocates. A role such as this within the healthcare team has the potential to comfort Noongar women to a degree which decreases dangerously premature discharge from hospital before medically advised. Furthermore, cultural advocates would have the ability to provide contextualised informal cultural education and advice to other members of the healthcare team.
- Specifically designed culturally acceptable antenatal education and care, if developed in collaboration with Noongar women, will positively affect the childbirth experience and beyond.
- As an extension of antenatal education, community focused gatherings where Noongar women's knowledge is included and valued are recommended. This strategy will connect Noongar women with other Noongar women and is an important social networking opportunity to increase the family's information support network. This would need to be a community initiative supported by the healthcare system but not necessarily a public healthcare system initiative.
- The role of Aboriginal Liaison Maternity Visitor to be developed. Aboriginal women with a strong cultural focus would occupy this role with the responsibility to visit new mothers who require follow-up especially after discharge from hospital before medically advised. This woman would be a link to healthcare services, and as such would not be a professional midwife, nurse or doctor. This role could be an extension of the Cultural Advocate in Maternity Care mentioned above, or may be a

separate role focused on the community rather than the hospital environment.

- The Australian College of Midwives and the individual state Departments of Health could be instrumental in steering the initiatives outlined above.

Recommendations for Education

- Cultural competence and sensitivity professional development education for midwives to be provided. This education must be the responsibility of the employer, thus enabling organisational discrimination and colonising behaviours to be addressed as a matter of urgency. A pre-employment and annual education program in culturally congruent communication at an advanced level is imperative to ensure midwives and other staff can interact with Noongar women in a respectful and caring manner. Staff must be educated about and account for Noongar women's varied encounters with historical and ongoing colonisation.
- Mandatory professional development education of university lecturers responsible for educating midwifery students. Given that the Australian Nursing and Midwifery Accreditation Council require all education providers of current registrable midwifery courses in Australia to incorporate Aboriginal and Torres Strait Islander education throughout the pre and post graduate maternal health curriculum, it follows that well informed educators are best placed to ensure that required syllabus is provided to students. Responsibility for this education could be ensured by the individual university, the Council of Deans of each school or college within each university, Universities Australia which is the peak body representing the university sector and the Australian Nursing and Midwifery Accreditation Council.
- Core units in Aboriginal and Torres Strait Islander cultural studies mandated at the approval and ongoing accreditation of all Australian and Torres Strait Island universities and vocational training institutes. These core units should apply to all students and not be specific to healthcare students alone. This education must include exploration of the history of colonisation, present day challenges, personal reflection and decolonising strategies as they apply to Aboriginal and Torres Strait Islander peoples.

Geographically specific enquiry must be included in order that healthcare professionals are aware of the uniqueness of individual Aboriginal and Torres Strait Islander groups and cultures in which they live.

Achievement of the required level of this underpinning study, commensurate the Australian Qualifications Framework, to be a requirement of every educational award offered to students. This responsibility currently lies with the individual university; however, it is reasonable to assert that the Council of Deans of each school or college within each Australian university and Universities Australia could drive this initiative.

- Specific inclusion of commitment to education in Aboriginal and Torres Strait Islander knowledge and understanding must be included in all educational graduate attributes in Australia and the Torres Strait Islands. At the highest level of education policy within institutions and government a commitment to reconciliation with and support of Aboriginal and Torres Strait Islander peoples and culture must be demonstrated.
- Continued effort to support the education of Aboriginal and Torres Strait Islander midwifery and allied maternal health professionals is essential. This must be facilitated by the combined effort of tertiary institutions, healthcare providers and State and Commonwealth Health Departments in the form of collaborative partnerships. Financial assistance for Noongar students in the form of scholarships and learning environments in tertiary institutions that promote cultural security will assist retention of students in midwifery courses.
- Documented commitment in the healthcare sector to recruiting and increasing Noongar and Aboriginal midwives as a defined strategy. It is evident in the present study that Noongar women are in need of cultural support at all levels. The knowledge deficit, which directly impacts on the provision of acceptable healthcare for childbearing Noongar women, is also clearly apparent. This healthcare insufficiency is most ably filled by Noongar midwifery and allied maternity healthcare professionals who can provide cultural wisdom and guidance to both childbearing women and healthcare professionals. To this end education of Noongar midwives

should be supported in all possible ways. Additionally, recruitment of Noongar midwives into the healthcare workforce must be accompanied by strategies to achieve retention of graduate Aboriginal midwives with as high a degree of mentorship as is required to sustain employment in the transition to professional life. This initiative must be championed and financially supported by the state Departments of Health and implemented by individual hospitals.

Recommendations for Policy

- Mandatory cultural sensitivity and safety education competencies to be linked to, and monitored by, the Australian Health Practitioner Regulation Agency annual registration of midwives and other maternity healthcare professionals.
- Development of a charter of patient and staff rights, roles and responsibilities to be developed and displayed in all hospitals that care for childbearing Noongar women. This initiative will, in part, enable women to request help and inform organisations of the potential for healthcare organisational prejudice and racism. Improving access to healthcare by reducing discrimination against Aboriginal Australians in health service delivery is a national priority requiring a multi-tiered commitment from all Australians. The Department of Health of each state must take ownership of this initiative.
- The individual Departments of Health must be held accountable to ensure that policies and procedures are in place which prevent perpetuation of a hegemonic social system that normalises disadvantage of the vulnerable, while ensuring privilege of the dominant white society. This can include, but is not be limited to, inclusion of a Noongar woman on the midwifery and medical advisory boards of hospitals that care for childbearing Noongar women.
- The Commonwealth Government of Australia must appoint an Aboriginal and Torres Strait Islander Health Consultative Committee, answerable to the Nursing and Midwifery Board of Australia, with responsibility to comprise in part a Professional Standards Committee, a Patient

Complaints Committee and an Aboriginal Advocates and Aboriginal Health Worker Committee.

Knowledge Translation Plan

Translation of knowledge will occur after the present research is concluded. A knowledge translation strategy will be agreed in collaboration with the Aboriginal Women's Reference Group and in consultation with any other advisers deemed necessary. Additional advisers may include participants of the study, care providers and policy makers. A power sharing model of actioning knowledge transfer such as this, will enable reporting and dissemination of outcomes of the study to reach Aboriginal people in a variety of meaningful ways. Examples of ways in which knowledge may be translated include, but are not limited to, conference presentations, journal publications and plain language articles written primarily for readers outside of the academic community.

Given the shared and mutually beneficial intent of the study, the researcher will embrace creative strategies that enable the shift of research insights and recommendations from aspiration to outcome. The Aboriginal Women's Reference Group has been instrumental to the success of the present project and members will be appropriately acknowledged in all publications and presentations resulting from this research. This benefit to Aboriginal people ensures the value of reciprocity (National Health and Medical Research Council, 2003) is maintained and honoured.

Suggestions for Future research

Research of Aboriginal and Torres Strait Islander peoples must include those within the culture and have cultural advisors at its foundation. Guidance from within the culture must be evidenced from the planning stages of research and continue throughout the study. It is imperative that collaborative research endeavours are undertaken involving Aboriginal and Torres Strait Islander individuals, consumer groups and professionals.

It is strongly suggested that students and novice researchers be encouraged to undertake research that can potentially support Aboriginal and Torres Strait Islander peoples. As the present study demonstrates, poor health outcomes are complex,

multifaceted and culturally significant. Research at the cultural divide is challenging for the non-Indigenous researcher, however it should not be discouraged. Given the amount and severity of health compromise for Aboriginal and Torres Strait Islander peoples and the number of research students and professionals within the culture, it is irresponsible to confine research enquiry and exploration to those within the culture alone. The task is too big.

It is proposed that further research be undertaken that builds on the findings of the present research by exploring Noongar women's preparedness for childbirth. The insights gained will enable effective culturally congruent programs to be developed for geographically specific cultural groups of Aboriginal and Torres Strait Islander women.

Exploration of Noongar women birthing on country is suggested as a valuable area of exploration. The importance of place of birth for Noongar women, if understood, may have an impact on decisions concerning geographical dislocation for birth.

Evaluative studies exploring women's satisfaction with new education models for antenatal care, culturally congruent woman centred models of birth and postnatal follow up programs are vital to ensure adaptive and reflexive program development strategies.

Exploration of the lived experience of mothers of childbearing Noongar women would add to the present study by providing further insight to Noongar women's birth experience. Given the vital role of mothers within the family, this research will potentially to inform future best practice.

Research that explores the role of fathers in Aboriginal and Torres Strait Islander populations will enhance understanding of the perspective of men as they experience childbirth and family. Such information has the potential to bring the voice of men into the healthcare arena.

Given the multiple stressors participants of the present study have endured from childhood and the health burden this imposes on family, community and country, it is proposed future research be extended to include an investigation of the cumulative effect of numerous stressors on the long term health of Noongar women.

Exploration of the experience of midwives who work with childbearing Noongar women will provide a valuable perspective, build on the present research findings and potentially enhance the birth experience for Noongar women.

Future research is needed to evaluate the outcomes and cost effectiveness of any new programs recommended, such as the cultural advocacy role in maternity care in the hospital setting, or the community based partnership model including the Aboriginal liaison maternity visitor.

Conclusion

This study has given voice to a small group of Noongar childbearing women. Their perspectives, insights, advice and recommendations have been explored and are valued. Participants have contributed their authoritative knowledge on birth, by sharing experiences in a candid and honest manner. The study did not find any solutions to the many and varied stressors experienced by Noongar women in birth, rather, it brought into focus the many problems and challenges which are under-researched and presently unresolved. The many insights provided by Noongar women in this study have provided impetus for change in clinical practice, education, policy development and research, which can potentially lead to improved outcomes for Noongar women and their babies in childbirth. In essence, this study has unlocked the enormous transformative potential of Noongar women's voice.

APPENDICES

Appendix A: Letter of Support Aboriginal Women's Reference Group

November 17th 2010

To Whom It May Concern,

Judith Wilson is conducting a research project for her Doctor of Philosophy course at the University of Notre Dame Australia and has asked us to constitute an Aboriginal Women's Reference Group to provide guidance on cultural matters throughout the life of the study.

We were each approached individually by Judith on separate occasions. Judith has explained the aims and purpose of the project and also the role she proposes the Aboriginal Women's Reference Group will play in the research project.

We understand that Judith will be conducting a study of Noongar women's experience of birth. This study will involve interviewing Noongar women who have given birth in the past two years. As Judith is not an Aboriginal woman, she is seeking advice from a small group of Aboriginal women who are leaders in the community. As the three members of this group and we are happy to assist in this project.

This collaborative and consultative method of research will help Judith interact meaningfully with Noongar women. If the women in this study feel they are treated with respect and dignity they are more likely to share their stories fully in the interviews. Judith has acknowledged that research with Aboriginal women, in such a sensitive matter as birth, must be conducted in a manner that is respectful and inclusive of Aboriginal values and cultures. As a reference group we can help Judith to understand these values and cultures and guide her in ways that show Aboriginal women respect.

We all agree that this study is valuable to Aboriginal women and Noongar women most particularly. Through this study the voice of Noongar women will be heard and they will be acknowledged as the authority on Noongar birthing. This study will bring together the past and the present and will generate knowledge for future generations about the experience of birth within Noongar culture. It honours the value of community and family to Noongar people. Because this study is centred on Noongar women, it emphasises this group's uniqueness and highlights all Aboriginal groups' right to be different. We feel this project will help to protect Noongar culture and identity from erosion.

We all agree this research project will be valuable to Aboriginal women and we will help Judith with our advice and guidance on cultural matters.

Sincerely,


Yvette Cottier


Marion Kickett


Melanie Robinson

Appendix B: Information Letter



INFORMATION SHEET

Dear potential participant,

My name is Judith Wilson. I am a student at The University of Notre Dame Australia and am enrolled in a Doctor of Philosophy degree. As part of my course I need to complete a research project.

The title of the project is Noongar Women's Experience of Birth. My research is concerned with hearing Noongar women tell their stories of how it was for them when they gave birth to a baby in the last two years.....

The purpose of the study is to gain an understanding of the lived experience of birth for Noongar women and to understand this from within Noongar culture. This understanding will acknowledge Noongar women as the authority in Noongar birth.

Participants will take part in a 50-60 minute tape-recorded interview. Information collected during the interview will be strictly confidential. You will be offered a copy of the main themes I use to describe the experiences of all participants, and I would be grateful if you would comment on whether you believe I have captured your experience.

Before the interview I will ask you to sign a consent form. You may withdraw from the project at any time.

Data collected will be stored securely in the University's School of Nursing for five years. No identifying information will be used and the results from the study will be made freely available to all participants.

Due to the sensitive nature of this issue, the interview may raise some difficult feelings for you. If this happens I will make sure that support is available for you if you desire it. You will be provided with free Indigenous counselling information at the interview and I will contact you one week after wards.

The Human Research Ethics Committee of the University of Notre Dame Australia has approved the study.

Dr Adrian Morgan of the School of Nursing is supervising the project. If you have any queries regarding the research, please contact me directly or Dr Morgan by phone (08) 94330249 or by email at Adrian.Morgan@nd.edu.au

I thank you for your consideration and hope you will agree to participate in this research project.

Yours sincerely,

Judith Wilson

Tel: (08) 9433 0259

Email: Judith.Wilson@nd.edu.au

If participants have any complaint regarding the manner in which a research project is conducted, it should be directed to the Executive Officer of the Human Research Ethics Committee, Research Office, The University of Notre Dame Australia, PO Box 1225 Fremantle WA 6959, phone (08) 9433 0943.

Appendix C: Consent Form



THE UNIVERSITY OF
NOTRE DAME
AUSTRALIA

CONSENT FORM

Noongar Women's Experience of Birth

INFORMED CONSENT FORM

I, *(participant's name)* _____ hereby agree to being a participant in the above research project.

- I have read and understood the Information Sheet about this project and any questions have been answered to my satisfaction.
- I understand that I may withdraw from participating in the project at any time without prejudice.
- I understand that all information gathered by the researcher will be treated as strictly confidential.
- I agree that any research data gathered for the study may be published provided my name or other identifying information is not disclosed.

PARTICIPANT'S SIGNATURE:		DATE:	
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RESEARCHER'S FULL NAME:	JUDITH PAMELA WILSON		
RESEARCHER'S SIGNATURE:		DATE:	

If participants have any complaint regarding the manner in which a research project is conducted, it should be directed to the Executive Officer of the Human Research Ethics Committee, Research Office, The University of Notre Dame Australia, PO Box 1225 Fremantle WA 6959, phone (08) 9433 0943.

Appendix D Notice to Potential Participants

Research Project about Noongar Women's Birth Experience

Hello my name is Judith Wilson and I am a student at the University of Notre Dame in Fremantle.

I am conducting a research project as a part of my personal studies at the University.

My research project is looking at Noongar women's birth experience. The aim of the project is to hear about the experience of birth from Noongar women. This means how all things relating to pregnancy, birth and the early times after the baby is born were for the Noongar woman being interviewed.

If you are a Noongar woman who is at least 18 years of age and has a baby of up to 2 years old and you are interested in participating in this project, I would like to hear from you.

I would like to interview you and to record the interview. This should take about 1 hour and can take place at a time and place that suits you.

I will give you a \$50 Coles/Myer voucher in recognition of your time and any babysitting or travel expenses you might have to pay to take part in the interview.

You can either contact me directly on the numbers below, or if you would prefer, you can speak with [name of the manager of the health centre] who will pass on your contact details to me.

Thank you for considering this

Judith Wilson

0409 370 276

jayzedw@inet.net.au

Appendix E: Semi-structured Memo

Participant 3 and 4 - POST-INTERVIEW MEMO
PAGE 1

This is a recording immediately after the interviews that I have done with P3 and P4 today on the third of June, 2011.

So we went into a bedroom and we sat on a double bed and I set up the recorder and did the recording. And the interview was good with P3. I found that she's a very sweet young woman. I tried some other techniques that I haven't done before, and that is that I talked around the subject. Before I turned the recorder on, I explained the information letter and so on. And when I was interviewing P3, I started off talking about her own family, how many children she had, how many brothers and sisters she had and where she fitted in and all that sort of thing, and then about her baby. And then, rather than asking her the questions that I thought I would ask, like how to do you see yourself as a woman and can you tell me the story of your baby's birth, I feel now that those questions are probably difficult for Noongah women to answer inasmuch as they're very "there's the question now you fill in the whole lot yourself." And I guess that I'm going to come across women that I interview that can actually just start talking and not stop and not need prompting.

But, anyway, I made the call in these interviews to ask questions that I thought would engender more conversation from them. So a lot of them were closed questions: Is this your first baby? Did you intend to get pregnant? Did you plan the pregnancy? And although "did you plan the pregnancy" is a closed question, that question was good and from that stemmed a big story of how no, her pregnancy wasn't planned, and what she felt when she found out she was pregnant and how she wanted to terminate the pregnancy, and how she came around and then decided she didn't want to, and so on and so forth. So I've strayed a bit away from my intended questioning technique, and this has come about because of having my first interview, which was really short, and yes/no answers, and trying now to pick up on things.

I still feel that when I interview we dance right around the countryside to get back to one spot, and a lot of deviation from the core kind of aim of the interview. But, again, I think that with me non-Aboriginal and trying to build trust with Aboriginal women, this is probably the way it's got to be.

I was very happy with the interview with P3. She's a really nice young woman and she had some nice things to say, good things to say. The interview tailed off at the end and I took the cue and finished the interview saying to her that I would ring her in a week's time and if she thought of anything else I would come and that I would interview her again if she wanted that to happen, that I would also give her another gift voucher if I came to interview her again. So it was a very pleasant interchange and I don't know how long it lasted, but it felt as though it lasted about 40 minutes.

The second interview that I did immediately afterwards was with her P3's sister, who is P4. P4 had come home in the meantime. P4 was different. P4 was a little bit less soft. And I did the same thing with her, talked about her family, how she fitted in, what children she had, and then went through the information sheet and the consent form, and then turned on the tape and started to record. There's a lot of pauses and a lot of silences in the interview and I'm becoming more comfortable with just big silences. I hesitate to jump in there with another question because I think that can be quite off-putting for the women. But the interview was still good and some interesting things came out of it.

I didn't feel in any way threatened or anything. I must say that I felt a bit wary or unsure about being in the home of Aboriginal women. I understand that is my own upbringing surfacing and I am now facing personal biases I didn't realize existed. Anyway, I got the impression that P4 is a little bit more hardened, if I can use that word, and as the interview went on she was a bit more guarded in talking to me, a little bit less open, and talked a bit about prejudice. As the interview went on, it came out that she had used drugs and that she had been living down south and that she had a different father to her sister and had only found that out in recent years. And so there was a little bit of kind of - I don't know - sadness or aggression there that I didn't find with her sister. But the interview was good, again, and it will be interesting to have it transcribed and to study it and analyze it and try to put these together and do a little bit of analysis on them.

I think that's all. I get a strong sense with both of these young women that family is extremely important to them, and certainly interviewing them in their own home was

interesting. I certainly, in the beginning at least, felt the balance of power tip in their favor because of this. The other two interviews have not been in the participants' homes. We did have quite a bit of interruption with the little sister coming in and out, and then, in the last interview, with P4's baby coming in for a breastfeed. But I just rode with that and interviewed around it, and I think that's the way to go, because they are themselves and their family and it's all mingled up together. So it's trying to separate it out and to say no, your children have to stay out, and we'll have this interview in a sort of closed area often just doesn't work, even though we start off that way. And I think I just have to be flexible and adaptable with that.

If I'm trying to situate myself within the interview, I really didn't pick up on anything that wasn't presented to me, I don't think. The context of it was that these two young women - one's 18, and one is 20 - have both recently had babies. They live with their mother and I don't think their father lives there, so there's just their mother, the two young women, and today there was a brother there. Now, both of these young women have partners, they still see their partners, but their partners don't live with them. And both P3 and P4's children live in the house. So we've got the mother of the house, who has older children and a three-year-old, and then we've got these two children of hers, one 18 and one 20, who both have now new babies. So there's three adult women living in the house and three children, the eldest being three, the youngest four months of age. So, interesting, interesting. But people coming and going and the extended family is quite large, by the sound of it, with fathers, grandmother and great-grandmother being mentioned in the interview today, as well as partners, cousins and sisters and brothers and their children. So it was really interesting and I enjoyed it very much and hopefully I'll get a lot from it.

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