Obligation and Compromise: Aboriginal Maternal Infant Care Workers successes, challenges and partnerships.

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CONTENTS

THESIS SUMMARY

Marked inequalities in maternal and child health exist between Australia's Aboriginal and non-Aboriginal populations. Improving the care of Aboriginal women before and during pregnancy has been identified as a key strategy to closing the gap in health outcomes. In 2004 a new birthing model of care was introduced into Port Augusta and Whyalla with the implementation of the *Anangu Bibi Regional Family Birthing Program* and the *Aboriginal Regional Family Birthing Program.* The model includes Aboriginal Maternal Infant Care (AMIC) workers, a specialised role unique to South Australia, working in partnership with midwives and other care providers to deliver antenatal and postnatal care. This project broadly aims to increase understanding of the role of the AMIC worker and explore the ways in which they manage the interface between the biomedical model of maternity care and Aboriginal knowledge and beliefs about reproductive health.

This study was preceded by consultations with Aboriginal community leaders in Port Augusta and Whyalla, the State-wide Steering Committee overseeing the programs, Pika Wiya Health Service and the Port Augusta Regional Hospital. The data that informs the research include narratives from semi-structured interviews that were undertaken with six AMIC workers, six program midwives, five ward midwives, two medical practitioners and eleven clients. Analyses were undertaken to identify the major factors influencing the role and wellbeing of AMIC workers and the program environment.

Analyses revealed a number of key influences on the ways AMIC workers negotiate the space in which they work. These included the strength of their relationships with colleagues and clients, their ability to advocate for both parties, and their level of confidence and self-worth arising from the value they place on clinical and cultural knowledge. AMIC workers continue to be challenged by the recognised differences between Aboriginal and Western cultures in relation to views about health, and this is often compounded by the intensive medicalisation of pregnancy and birthing. Furthermore, the traditional Westernised work ethic in place in a highly medicalised health system creates expectations about the 'ideal worker', which are outdated and inappropriate to AMIC workers, who often have many cultural and family obligations. These expectations, along with other systemic factors (e.g. inflexible visitation times, experiences of institutionalised racism) and aspects of AMIC worker's private lives (e.g. extent of caring responsibilities) contribute to experiences of

emotional labour and burnout. However, a strong AMIC-midwife partnership may act as a buffer to the challenges associated with the AMIC role, as it provides opportunities for two-way learning and promotes respect for individuals that may have different worldviews.

This study has identified a number of complexities facing AMIC workers that are often invisible to the systems and institutions they are working in. Strategies that support the development of positive relationships between health professionals will help to ensure the sustainability of this model of care. These include training in cultural safety, promoting awareness of systemic issues that create challenges for AMIC workers, and creating more widespread positive recognition of the role. Essential resources that will improve the working environment for AMIC workers have also been identified and include an appropriate space conducive of a culturally safe and respectful environment.

My research highlights that while there are discourses recognising that AMIC workers are essential to improving Aboriginal maternal and infant health outcomes, they are rarely dominant and thus do not drive priorities or change. Until the AMIC workers are truly valued (by way of respect and autonomy to care appropriately for Aboriginal women and their infants), I argue that improvements to Aboriginal health will not be realised.

This thesis is dedicated to my second father Tim Whitelum
who always advocated for what was fair and just.

ACKNOWLEDGEMENTS

Having watched many Aboriginal women throughout this country weave baskets, in the most spectacular places under the most incredible circumstances, I have likened my PhD journey to this ancient practice.

A basic knowledge of structure and process was known before embarking on the activity. Countless hours, conversations, learnings, writings and rewritings resemble each thread. As knowledge grew, so too did the basket. The weaves became more intricate and the strands of detail much longer. It took one thousand, nine hundred and twenty seven sunsets before this basket could stand complete.

There are a number of people that must be acknowledged for their contribution to this work, without whom this thesis would not have been possible.

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Finally, I hope this thesis does not exist as an empty shell in the depths of a library as so many do. Rather, I hope it can continue to resemble the ancient basket that was designed to be purposeful. One that encourages new thoughts and influences positive action for the benefit of Australia's Aboriginal women and their families.

DECLARATION

This thesis contains no material that has been accepted for the award of any other degree or diploma in any university or other tertiary institution. To the best of my knowledge and belief, this work contains no material previously published or written by another person, except where due reference has been made in the text.

I give consent to this copy of my thesis, when deposited in the University Library, to be made available for loan and photocopying, subject to the provisions of the *Copyright Act 1968*.

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Renae Kirkham *Date*

TERMINOLOGY

It is important to clarify from the outset some of the terms that I use throughout this thesis. My use of the word Aboriginal refers to people who identify as being of Aboriginal and/or Torres Strait Islander descent. In Port Augusta, where the population is predominantly Aboriginal (with very few people of Torres Strait Islander descent) the term Aboriginal is preferred. After consultation with two local Aboriginal elders, both informed me that they consider the use of the word Indigenous offensive, and I have therefore chosen not to use it. As there are over 32 recognised Aboriginal languages used in the surrounding area, there is also no term in Aboriginal language that is appropriate for all cultural groups within the region (like the term Koori used in New South Wales). The only time the word Indigenous appears in this thesis is when it has appeared in the literature, is used by a participant in the study, or when discussing Indigenous cultures from other countries. Aboriginal and Torres Strait Islander people are hereafter referred to as Aboriginal people, and in all instances I use this term respectfully. Although I use the term to refer to both Aboriginal and Torres Strait Islander peoples, I acknowledge that Torres Strait Islander peoples have a distinct linguistic and cultural identity to Aboriginal people.

The use of the word ‘traditional’ in relation to an Aboriginal person is not intended as comment on the strength of their ties to their own culture. Rather, it reflects the use of the term by participants in this study, and I understand that there may be different interpretations of the term. I am respectful with my use of this term, and use it only in the contexts described to me by the participants.