CHAPTER ONE: INTRODUCTION

Aboriginal people are getting a lot stronger. They’re feeling like their own people. They’re uniting more. And they’re doing a lot to rejuvenate the culture, just bring it to people’s eyes. Once people know about where they come from - their country, their tribes - and they’ve met their families, then they’ve got it inside, and they know a little bit about traditional society and how traditional people lived: that’s all they need.

(Bowden & Bunbury, Eds. 1990, p16)

An understanding of the situation of Aboriginal people is required rather than just patience and sensitivity, so that when Aboriginal people encounter mainstream services they are not alienated by an intimidating and humiliating experience (Backhouse, 1994).

As a result of the research project of which this is a report, I believe that it is time nurses allowed their Aboriginal clients to bring to nurses’ eyes their culture, so that nurses can provide socially and culturally acceptable care to indigenous Australians. I believe that because of the accessibility of nurses to clients, acceptability of nurses in general, and the amount of time nurses spend with clients, nurses are in the best position and the most able to lead the way with providing this culturally acceptable care. With Aboriginal people gaining strength in exploring their traditions, and now beginning to “feel like their own people”, the opportunity to get it right for health service providers is upon us and the area of maternity services is the ideal starting point, with midwives and Aboriginal women working together. Many Sydney residents are surprised when they find out how many Aboriginal people reside in Western Sydney and so it is important for health professionals to acknowledge and inform themselves about this cultural group in the course of their work. Gray, Trompf and Houston (1991) agree that "...Aboriginal people at the community level say that Aboriginal communities are strong and getting stronger" (p. 118) giving truth to the suggestion that mainstream white health services must be proactive in providing culturally appropriate services for Aboriginal people. As urban Aboriginal people gain strength, explore and rekindle their cultural heritage, health workers in mainstream or non-Aboriginal services will need to become
aware of, and allow for, Aboriginal cultural practices in their everyday practice.

My experiences as a midwife and my personal discoveries of meeting Aboriginal people and challenging my own previously held stereotypes, have led me to this exploration of the experiences of urban Aboriginal women from Western Sydney when they become involved with mainstream health services surrounding the events of childbirth. It is important to note that I am not of Aboriginal descent and I have come to this investigation as a midwife.

Motivation for this project

My professional background includes many years of experience as a Registered Midwife in Western Sydney, and during this time I have cared for some Aboriginal families. There has been a lack of information available to people like me about cultural mores and culturally-specific care for urban Aboriginal women in relation to childbirth, particularly in contrast to the amount of research published about women from non-English speaking backgrounds. Anecdotal evidence, from my own experience and that of colleagues, suggests that the women are not happy in hospital and leave early, often against advice (also noted by Shearman, 1989). This point was re-iterated to me in conversations I had with health professionals in the Northern Territory where the client population comes from both urban areas and outlying and remote communities. During my visit to a public hospital in the Northern Territory, I witnessed Aboriginal clients sitting outside the main entrance of the hospital, on the concrete, which is where some Aboriginal mothers spend their days after confinement because they do not feel comfortable in the wards. Care for these mothers is provided in the ward, so if they are not in the ward at the time of the service, they miss out. It is not uncommon for the mothers to take their babies downstairs and outside, raising the question - why are they in hospital?

I am a Registered General and Midwifery Nurse with 21 years post-certificate experience, of which 16 years have been midwifery experience. During this time I achieved the status of Clinical Nurse Specialist, Midwifery. In this role I participated in the consultation phase of the Ministerial Task force on Obstetric Services in New South Wales conducted by Professor Shearman (1989). Following the publication of Shearman's report (1989) I was invited to join the Implementation Committee of the Wentworth Area Health Service, chaired by Dr Brian Spurrett. The role of this committee was to implement the
changes recommended in the Shearman Report pertaining to the Wentworth Area Health Service.

As a result of this experience, I became aware of the number of Aboriginal people living in Western Sydney, the lack of culturally appropriate maternity services available for Aboriginal women in Western Sydney, and the recommendations of Professor Shearman regarding maternity services in Western Sydney. I also reflected on my midwifery experience which involved nursing Aboriginal people with a complete lack of up-to-date knowledge about their culture which seems shameful to me when I am more aware of some of the cultural mores of Asian, Muslim and other cultural groups than our Aboriginal people. There is a dearth of information about urban Aboriginal people in the nursing and related medical literature. Most literature focuses on the health and culture of Aboriginal people in the country and outback regions of Australia. I attended the 23rd Annual Public Health Association Conference in Alice Springs in 1991 where I found that the Aboriginal presenters were positive and forward thinking, organised and articulate, which further inspired me, although I also felt awed and dwarfed by the responsibility.

The Aboriginal Population of Western Sydney

The Australian Bureau of Statistics census of 1991, (cited in Aboriginal and Torres Strait Islander Commission [ATSIC], 1994) shows that Aboriginal people comprise 1.6% of the total Australian population, of whom 22,905 people resided in Sydney in 1991. This figure of 22,905 people is expected to increase to over 300,000 by the 1996 census and is due to a high natural increase and more people identifying as Aboriginal or Torres Strait Islander. Westir Newsletter (1991) shows that there were 10,836 Aboriginal people living in the area covered by the Western Sydney Area Assistance Scheme which includes the Local Government Areas of Auburn, Bankstown, Baulkham Hills, Blacktown, Blue Mountains, Fairfield, Hawkesbury, Holroyd, Liverpool, Parramatta and Penrith. The median age for the Sydney group was 19 years which highlights the youthfulness of the population, compared to the Australian median of 32 years (ATSIC, 1994). The need for appropriate obstetric services for this growing, mostly youthful, Aboriginal population is therefore about to increase dramatically.

The review of the literature conducted for this project (Chapter 2), shows that there is a gap relating to urban Aboriginal women and mainstream maternity care, in particular culturally acceptable nursing care for Aboriginal
women. This project will address cultural concepts, needs and preferences that Aboriginal women residing in Western Sydney identify as important to them when receiving maternity care from health services.

The Shearman Report, 1989

Professor Rodney Shearmann was invited to chair a task force in 1987 with the purpose of consulting with the various stakeholders about maternity care issues and to provide the directions for the health system which were appropriate and affordable. This task force grew out of a previous report which had "documented the dissatisfaction of some groups of women with the range and orientation of maternity services available in NSW" (Cranny, 1994, p. 376).

Shearmann (1989) reported that there was a lack of information about Aboriginality, as well as the needs and preferences of Aboriginal women living in Western Sydney in relation to maternity care, even though it was estimated that sixty percent of Sydney Aboriginal women did reside in Western Sydney in the Blacktown, Campbelltown and Penrith Local Government Areas and that there were 84,000 Aboriginal/Torres Strait Islander women of child bearing age in New South Wales.

Shearmann's 1989 Final Report of the Ministerial Task Force on Obstetric Services in New South Wales identified the following problems pertaining to Aboriginal women and obstetric care in New South Wales:

- the higher perinatal and maternal morbidity and mortality in Aboriginal and ethnic groups is related to lack of access to adequate antenatal care and some economic disadvantage.

- over 30% of Aboriginal confinements were of women aged under 20 years of age, compared with 15% of all births in New South Wales.

- 14% of Aboriginal mothers were of high parity (four or more previous births), compared to about 4% of the non-Aboriginal mothers. The percentage of low birth weight babies born to rural Aboriginal women is double that for non-Aboriginals (pp. 87-88).

Advice was given to Shearmann from Region and Area Health Services as well as Aboriginal community groups and health workers, that if hospital utilisation by this group was to increase, then Aboriginal health workers with specialised training in maternity care needed to be recruited. Antenatal
services provided by hospitals in the West needed to be linked with Aboriginal Medical Services, using the Redfern Aboriginal Medical Service (AMS) and King George V Hospital models (Shearman, 1989).

The Task force was concerned about the lack of sufficient information about Aboriginal women and maternity service needs and preferences, and advice given by Region and Area Health Services as well as Aboriginal community groups and health workers included recommendations for hospitals servicing large Aboriginal populations. It was suggested that in order to increase utilisation of their maternity services by Aboriginal women, they should employ specially trained Aboriginal health workers and that links based on the Redfern A.M.S. and King George V Hospital shared care scheme be established with Campbelltown, Blacktown and Nepean Hospitals. The shared care scheme has been implemented between Nepean Hospital and Daruk A.M.S., Mt. Druitt and both Nepean and Blacktown Hospitals now have an Aboriginal Liaison Officer. At the time that this research was being conducted the appointment had not been made at Nepean Hospital. The appointment of Aboriginal Liaison Officers is the first step towards implementation of Recommendation 3.7.7 (Shearman, 1989) which states "That consideration should be given to encouraging traditional Aboriginal support to women in pregnancy and labour" (p. 167). Recommendation 3.7.9. covers the area of the Aboriginal antenatal service between Daruk A.M.S. and Nepean Hospital.

Two particular areas of concern about postnatal care were raised with the Task force; the poor health status of Aboriginal mothers and babies and the sense of alienation which the mothers feel which then leads them to leave hospital earlier than advisable, into a situation where there is no professional care available (Shearman, 1989).

Health problems faced by Aboriginal women include "diabetes, obesity, previous foetal loss, poor nutrition, tobacco smoking, drug and alcohol dependency, complications of pregnancy, and increasingly, STD and hepatitis B" (Shearman, 1989, p. 229). Shearman also states that:

Obstetric risk factors also tend to be greater for other culturally based reasons, i.e. the greater likelihood of teenage pregnancy, ex-nuptial pregnancy and larger families common among Aborigines. Lifestyles associated with poverty, unemployment and drug/alcohol dependency exacerbate these risks; so that perinatal outcomes are frequently poorer and Aboriginal babies considered to be 'at risk'. (p. 229)
Shearman (1989) also noted that breastfeeding rates among Aboriginal women, particularly urban Aboriginal women, were low. An outreach program on the North Coast, using Aboriginal Breastfeeding Outreach Workers trained by the Nursing Mothers' Association, was successful, with these workers being accepted by the supported women. In his report, Shearman (1989) raises the issues of lack of continuity of care, preferred attendance by Aboriginal people, as well as discriminatory or unsympathetic attitudes found in hospitals which compounded confusion and alienation of Aboriginal women and led to early discharge. The report stated that Aboriginal health workers need to be involved in the care of Aboriginal women both antenatally, intranatally and postnatally, with close co-operation between all professionals to ensure the provision of a culturally appropriate and quality service.

Even though there has been incentive funding, in Western Sydney, not all of these recommendations have been implemented. As already noted, Nepean Hospital conducts a shared care antenatal and postnatal service with an A.M.S., and the women are cared for post discharge on the Domiciliary Midwives Program if discharged early, or by follow up from the A.M.S. This investigation assesses the degree to which Shearman's recommendations about maternity services to Aboriginal women have been implemented in Western Sydney, through an analysis of interviews with six Aboriginal women, who use maternity services in Western Sydney.

Outline of the Project

Not only do Aboriginal and Torres Strait Islander peoples face the health hazards of a hostile physical environment, but inequity [the unequal access to equal care appropriate to need] is manifest in their diminished access to health-promoting knowledge and to the mainstream medical and health - care services. There is endless anecdotal evidence that explains such lack of equitable access in terms of prejudice, discrimination, ignorance and other perverse behaviour against Aboriginal and Torres Strait Islander peoples by society in general and its agents working in health services in particular. It is true that anecdotes also exist which tell of the reverse qualities, but a huge gulf still separates the ideal from the actual in terms of the attitudes and behaviour of non-Aboriginal Australians to Aboriginal and Torres Strait Islander peoples in need of health care ...

(National Aboriginal Health Strategy Committee, 1994, p. 1)
It is in this climate that I set out to discover what the cultural needs of urban Aboriginal women are when presenting to a hospital for confinement and postnatal care in Western Sydney. I attended the Daruk A.M.S. antenatal clinic weekly for approximately five months and sat with the women attending the clinic, participating in their conversations. I interviewed six Aboriginal women and recorded the interviews on tape.

Analysis of the taped interviews led me to discover that most of the women did not know, or had not thought about traditional cultural mores related to childbirth, but that some of the women did have an interest in them. The women were not well informed about the childbirth choices available to them. *The Goals and Targets for Australia's Health in the Year 2000 and Beyond* (Nutbeam, Wise, Bauman, Harris and Leeder, 1993) include increasing the rate of breastfeeding, with Aboriginal people being a specifically targeted group, yet the issue of breastfeeding had not been discussed with the women while they were pregnant. While I was attending the clinic I had only witnessed the use of one educational video.

My research demonstrates some areas where existing Aboriginal health policy has not been implemented. I have therefore included specific recommendations for midwives to actively incorporate in their work strategies for promoting breastfeeding during the antenatal period as well as immediately after birth, and promoting culturally sensitive practices for Aboriginal mothers during the entire perinatal period. In particular, strategies need to be put in place to provide these women with real choices about the kind of birth experience available to them. At present, their own lack of access to knowledge about the traditions surrounding birthing in the Aboriginal community forces them to accept the services of white Australians whose own racism is a problem for these women. Racist attitudes among midwives have also apparently prevented Aboriginal women from being adequately informed about the range of birth experiences now widely known to white women, including options for special birth plans, pain relief, rooming in, etcetera. Ironically, the one option about which they had been informed was the option of early release from hospital after the birth.

**Significance of the Project**

The needs and preferences of urban Aboriginal women when seeking maternity care will have implications for local maternity health services. At the
time of writing, there are few publications relating specifically to urban Aboriginal women and the provision of maternity services. Of these publications, *Women's Talk* (Gosden, 1992), in which urban Aboriginal women from the inner city are interviewed about pregnancy, birth, motherhood and community, is the most relevant to my interests. Other documents which alert us to the issue are Shearman (1989) and *The National Aboriginal Health Strategy* (1989). Bastian (1993) quotes the *National Health and Medical Research Councils' 1993 Report on Maternal Deaths in Australia 1988-1990* which found that 'Aboriginal women were eight times more likely to die around pregnancy and childbirth than non-Aboriginal women' (p. 571). Some of the explanations for these figures, Bastian (1993) believes, can be found not only in figures for maternal deaths alone, but in the issues of acceptability and accessibility of appropriate services. It is interesting to note that childbirth is the leading cause for admission into public hospitals with between 76,000 and 79,000 separations each year (Cranny, 1994).

The significance of this project is that a midwife has interviewed urban Aboriginal women, to find out what their needs and preferences are, in relation to the provision of appropriate maternity services by mainstream health agencies. This is the first time that a midwife has made a systematic attempt to find out what Aboriginal women in Western Sydney have to say about maternity services. It is also significant because what the women have to say has important implications for the services in terms of the women's needs. Once the needs are identified, strategies can be suggested to meet them. My hope is that communication of the findings and recommendations which form the conclusion of this report, to midwives and other health professionals via journal articles will influence local existing and potential health services to increase the cultural appropriateness of the services offered to Aboriginal people. In particular, the services will address the needs and preferences that Aboriginal women identify when they use mainstream services for care during pregnancy and birth.

As there is a dearth of studies involving urban Aboriginal women in Western Sydney and their experience of mainstream maternity health services, I also hope that this work will lead other researchers to further develop this area. As this work is a pilot project, I would recommend strongly that a larger study be conducted by an Aboriginal researcher, covering the same areas as this project.
CHAPTER TWO: RELEVANT LITERATURE

The health of Aboriginal people today

In order to appreciate the significance of this topic it is necessary to look at the state of health of Aboriginal people today in Australia, firstly in general terms, then specifically related to childbirth. Non-Aboriginal Australians living in today's society can expect to live, on average, for 75 years if male, and 81 years if female, (Aboriginal and Torres Strait Islander Commission [ATSIC], 1994) with the major causes of death being the so-called lifestyle diseases of circulatory disease, cancer, respiratory disease and accidents (Davis & George, 1988). Causes of these lifestyle diseases are said to be related to the way we live in regard to diet, smoking, alcohol, stress and motor vehicles (Davis & George, 1988). In contrast, Aboriginal men can expect, on average, to live for 57 years, and Aboriginal women 62 years (ATSIC, 1994).

At any age, Aboriginals and Torres Strait Islanders are more than twice as likely to die as are non-Aboriginals. For Aboriginals aged 25-44, the risk is five times greater than the national average (ATSIC, 1994, p. 6).

This contrast between the health status of Aboriginal and non-Aboriginal people had already been found by Thomson (1991), when he reported that the overall standard of health amongst Aboriginal people in Australia was low, with death rates up to four times higher than the rest of the population, and a life expectancy of up to twenty-one years less.

Hospital discharge rates for Aboriginal people are 70% higher than the national average for men, and 57% higher for women; infectious diseases cause an age - standardised mortality rate for infectious diseases to be 12 times higher than the national average (ATSIC, 1994). The chronic diseases of diabetes, trachoma,
chronic ear disease and chronic renal failure are serious health problems for Aboriginal and Torres Strait Islander people. The rate of alcohol consumption per population is lower than the national average, but the amount consumed by the drinkers is likely to be harmful. Smoking rates are double the national average (ATSIC, 1994).

Diseases of the circulatory system head the list of leading causes of death for males and females, followed by external causes of injury and poisoning, then respiratory diseases for males and respiratory diseases followed by external causes of injury and poisoning for females (Honari).

There has been some improvement in Aboriginal health for example:

- Death from lung cancer is declining among Aboriginal men, although not among Aboriginal women.
- Alcohol-related deaths are declining.
- Deaths from car accidents declined by 27% in men between 1985 and 1992, although they remained stable in women.
- Deaths from homicide declined by 50% in men in the same period, although they remained stable in women.
- The number of deaths from pneumonia, which to some extent is a disease of poverty and poor social status, remains stable... (ATSIC, 1994, p. 7).

In comparison with other indigenous populations in developed countries whose health status has improved, in some cases to nearly the same as the average population, the health status of our indigenous peoples has declined by some measures such as death from diabetes, and overall the health status has not improved as much as it should (ATSIC, 1994). Aboriginal mothers are often over-represented in the risk groups of poor nutrition, excessive smoking or drinking and
poor social circumstances, which research has shown can lead to low birth weight infants and preterm births. "Babies with low birth weight are at greater risk of neonatal and post neonatal illness or death" (Najman, Williams, Bor, Anderson & Morrison, 1994, p. 186).

**Fig 1 Life categories 1991**


It can be seen from Figure 1 that the population of Aboriginal people shows proportionally more infants, children and youth, and fewer adults and elderly than the total Australian population. Two-thirds of Aboriginal people live in urban areas and the fertility rate for Aboriginal women is higher than non-Aboriginal women which reflects the trend for babies to be born to teenage mothers (Thomson, 1991). There is also a difference in the birth weights of Aboriginal babies, being 150-350 grams lighter than non-Aboriginal babies (Thomson, 1991). NSW Department of Health 1993 statistics report that low birth weight babies (less than 2500g) were born to Aboriginal women at twice the rate of non-Aboriginal women, with preterm births (less than 37 weeks gestation) occurring one and a half times more frequently. In 1992 in NSW, 22.3% of Aboriginal births were to teenage mothers and 1.9% of all confinements of Australian Aboriginal women occurred in the
Western Sydney and Wentworth Area Health Areas (NSW Department of Health, 1993). Eleven point four percent of these confinements were to women aged between 12 and 19 years (NSW Department of Health, 1993).

In 1992, the perinatal death rate (to non-Aboriginal Australian born residents of NSW) was 9.5 per 1,000 total births, compared to 19.4 per 1,000 total births for Aboriginal women (NSW Department of Health, 1993). Davis and George (1988) suggest that while there has been some improvement in this figure since 1977 when the perinatal death rate was 42.6 per 1,000 births, the resultant trade-off has been more confinements in hospitals with the subsequent loss of cultural practices, for example what Aboriginal women refer to as 'women's business' now becoming the domain of male doctors. This transfer to the medical model and loss of ownership by the traditional keepers is the key issue addressed by this project, based as it is in Western Sydney where, perhaps, deculturalisation has had its greatest impact, i.e. on urban populations. It is also important to note, that in keeping with the medical model, nurses and other health professionals have assisted with this deculturalisation and have tried "...to increase the compliance of people [from other cultural backgrounds] to Western medical therapeutic regimes..." (Greenwood & Kearns, 1996, p. 27).

Maternal and infant mortality rates are higher for Aboriginal people. Increased rates of still-birth, neo-natal and postnatal deaths accompany low birth weights. Aboriginal mothers account for almost 30% of all maternal deaths but less than 3% of all confinements. Throughout the world, the outcomes for mother and baby are used as the indices for health and health care for communities (Shearman, 1989).

In the light of the evidence presented about the higher fertility rate of Aboriginal women, the higher rate of births to teenage Aboriginal women, and the increased number of babies born with a low birth weight (<2500g) it is timely to look at the issue of the provision of culturally appropriate maternity services for the Aboriginal women of Western Sydney.
Further support for the need for culturally appropriate maternity services comes from the findings of Gray and Khalidi (1990) who showed that Aboriginal women are at higher risk during childbearing in nearly every age group, with the higher rate of Aboriginal teenage pregnancies enhancing this risk (S.A. Health Commission 1988; Western Australia Department of Health 1986). The Queen Elizabeth Hospital (Adelaide) data shows that in 63 Aboriginal obstetric cases during 1987, 23% of the mothers were between the ages of 15-19 and 56% were single. These mothers were mostly resident in urban Adelaide, with 13% coming from the country, with first pregnancies between the ages of 15-19 rating at 79%. Of the 63 women, 33 had attended less than seven antenatal visits and 24 had only had four or less antenatal visits. At discharge, less than half of the women were breast feeding their babies. The South Australian Health Commission found in 1988 that Aboriginal women had more medical complications with pregnancy than non-Aboriginal women. Gray and Khalidi (1990) found that the level of antenatal care was the most crucial variable affecting risk births, stating that "for women who have fewer than six antenatal attendances, about 50% of them will have at-risk births. All the other effects are very small by comparison" (p. 15). The authors also believe that by the provision of adequate antenatal care to Aboriginal women, the opportunity will be presented to further provide services for Aboriginal women about other health matters.

The importance of women receiving adequate antenatal care is highlighted by the above authors and by Najman, Williams, Bor, Anderson and Morrison (1994), therefore, it is important for health professionals to consider why the women do not attend. The women interviewed for this project did attend their appointments, but one who seemed keen to contribute, started not attending the clinic, and I was therefore unable to include her in this project. This particular woman had complications related to pregnancy and was attending the Aboriginal Medical Service (A.M.S.), so maybe that service was not meeting her needs either.
Support also comes from a study conducted by Najman et al. (1994), in which the pregnancy outcomes of a population of Aboriginal women living in a major urban city in Australia, were compared with a non-Aboriginal population living in the same city. The Aboriginal population were found to have at least one and a half to two times the adverse pregnancy outcomes of the non-Aboriginal population studied. This figure represents a better outcome than for those Aboriginal women residing in rural areas. The researchers believe that this difference between urban and rural pregnancy outcomes may reflect the generally better quality obstetric care received in the city (Najman et al., 1994). The authors concluded that the differences in pregnancy outcomes fell into two broad groups. The first group contains the higher rate of risk-taking behaviours, such as cigarette smoking and use of alcohol, of the Aboriginal mothers, reflecting the social, political and economic context in which they live. The second group reflected the lack of use of the existing antenatal services or lesser use than the non-Aboriginal population, where the services were sought "too little and too late" (Najman et al., 1994, p. 189).

An outreach service for Aboriginal women is recommended by Najman et al. (1994), the authors however, do acknowledge that if the women are not using the existing services because of a dissatisfaction with those services, then alternatives which address those issues need to be found. They also conclude that the provision of sophisticated services to Aboriginal women is only part of the solution for addressing the inequality in pregnancy outcomes for those women. Attention needs to be paid to the structural causes of ill-health amongst Aboriginal people today and could follow the template set out by Bartlett and Legge (1994) under the section Aboriginal Health Policy, later in this chapter.

These statistical facts underline the state of Aboriginal health today, in particular the morbidity and mortality related to pregnancy and childbirth and point to the need for improved maternity services for Aboriginal women.
Franklin and White (1991) show that Aboriginal people are still trapped in a cycle of poverty and powerlessness and this in itself creates health problems. Najman et al. (1994) would agree with this statement, on account of the lifestyle factors that they found contributed to the poorer pregnancy outcomes of the group they studied.

Aboriginal people who now form the population classed as urban dwellers (defined as part of a population of 1,000 or more people, Australian Institute of Health, 1988), may have always been urban dwellers, or may have come to urban areas from the country.

Urban cultures must... be studied in part from an historical perspective. The history of culture contact and 'chain migration' of Aborigines to the cities and towns has meant that Aborigines have responded to many different European situations, and brought their changing cultures and identities with them, forming diverse, unique communities with one thing in common, their Aboriginality (McConochie, K., Hollensworth, D.& Pettman, J. 1989, p. 21).

These urban Aboriginal people may return to the country for various reasons such as family commitments or work, and "many ...will still identify with the former settlement areas of their kin" (Young 1981; Barwick 1974; Beasley 1975). Beasley (1975) found that looking for work was an important reason why Aboriginal people turn to the city and, Young (1981), found that access to health services and better opportunities for children were additional reasons. This identity with the ancestral lands becomes critical in knowing who Aboriginal people are and to which group they belong, thus identifying and strengthening the kinship allegiances, as well as providing a possible explanation for intermittent attendance at health care agencies.

In 1982, Meredith Burgmann wrote about urban Aboriginal women and their relationship to the white women's movement. She noted the " ...erroneous pre-conceived ideas of the white community which black women are trying to overcome" (p. 27). One of these ideas is that white women are mirrored by urban
Aboriginal women, or are culturally the same in regard to lifestyle, which emanates from an ethnocentric and static perspective on culture. Burgmann argues that urban Aboriginal people have made their own lifestyle, with many traditional features as well as differing ones, and that an Aboriginal lifestyle is very different from white and poor white urban lifestyles. Burgmann argues that the single most important fact that divides women from black and white societies is that the woman in the black society is frequently the head of the family. This fact may have come about because the male is often away from home, the woman has to maintain the family and easily fits into the leadership role. This is supported by the findings of the Poverty Commission in 1975 (cited in Burgmann, 1982), which found in most families visited that the woman had assumed that role, and 50% of adult Aboriginal people were classified as married or de facto, compared to about 75% in the general population (Gale, 1972).

Differences in lifestyles between white and black women also exist in the close communities with geographical ties in which Aboriginal women live and support each other. In addition the notion of nuclear families exists in white society, but not in Aboriginal society, where children are deemed to be the responsibility of all, not just the mother, and where the idea of single motherhood is more readily accepted.

The kinship ties are evident in urban Aboriginal culture today, with the population holding onto the community ties. "...it's something we (Aborigines) have held on to - it's one of our most important weapons" (McDermott, cited in McIntosh, 1996, p. 99). Aboriginal women find support, a common background, a sense of place and belonging, and identity from these close associations with other women, as well as a responsibility towards the community. This communal lifestyle also has other advantages for women, "Women in Aboriginal societies are not solely dependent on having a male partner for support. When the kids are sick they have all that support from other women. Or if their husband leaves them they have a big
network of people - women - who will step in and help" (Hamilton, cited in McIntosh, 1996, p. 99).

Franklin and White (1991) also believe that there is a cultural gap between white Australians and Aboriginal people, and white Australians need to acknowledge and value the cultures of Aboriginal peoples, and work with them in order to develop the culturally specific health services required.

Culture and childbirth

This section of the literature is divided into sub-sections dealing with the cultural aspects of childbirth from the point of view of various Aboriginal authors, and what is happening today in the push for culturally acceptable care for Aboriginal women.

Congress Alukura

Congress Alukura - A Women's Health Service (Congress Alukura) was set up in 1987 by The Central Australian Aboriginal Congress (Congress), which itself began in 1973 to be the voice for Aboriginal people in Central Australia (Carter, Hussen, Abbott, Liddle, Wighton, McCormack, Duncan & Nathan, 1987). The preferences of Aboriginal women regarding obstetric care were examined, using funds from the Commonwealth Department of Health in 1984, in conjunction with the evolution of a program of obstetric care controlled by Aborigines. This research was carried out mainly in the ancestral lands of the Aboriginal people in Central Australia and identified that Aboriginal women are most disadvantaged in terms of appropriateness, influence and choice of service when accessing health services. Congress also found that there was very little understanding amongst western health providers of Aboriginal culture, language, traditions and responsibilities as well as the fact that Aboriginal women's knowledge was not utilised or made available in the system.
Congress Alukura aims to provide a culturally appropriate health service and ‘borning centre’ (explained below) to Aboriginal women, with an emphasis on health promotion and prevention of illness. This health facility is based in Alice Springs and fits with the primary health care model of accessible, affordable and acceptable services.

The lack of understanding of Aboriginal cultures by Western health care providers is interesting as these providers are working in geographical areas where contact with Aboriginal people would be much more likely than those working in Western Sydney for instance. It follows that if the health providers who have contact with Aboriginal people are not aware of cultural mores, it is no wonder that health professionals from areas where there are few Aboriginal people are oblivious to those cultural aspects. This is not to say, however that it is acceptable behaviour for health professionals, especially with the facts of two-thirds of Aboriginal people now residing in urban areas and with the problems of the health status of Aboriginal people in our society.

Borning

This section is based on the work of Carter et al. (1987) and is used because of its relevance to the contemporary fight for culturally acceptable care by Aboriginal women all over Australia. As mentioned previously in this work, Aboriginal urban dwellers may have been born in the city, or have come to the city bringing with them identification from the settlement areas of their kin. Either way, they now belong to a sub-culture which has Aboriginality as the core element. Therefore, in the city we are dealing with women from differing community histories. The work of Carter et al. (1987) is baseline research in this field, coming from the work of the Central Australian Aboriginal Congress in Alice Springs, and published for the wider Aboriginal community.
In traditional Aboriginal culture, the process of borning relates to kin, country and the Dreamtime, with women who have particular affiliations attending the birth. These women are usually the grandmothers and aunts and usually "represent the major institutions including initiation and ceremonies for country" (Carter et al., 1987, p. 6). Borning is the term I will use when describing the Aboriginal point of view. Carter et al. (1987) describe borning in this way:

Borning, determined by the Law and the Dreamtime, is firmly situated in a tradition of belief about life and death, the relation of people to their origins and the rights and responsibilities of people to kin and country. Borning has a holistic, purposeful and sacred character, and these dimensions of life are carefully woven and directed in the borning process. Borning is a symbolic and progressive happening that encapsulates spirit, country and Dreaming. A social and spiritual identity and not merely a physical organism comes into being in a cycle of past, present and future relationships (p. 8).

Implicit in this idea is that indigenous beliefs and practices of Aboriginal women must therefore be given equality along with the model of western care and the differences in belief systems need to be studied and valued.

Aboriginal people in Central Australia believe that ancestral spirits belonging to the country send the spirit child and a woman who either wants a child or who is already with child knows the special places to go where the spirit child enters her or turns into an emu or kangaroo or other game which the woman later eats. In addition the woman or her husband may hunt game which includes a spirit child, the husband may give the woman some game which then enters her. The husband may also have a "dream" announcing the arrival of a spirit child (Hamilton, 1981). Now we see that the spirit child has linked the present time and the Dreaming, the first recognition of the spirit child, comes with quickening when the "spirit child is found on country... which may be the grandfather's or grandmother's country" (Carter et al., 1987, p. 8). The spirit child has been "found", "come up", "looked
after", and "built up". In equivalent terms western society describes fertility, ovulation, conception, pregnancy and birth etc. Western antenatal care's equivalent becomes "coming up" and special kinship women massage, rub and make feeling movements on the woman's stomach, certain foods may also be taboo in case they harm the spirit child. Normal responsibilities and obligations are carried out by the pregnant woman during this time.

In the tradition of borning, women learn about birth when they have their first labour, which is conducted using certain procedures and techniques directed by the Grandmother's Law, in a "warm, supportive, familial, ancestral process..." (Carter et al., 1987, p. 8). The women prepare a camp away from the main camp, called the Alukura, and the woman has complete control over the birth unless something goes wrong, the attending women remain naked and support the woman, rubbing her stomach and placing a knee at the labouring woman's back to help with the delivery. The woman fasts and is given no pain relief, being urged not to scream while two women help with the delivery. The grandmother delivers the baby onto the ground, the baby cries, then it is put to the breast. The cord is cut and warm sand applied, the cord is then placed around the baby's neck to give the baby strength and protection from bad spirits. The mother and baby are rubbed with warm sand to help 'paining', the stomach is sometimes massaged to help with removal of the placenta, which is buried. The mother and baby are smoked to make them strong, stop bleeding and ensure plenty of milk for the baby. During this time "borning songs" may be sung. At times ceremonial and preventative rituals may be performed. Food is supplied to the Alukura by the husband and presents for the baby are brought by the mothers and sisters, the borning process is completed after the mother returns to her own camp. The women are not scared, alone or shamed and are supported by "kin women relations, the familiar and wise, in spiritual solidarity" (Carter et al., 1987, p. 10).

The borning process which is guided by the Grandmother's Law, is tried and true, refined by tradition and time and remains a "life source and the base for future
generations" (Carter et al., 1987, p. 11). Carter et al. (1987) briefly described both the traditional ways of birthing and western obstetrics and found that the differences reflected the essential differences between Aboriginal and western society but that there were some specific areas of divergence. Primarily seen as women's business, particularly that of the older women with matrilineal affiliations, the knowledge is shared and passed on to younger women who actively participate. Carter et al. (1987) also state that "Beliefs about being sent, being found and coming into being are part of the common body of knowledge within the all-embracing mythology and social organisation" (p. 8).

These researchers found that in Central Australia, the Grandmother's law has been maintained with births in the single women's camps in the country, and some parts of the law have been maintained if the baby is born in hospital, such as the grandmother naming the child for his or her country. Because of the increased infant mortality and morbidity rates amongst Aboriginal people, the medical answer has been to try to increase the antenatal visits by the women, births at the hospital and education, all supported by increased transport for women from remote communities. The increased hospital births have decreased the infant mortality rate, but these strategies are seen as crisis and interim relief and rejected by the women of Central Australia (Carter et al., 1987). Aboriginal women in Central Australia have mostly been forced to use Alice Springs Hospital for confinement and thus accept western medicine's philosophy of obstetric care which is a foreign belief system to the Aboriginal women (Carter et al., 1987).

Obstetrics in western society has become technology-driven, medically-managed and male-dominated. These attributes are and have been questioned in western society over at least the last fifteen years and the trend is away from high-tech births, back to the more natural birth, for example, the use of birth-centres and homebirth. Aboriginal people have to date accepted the western model of care for a number of reasons, such as lack of alternatives, its predominance, ignorance and "whitefella sickness". According to Carter et al. (1987) there has been no
reciprocal aid from western medical practitioners about traditional Aboriginal birthing beliefs and no acknowledgment of the current trends in birthing by Alice Springs Hospital in the provision of a birthing centre, or home-birth. The researchers state that Aboriginal people today accept that as birthing is a two-way process, they must learn both the white-fellah and old-time ways, and non-Aboriginal people must understand and consider the sacred processes of Aboriginal birthing and birning.

Non-Aboriginal interventions

...in western society... the medical influence on life has reached the point where birth, old age and death are controlled by medical caretakers (Carter et al., 1987, p. 11).

The natural event of birth has been turned into a medical, hi-tech, pathological specialty, where society has rejected the traditions which included lay female midwives with their "natural practice" of "care without intervention" (Carter et al., 1987). Male midwives made their appearance in the seventeenth century and thus commenced the struggle between male and female midwives till the twentieth century. Doctors moved into this area of practice following the loss of midwives when changes to urban industrial life disrupted traditional communities during the 1800's. The United Kingdom set the standard in 1886 that medical practitioners had to be qualified in midwifery and obstetrics became the first medical specialty taught in medical schools in the United States (Willis, 1983). In 1862, medical controlled midwifery training began, with only men being allowed to practice. Later a formal midwifery course was established with general nurse training being an entry qualification. "In this way, midwifery was being made a profession by male medical doctors and subordinated by its incorporation in nursing" (Willis, 1983, p.103).
High infant and maternal death rates led to increased medicalisation of childbirth, puerperal fever claimed the majority of maternal lives and midwives were blamed for the epidemics. A maternity allowance was introduced which led to increased medical attendance and the rate of midwife attendance at birth halved, but the maternal and infant death rates were not significantly reduced. The provision of a surgical environment for childbirth became popular, midwifery became a specialty within nursing in 1928 and childbirth became the province of the medical profession, with the subsequent demise of midwifery. Interestingly, in Australia, white women from outback properties were often assisted during childbirth by Aboriginal women. Western women have now become socialised into believing that birth is a medical event and it is important to be in hospital, near emergency equipment if things go wrong.

The differences between the two societies in matters of childbirth are based on belief systems. One is imbedded in the cultural traditions of the Law and the Dreaming, is holistic and grants women control and autonomy as well as being part of a cultural process which is progressive, going beyond the childbirth event. The other system is "... mainly specialist, gender specific, mechanistic and scientific, and in it the emphasis on pathology is paramount" (Carter et al., 1987, p. 13). Some of the areas of similarity are forms of antenatal care, the presence of birth attendants, medicines - either western or traditional bush cures, and techniques and procedures at the actual birth such as place of birth, control of bleeding.

The authorities in the Northern Territory have accepted the practice of western type obstetrics for Aboriginal women without looking at the processes which have led to the natural childbirth movement or the beliefs and practices of traditional Aboriginal women in the birthing process. This policy has made birth a highly traumatic experience for Aboriginal women in Alice Springs according to Carter et al. (1987) and they believe that the resources should be placed into the area of developing the traditional ways of birthing, along with the use of the best western obstetrics when required. Women who are at serious risk during pregnancy and/or
birth would be referred to a hospital, and those women who choose to give birth in
the bush, away from the facilities of the Congress Alukura would be supported
through the Royal Flying Doctor Service.

Hospital based births for Aboriginal women in Central Australia can be
traumatic, and regarded with great trepidation for a number of cultural reasons.
These reasons emanate from beliefs held by the women about borning, and
because they deliver in the hospital they believe that they are in a "silent, fearful
world" (Carter et al., 1987, p. 16). The women miss the support of their womankind,
English language is used in the hospital, and they are frightened by the use of
technology. The women lose their control and autonomy as in the Law, the
Dreamtime and their country, and are "shamed" by the attendance of male doctors
who give them no choice if they want a healthy baby. Many women fear the
procedures such as intravenous infusions and surgery, because there are no
equivalents in traditional culture. Their lack of understanding about what is going
on is exacerbated by their consequent distrust of the white ways. The disposal of
the placenta by the hospital is alien to Aboriginal women, who bury it, in accordance
with the Grandmother’s Law and the way the umbilical cord is cut is another
practice which violates traditional Law.

Because of the classification of high-risk which is given to Aboriginal mothers,
medical providers of western obstetrics are legitimised in their practice. This has, in
turn, devalued the traditional borning practices. However, Carter et al. (1987)
believe that some Health Department employees show some awareness and are
not as certain that western obstetric practice is always appropriate for Aboriginal
women.

Current practice in mainstream care for women is not tailored to Aboriginal
women, partly because of their socio-economic status which automatically assigns
them to antenatal clinics at hospitals, and to the doctor on call on the day that they
deliver. By the very nature of busy antenatal clinics, individualised care is hard to
come by, especially as, for instance, there may not be any female doctors rostered,
and women tend to accept what is offered. Women also have to know what they want and be assertive if required to achieve this, which is not the way of many Aboriginal women and those from lower socio-economic backgrounds. Because of the high-risk status of pregnant Aboriginal women, they are not likely to be assigned to midwives clinics if they are available, thereby losing another opportunity at individualised care. Midwife care represents the best opportunity at present to achieve culturally acceptable care in mainstream health services.

The sustainability of western obstetrics in the Centre is ensured by the success of hospital delivery and the reduced mortality results (Carter et al., 1987). The medical providers have looked at the problems, prescribed the solutions and believe that they know what is best for Aboriginal women. Some believe that the women themselves are at fault because of their habits, or don't care less, or that the very culture of Aboriginal women is at fault. The focus on morbidity and mortality blurs the underlying causes of ill health, and allows the providers of medical services an unscrutinised free run. Carter et al. (1987) argue that "The lack of understanding on the part of Aboriginal women, according to this way of thinking, is produced by the limitations of traditional practices and not by the lack of cultural appropriateness and accessibility of western obstetric practices" (p. 19). The traditional practices are seen as deficient.

When interviewed by Carter et al. (1987), most Northern Territory Department of Health medical caretakers had scant knowledge of traditional birthing ways, were unabashed by their ignorance and said that the traditional ways were no longer relevant. The researchers thought that very little consideration was given to interaction between the cultures, one doctor thought that two-way interaction was inconceivable, and any compromises between indigenous and western childbirth practices which were said to have been implemented, were either inadequate, misunderstood or not encouraged. There is also no continuing education for staff about Aboriginal matters, with most staff saying when interviewed that the issue of
gender was not important, although most recognised the advantage of female doctors at the hospital (Carter et al., 1987).

These attitudes towards Aboriginal women are what we need to change if we are to implement culturally appropriate care which will lead to improved health outcomes for Aboriginal women and their babies. The availability of female doctors seems to be generally accepted in our communities now and they are available in Aboriginal Medical Services, but steps have to be made to expand their availability past the hospital front door.

The shyness of the Aboriginal women, along with the natural quietness of Aboriginal people provided an area of confusion for medical providers. A lack of communication was described as the women only speaking if they were not happy about something. At the Alice Springs Hospital, even though nearly half of the Aboriginal women who deliver there are from remote tribal areas and have a poor command of English and even though interpreters are available through the Institute of Aboriginal Development, they are rarely called. Carter et al. (1987) found that language and communication are a very major problem, and many Aboriginal women deliver their babies in solitary confinement.

This situation flies in the face of the importance afforded and given to the provision of interpreters in the health care setting elsewhere in Australia. One must ask the question - why are the interpreters not used? Is it because the interpreters are not readily available, or is it related to the attitudes of the health providers? In New South Wales, public hospitals have policies regarding the use of interpreters in health care settings, why are our own Aboriginal people missing out on this service? While the issue of language may not be present in Western Sydney, I believe that it illustrates the attitudes of hospital staff who don't even consider the needs of Aboriginal women, who are not looking for ways to individualise care in a culturally acceptable way. On a wider note, language and health care may be an issue outside major cities, and where Aboriginal people are referred to large centres such as Adelaide and Townsville.
When talking about Aboriginal midwives, Grace Quinlan Kelly (1992) says that: "the women were the teachers. They always had their children with them when they were hunting and gathering- teaching them. The elderly women passed on all that knowledge and support" (p. 148). A group of women would look after the mother and the baby and there was always a lot of massaging, both for the mother and the baby, the massaging was seen as healing. The woman who was pregnant was made special and looked after by her grandmother, mother and aunts, and the women shared the birth together. Breastfeeding was encouraged, with the baby being put to the breast soon after birth, in fact Kelly (1992) states that "Breastfeeding was seen as a baby's birthright" (p. 149). The advent of hospital births saw all of the Aboriginal women segregated into their own ward and the babies were put into the nursery, breastfeeding wasn't encouraged and thus the babies lost their good chance. The bond between the women was broken and now Kelly (1992) says that "...We've seen so many changes in our lifestyle, we're just starting now to relearn what our people knew in the past" (p. 150). This alerts us once again to the opportunity that is presenting itself to health professionals now, the chance to work with Aboriginal people in order to institute the necessary change.

**Relevance to Western Sydney**

Recommendations from the Shearman Report (1989) include a shared care system based on the Redfern A.M.S. and King George V Hospital model. This service has been set up between Daruk A.M.S. and Nepean Hospital and is currently operating. It is useful to note the comments of Aboriginal women attending the Redfern childbirth education classes for their relevance to Western Sydney.

In 1990, during childbirth education classes held at the Redfern A.M.S. and the Aboriginal Health Service in Redfern, it was discovered that there was a lack of written and audio-visual material relevant to the group about pregnancy, birth and
motherhood, and the cultural links of traditional Aboriginal birthing and the practice of today (Gosden, 1992). The group of women attending the classes were interested in reading and viewing more, and were mindful of the fact that traditionally these subjects were part of 'women's business', which was passed on from older to younger women. Gosden (1992) states that:

The dislocation of Aboriginal traditional culture has meant a break with this pattern of communicating knowledge of health in pregnancy, birth and mothering, but has produced no satisfactory substitute, as is illustrated by the statistics in the 1987 Maternal and Perinatal Report by the N.S.W. Department of Health (Introduction).

Aboriginal people are very good at reading body language, and if the staff are seen to be unfriendly by Aboriginal people, then the Aboriginal people will not return to that service as they feel bad about it. It is also important for staff to make people comfortable, make it easier for users to seek advice, gather information and open up with information necessary for their care (Mulcahy, 1992). By increasing the numbers of Aboriginal health workers (various categories) it will be possible to break down the barriers of communication between health staff and Aboriginal people. The provision of information to non-Aboriginal health staff about Aboriginal culture will enhance communication, which will ultimately benefit the Aboriginal people as well as creating greater resources for all in the health field (Mulcahy, 1992).

As the needs of Aboriginal women are different to those of non-Aboriginal women, the way ahead is not to force Aboriginal women to use mainstream services that are not culturally appropriate. Ceissman and Gordon (1992) say that Aboriginal women will not go to a place where they don't feel comfortable, or where there aren't any other Aboriginal people, and speak about personal things. They believe that the difference in values, morals and needs between each group precludes Aboriginal women being comfortable in the mainstream situation.
Aboriginal people also have learnt over a long period of time not to trust community organisations or Government workers, stemming from the invasion of their country. This distrust is deeply ingrained (Ceissman & Gordon, 1992). The authors believe that a service that understands the culture, problems, values and needs of Aboriginal women is what is required in order to support Aboriginal women. We see here the connection between the needs of Aboriginal women around the time of childbirth, whether the women are urban dwellers living in Redfern, or living in or around Alice Springs.

When looking to the needs of Aboriginal women, nurses and other health professionals must firstly, become aware of the culture. In the words of Bush and van Holst Pellekaan (1995):

Above all, by observing the management of community health matters by ATSI people, nurses can learn skills which bring them closer to the successful delivery of holistic health care. The ATSI contribution can be thought of as a trail of footprints, for in traditional culture footprints are a revealing and identifying sign of a person within the group. If nurses recognise the footprints they may finally see the person, the group and the culture that has survived (p. 232).

Finding those footprints can be seen as analogous to the tenets of primary health care.

**Primary Health Care**

The philosophy of Primary Health Care provides us with the framework for midwives to provide culturally appropriate maternity services for urban Aboriginal women. Primary Health Care (PHC) is the strategy adopted by the World Health Organisation in 1978, by which to achieve its goal of "Health for All", giving people the right to health services at home and work as well as enabling people to take the
responsibility for community and personal well-being (Australian Nursing Federation (ANF), 1990). The World Health Organisation's shortened definition of Primary Health Care is "essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford" (ANF, 1990, p. 2). The Australian Nursing Federation's 1987 position statement endorsed the view of the World Health Organisation that nurses had a leadership role in the implementation of primary health care, while endorsing the primary health care strategy in Health for All (ANF, 1990).

Primary Health Care is the first level of contact with the health care system and the representative of that system may be nurses, doctors or other health care workers and professionals who are community based. The main emphases of primary health care include:

- community education in preventing health problems,
- maternal and child health,
- adequate supply of safe water and basic sanitation,
- adequate nutrition and the promotion of a healthy food supply,
- prevention and control of locally endemic diseases,
- immunisation against the major infectious diseases,
- appropriate treatment of common diseases and injuries,
- provision of essential drugs (Rice, 1989, p. 20).

One of the recommendations from the Health Targets and Implementation Committee (1988) is that inequalities must become a major project goal, and one of the principal areas was Aboriginality, where a 25% reduction in the health status differences should be apparent by the year 2000.

The Primary Health Care model (World Health Organisation, 1978) of accessible, socially and culturally acceptable and affordable health care, is one that can provide the building blocks for policy making by the providers of mainstream
maternity services. In particular this Primary Health Care approach has been adopted by the Australian Nursing Federation (ANF, 1990).

The issue of appropriate antenatal care is one which needs to be addressed. As pregnancy can be a very sensitive issue for Aboriginal women, appropriate services such as having Aboriginal health workers to talk to and female doctors at clinics are necessary to encourage Aboriginal women to attend. Accessibility is also a major issue for Aboriginal women, with importance placed on how to get to the clinic for appointments. Ways of ensuring accessibility include placing the service in strategic locations such as near public transport, or where Aboriginal women congregate for example, at schools. Other plans could encompass a pick-up/take home service or a mobile clinic, where the health professionals visit the women in their own homes. While a visit to the home would be most appropriate in some circumstances, it could lead to isolation for the woman, who could benefit from meeting other women in the same geographic location. The maternal education factor is an area that researchers Cleland and Van Ginneken (1989) found to be the strongest influence on child survival "irrespective of the proximity or effectiveness of health care provision" (p. 17). This research was carried out in developing countries and Brady (1991) believes that although no similar research has been carried out in Australia, we can hypothesise that the same would be true in Australia. A culturally acceptable service would be able to provide the necessary education for women, as a component of a primary health care approach to the problems of maternal and infant morbidity and mortality.

Community based health services can provide accessibility to the community they serve, both geographically and ideologically, with outreach services filling the gaps. In Western Sydney, one of the common problems encountered by people is lack of suitable and affordable transport.

Ian Anderson (1988) reports that mainstream health services have often been criticised for their lack of appropriate care for Aboriginal people and, as a result, have been under-utilised. Reasons for this under-utilisation include the
philosophical differences between providers and cultural groups eg western obstetric care, and the traditional area of childbirth being women's business. The strong kinship networks of Aboriginal culture, which hospital procedures ignore and sometimes even undermine, and the alienation that Aboriginal people may feel when surrounded by professionals and employees who have had no contact with Aboriginal people (which have been highlighted previously in this report) are other barriers. Another reason mentioned by Anderson (1988) is the doctor-patient relationship, which is largely authoritarian and may be compounded by previous bad experiences with health professionals. Looking at community development, focussing on achievable improvements and reflecting changing needs may be the answer to addressing the cultural-appropriateness of mainstream services (Anderson, 1988).

Cross-cultural interaction needs to be facilitated if health promotion programs for Aboriginal women are to succeed. Eckermann and Dowd (1992) list the structural obstacles to successful interaction as:

1. the highly institutionalised health system which isolates care from personal circumstance,
2. institutionalised racism and mutual stereotyping,
3. sometime emphasis on needs of professionals rather than client and care-giver,

While the feeling that as individuals, professionals have no power over the structural issues is understandable, it is important to encourage individual professionals to pursue the personal factors that can be controlled such as, for example: "perceptions and attitudes to cultural difference, professional roles and perceptions of and attitudes towards power and change" (Eckermann & Dowd, 1992, p. 17). Following primary health care philosophy, professionals would legitimise the ways of other cultures and encourage better health expectations by
increasing personal and collective autonomy and valuing personal contribution to that community. In addition, professionals may question the philosophy of treating everyone the same, regardless of race, creed etc., and think about the people who make up the individual minority groups (Eckermann & Dowd, 1992). In treating Aboriginal people in a standard way, we "...replace a complex culture, i.e. a beautiful piece of tapestry, with just the scraps of wool left over after it is completed" (Backhouse, 1994, p. 27).

Primary Health Care can become the vehicle for integrating the technical services which are narrowly focussed, intent on outcomes, and hierarchically controlled, and community development, which is community planned, involved and controlled (Bartlett & Legge, 1994). It is appropriate to now look at policy relating to Aboriginal health.

Aboriginal Health Policy

For Aborigines the invasion 200 years ago has caused widespread partial destruction of their way of life culminating in health standards more on par with Third World conditions than those of the affluent Australian society (Cummins, 1995, p. 357).

The health of Australian Aborigines has declined in the last 200 plus years since European contact, from a society of healthy hunter-gatherers with a low-salt, low-sugar, low-fat varied diet to that of the most disadvantaged society in terms of health in Australia today (as presented earlier in this chapter). The colonisers brought with them infectious diseases which Aborigines had no immunity from, and policies which placed them into small settlements and reserves, forcing upon them a poorer diet than that which they were used to. In addition, the diseases of psychological pain and spiritual despair were caused by the removal of ancestral lands and lifestyle (Cummins, 1995). Government policy of protectionism saw the
end of a healthy lifestyle for Aboriginal people and the development of racist attitudes became entrenched in policy.

The year 1967 marked a turning point in Aboriginal and Torres Strait Islander history. In a Constitutional Referendum, 90 per cent of voters gave the Commonwealth the power to make special laws for Aboriginal and Torres Strait Islander people concurrently with the States. This opened the door for much greater Commonwealth involvement in the provision of Aboriginal and Torres Strait Islander programs and services. Since then there has been a fundamental shift in Commonwealth Government policy...

( Commonwealth of Australia, 1993, p. 69).

This shift of policy meant that instead of telling Aboriginal people what is best for them, they were asked what their needs were and policy slowly moved (after much pressure) towards Aboriginal and Torres Strait Islander people taking control of their lives. As a result of this policy shift was the introduction of the National Aboriginal Health Strategy (1989) which included among other things nine new Aboriginal Medical Services and projects directed at women such as birthing centres, antenatal and postnatal programs. It was also acknowledged in the Royal Commission into Aboriginal Deaths in Custody: National Report (Johnson, 1991) that a change in attitude between indigenous and non-indigenous Australians was necessary if the disadvantage of Aboriginal and Torres Strait Islander people was to change. The Council for Aboriginal Reconciliation was set up in 1992 to achieve this change (Commonwealth of Australia, 1993).

Initiatives to address the inappropriateness of mainstream health services have included Aboriginal liaison officers in hospitals and Aboriginal health workers. These positions do provide an inter-face between health services and the community, but are sub-servient to the health service they represent and cannot always provide the level of culturally appropriate service required because of the rules and structures of the employing bureaucracy (Gray & Saggers, 1994).
However, research conducted by Griffin (1995) found that Aboriginal Liaison Officers were markedly respected by nurses, who believed that the role of these officers had certainly reduced stressors placed on Aboriginal people during hospitalisation. The stressors noted included the isolation, fear and loneliness felt by Aboriginal people once they were removed from their families and homes, into major metropolitan hospitals, and which often resulted in an early, unauthorised discharge. Nurses also noted that Aboriginal Liaison Officers had provided them with sensitisation programs which led to nurses having a better understanding of their clients. Although there was a problem with non-referral of clients at times, from the nurses to the liaison officer, and a lack of understanding about the liaison role, the close ties with Aboriginal communities and metropolitan hospitals had led to less stress by clients (Griffin, 1995).

Resources have been directed towards the medical management of illness, much of which has gone into the cost of infrastructure. The health promotion programs which have been instituted are necessary, but the effect is limited by the lack of attention to the structural problems of poverty, living arrangements and access to resources, which are fundamental to an increase in the health status of Aboriginal people (Gray & Saggers, 1994).

In an article in 1994, Dr. Carmen Lawrence stated that her approach to Aboriginal health would be preventative, and that the Australian Health Ministers Advisory Council had 'recognised that Aboriginal health workers have a critical strategic role in providing health care in rural and remote areas' and 'there is now a recognition of the role for self-determination in the design and delivery of health programs that did not exist 15 years ago' (p. 15). Lawrence announced the setting up of the Office of Aboriginal and Torres Strait Islander Health Services, and stated that 'Gains in Aboriginal health will come not from just increasing the funds available. Perhaps even more important is to set in place a system to ensure that they are spent fairly and effectively. This is my highest priority at this time' (p. 15). The structural reforms called for to improve the health of Aboriginal people are not
readily seen in Lawrence’s statement of her vision for the health of Aboriginal Australians.

Despite the change of policy direction and the money which has been directed at Aboriginal health, the health of Aboriginal people is still a national disgrace.

Summary

In this chapter I have reviewed the health status of Aboriginal people today, in general and then in particular, the health of mothers and babies during pregnancy and childbirth as well as the direction of policies pertaining to the provision of health services to Aboriginal people. The cultural practices of Aboriginal people surrounding childbirth and the relevance of those traditional cultural ways to Aboriginal women living in Western Sydney have been explored.

There are gaps in the literature about urban Aboriginal women and their experiences of mainstream health services. The literature is plentiful about the health status of Aboriginal people as a whole, and the causes of this ill-health, and there is a small amount of literature about Aboriginal people and the problems they face when confronted with mainstream health services. It seems to me that what I have found has been extrapolated from the needs of Aboriginal people in Central Australia and Western Australia. When it comes to Aboriginal women who live in urban centres, there is scant literature, especially about pregnancy and childbirth and there is nothing related to women from Western Sydney. Even the Shearman Report (1989) is based on information gained throughout the whole of N.S.W. Another gap I have found in the literature concerns breastfeeding amongst Aboriginal women today, particularly urban women. While some literature talks about Aboriginal women and breastfeeding, the statistics are scant and I have found it impossible to find any real facts about urban Aboriginal women and breastfeeding, apart from the work by Gosden (1992). Therefore, my study has
highlighted these issues in the coming chapters, and falls into line with the recommendations for further research made by Griffin (1995)

- Aboriginal values and norms which nurses should know about;
- desirable actions nurses should take to attain the best possible result in dealing with Aboriginal clients... (p. 297).

In order to explore these issues with urban Aboriginal women I chose to interview Aboriginal women living in Western Sydney and explore their conversations with me using a phenomenological method which is described in Chapter 3.
CHAPTER THREE: METHODOLOGICAL ISSUES

The philosophy which underlies my method is drawn from interpretive phenomenology which has as its central tenets:

... to understand the world of concerns, habits and skills presented by participants' narratives and situated actions... Understanding human concerns, meanings, experiential learning, and practical everyday skilful comportment, when they are functioning smoothly or are in breakdown, is the goal as opposed to explanation or prediction through causal laws and formal theoretical propositions. (Benner, 1994, xiv).

Included in the understanding of these meanings is the context and history of the participants, any changes that have occurred, and the time that the women are situated in. In this work, the stories of the women are the medium by which their voices are heard. The first-person narrative, "provides an inside-out perspective essential to understanding the terms in which the narrator understands his or her life" (Smithbatt, 1994). These stories provide a way for understanding ourselves and others, and the actions taken by others, and are meaningful though not always conforming to a theory.

Munhall (1989) describes the philosophical basis of qualitative method in the following way: "The philosophical underpinnings of qualitative research methods reflect beliefs, values and assumptions about the nature of human beings, the nature of the environment, and the interaction between the two" (p. 22). She postulates that nurses who chose the qualitative research method perceive that:

- reality and meaning can be assumed by the fact that individuals are active, interpretive of their own actions and creative of themselves by their inner existential choices,
- individuals and groups have their own histories and ideas of the future,
- there is constant change in both the world and its people,
- truth is an interpretation, temporal and cultural,
- objectivity is not necessarily suspended because of interactions with people,
- meaning is created jointly from the source, whose experience is valued and described, and from the interpretation of the researcher,
- linguistic, social and cultural patterning impact on meaning which comes from experience.

Nursing, which has both scientific and humanistic care dimensions, has spent many years establishing the scientific knowledge base of nursing and according to Ray (1985), has spent much less time exploring the humanistic identity of the discipline. Beliefs and values are inherent in humanism and Ray (1985) cites Munhall as remarking that "(beliefs and values) are found in such expressions as becoming, freedom, self-determination, autonomy, and human potential" (p. 82). These humanistic expressions are found in the work of such theorists as Leininger and Mayeroff in terms of caring (Ray, 1985), so for nurses to understand these expressions, they need to describe and explicate the meaning of lived experience in relation to nursing care. Ray (1985) believes that "the phenomenological approach as the explication of meaning in experience is one of the most promising of the qualitative methods by which to capture the interrelationship and interdependence of humanism and science in nursing" (p. 82). Phenomenological research questions the way that we experience and want to know the world, and by being in the world and questioning it, we become part of the world. This is called 'intentionality' (van Manen, 1990). This questioning brings the world into being for us, and research becomes a caring act by our finding out the things that are essential to being.

Phenomenology is a research method and a philosophy which arose in the late 19th century in Germany, appearing in the writings of Franz Brentano, whose ideas included the ability to be aware of one's own psychic ability and intentionality.
(Wilkes, 1991). Husserl, a student of Brentano, believed that the philosophy should have rigour as well as a humanism, endeavouring to secure the meaning of experience by reinstating the reality of humans in the life world, and relating phenomenology to ways of knowing (Gray & Pratt, 1991 and Munhall, 1989). He related phenomenology to the question of knowing.

Heidegger, who was a pupil of Husserl, developed existential phenomenology, which emphasises the way phenomena present themselves in the lived experience in human existence (Wilkes, 1991). This approach, a means to a solution, has three tenets, those being that humans self-interpret, that being an individual is an issue and that the individual's meaning is limited by culture, language and history (Wilkes, 1991).

Phenomenology asks the question: how does an experience assist us to understand the nature or meaning of our everyday lives in a deeper way. The phenomenological question asks what is the nature or essence of an experience, what some - 'thing' is, the internal meaning-structure of a lived experience.

Phenomenological human science is the study of lived or existential meanings; it attempts to describe and interpret these meanings to a certain degree of depth and richness ... phenomenology attempts to explicate the meanings as we live them in our everyday existence, our lifeworld (van Manen, 1990, p. 11).

Phenomenological reflection is a recollection that is retrospective, where one reflects on an experience after living through that experience. Of course, time, the actual event and the aftermath, may affect the memory of the event.

In phenomenology, there are no clearly defined steps in undertaking this methodology (Burns & Grove, 1987). They argue that the reasons for this are the potential to limit the creativity of the researcher and phenomenologists' tendency not to place importance on sequencing of events and time. However, certain principles are meant to be applied. "The interpretation must be auditable and
plausible, must offer increased understanding, and must articulate the practices, meanings, concerns, and practical knowledge of the world it interprets" (Benner, 1994, p. xvii). In the interpretation, one must guard against creation of findings that are not there, the imposition of the interpreters' thoughts of her/his own world on the text and making more or less of what is in the text. In the interpretation of the women's stories I have tried to remain true to their story and have indeed had my own views challenged (see also sub-heading assumptions). In the case of my study, phenomenological method is useful because of its power to make the voices heard, the practices and cultural concerns of the women visible, so that recommendations for policy will be attendant on the differences (Benner, 1994).

Evaluation of this work will encompass the questions of how well this work addressed the initial concerns of the researcher, that of the lack of cultural understanding of nurses and health professionals when dealing with urban Aboriginal women. Did this work uncover new meaning or ways of thinking for the researcher? If that has occurred, how will this impact on care for urban Aboriginal women in the future (Leonard, 1994)? I will leave the reader to judge what has occurred!

**Research questions**

What knowledge about the traditional Aboriginal ways of birthing do urban Aboriginal women living in Western Sydney have?

How important is this knowledge to the women when they are accessing mainstream maternity health services?

Has the Shearman Report (1989) had any effect on mainstream maternity health services in Western Sydney?

How can health professionals make a difference to urban Aboriginal women when they access mainstream urban maternity health services?
Data collection

Collection of data may occur in a variety of ways, and may be combined for the purposes of a study. For this project I chose to ask my informants to describe their experiences during in-depth interviews (Appendix 1), and during the time I was attending the clinic, I used some participant observation. The data collected was verbal and collected in a relaxed atmosphere, which allowed time for facilitation of the description (Burns & Grove, 1987). The interviews were taped using a micro-cassette recorder placed on a table between us, at first both of us were conscious of the recorder, but once the conversation was flowing well, the recorder was forgotten. Participant observation, where the researcher records verbal and non-verbal behaviours as well as the environment and the researchers response at the time (Burns & Grove, 1987), was background to the workings of the clinic and complemented what the women told me, and more importantly, as I was analysing the interviews, what was not said to me.

Interaction with the informants begins once the research questions are identified and involves discussions of descriptions and reflections of experiences (Bergum 1989). The researcher becomes part of the research and the informant may be seen as a 'co-researcher', with the researcher searching for the meaning to the informants' experience in the context of the research, as well as becoming part of the environment.

Sampling procedures and participant recruitment

Six women participated in this study. Five of the women were attending the antenatal clinic at an Aboriginal Medical Service (A.M.S.), four were booked in to confine at a local public hospital and one woman was planning a homebirth. All of these women had joined the project as a result of my attendance at antenatal
clinics conducted at the A.M.S. where I was able to speak to them about the project over a period of time and get to know them as well as they were able to get to know me. During these conversations we became comfortable with each other, discussing the project, my work and my family. It was important for the women to trust me and feel comfortable with me as they were going to be sharing an important time in their lives with a stranger. If I had been unsuccessful in gaining the trust of the women, they would not have been as frank and honest with the information they gave me. The sixth participant was a woman that I had met through my workplace, who showed an interest in the project and had been confined at a local public hospital for all three children.

Table 1. The Women in the Project.

<table>
<thead>
<tr>
<th>Informants' name</th>
<th>Age</th>
<th>Level of schooling</th>
<th>Post-school employment</th>
<th>No. of pregnancies</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joan</td>
<td>28</td>
<td>Year 9</td>
<td>Secretarial</td>
<td>3</td>
<td>1 boy &amp; 1 girl</td>
</tr>
<tr>
<td>Kay</td>
<td>20</td>
<td>Year 10</td>
<td>Retail</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Sue</td>
<td>17</td>
<td>Year 9</td>
<td>Retail</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Dianne</td>
<td>33</td>
<td>Year 12</td>
<td>Secretarial</td>
<td>3</td>
<td>2 boys</td>
</tr>
<tr>
<td>Jenny</td>
<td>30's</td>
<td>Year 10</td>
<td>Community work</td>
<td>3</td>
<td>3 boys</td>
</tr>
<tr>
<td>Liz</td>
<td>22</td>
<td>Year 11</td>
<td>Secretarial</td>
<td>3</td>
<td>1 boy &amp; 1 girl</td>
</tr>
</tbody>
</table>

Table 1 shows the demographics of the group. I have given the women new names, and have generalised the occupations of the women to protect their privacy. At the time of the interviews, four of the women were pregnant, one had recently delivered and one's youngest child was five years of age.

The sample was a purposive one as described by Ray (1985) where the only legitimate source of data is from informants who have actually lived the experience being researched and fits with phenomenological enquiry of the lived experience. Van Manen (1984) is cited by Baker et al. (1992) as observing "that the point of phenomenological research is to borrow other people's experiences in order to understand the deeper meaning of it in the context of the whole human experience" (p. 1357). Thus, this type of sampling is small and "in keeping with its aim of
illuminating the richness of individual experience..." (Baker et al., 1992, p. 1358).

As the women in this project are Aboriginal women who live in an urban setting in Western Sydney and who are currently pregnant or who have had babies while residing in Western Sydney, they make up a credible sample for this particular project.

The adequacy of this sample relates to a number of factors. Saturation, as described by Minichiello, Aroni, Timewell and Alexander (1990) "... refers to a process where no additional data can be found that would add to the categories being developed and examined" (p. 199). I have not achieved the point of saturation because of my inability to increase the size of the sample. This sample is the best I could do in the circumstances of a) a quiet time at the clinic, b) women who did not arrive for appointments, and c) the possible effect of my non-Aboriginal status.

I tried to increase the sample size by 'snowballing' as described by Minichiello et al. (1990) whereby informants are asked to nominate friends or acquaintances who then become informants and so the process goes on. I was unable to achieve an increase in sample size by this method and I put this down to my not being an Aboriginal person. Therefore a further larger study would be more appropriately carried out by an Aboriginal researcher. Further attendance at the antenatal clinic was ruled out because of time. It had taken me six months to get the six interviews that I did achieve and I did not believe that returning to the clinic was appropriate at the time.

The time/space dimension (Minichiello et al., 1990) enters the discussion here with the components being my time as the researcher, and the time/space of the informants. The informants were all Aboriginal women and I am a non-Aboriginal woman asking them for their views of the world in relation to maternity care. I am also a stranger to all but one of the women, so I had to gain their acceptance and trust to make this a meaningful exchange. The informants were either expecting their first babies in the very near future, or have other children to
consider when making the decision to become involved in the project. All of the women were at the stage of their pregnancy when they were focussing on the baby and the impending birth, so I felt very privileged to have gained entry into their private worlds. Some of the interviews were conducted at the clinic as that is where the women felt most comfortable.

One of the informants asked her boyfriend to join us while I was recording the interview. I wasn't sure whether this was the right way to go, but in the interests of the project, my acceptance at the clinic and limited access to the women, I continued. The effect that Tim's presence had on the interview was that at times I thought the responses to my questions may have been influenced by his presence. For example, Kay would look at Tim before she answered, as if she was looking for his acceptance. I did not have access to this informant again, so I do not know if that effect was valid. One other informant, who I was interviewing at her home, actually stopped talking if her husband came near the room, and we did have breaks for the arrival home of her children from pre-school. Thus the 'space dimension' was a definite influence on the research process. The time/space dimension also manifested itself in the fact that some of the women had other babies and toddlers which made the informants' time for me precious because of their commitments to their children (Green, 1991).

Participants

Six women participated in this study and are introduced below.

Joan is a 28 year old Aboriginal woman who is expecting her third child. Joan's first two children were born in a country town in N.S.W., in the area of Joan's childhood, where her parents still live. Joan now lives in Western Sydney with her children and the father of this baby, and is attending the antenatal clinic at the medical service as a result of attending the clinic at the local public hospital, where she was advised that she could attend the A.M.S. antenatal clinic. Joan then saw the Aboriginal health worker who happened to be at the hospital, thus the
arrangements were made for Joan's attendance at the A.M.S. antenatal clinic. Joan has a very bright and positive personality and appears to look on the bright side of life, taking everything in her stride.

Kay is a 20 year old Aboriginal woman who, with Mark, the father of the baby, is looking forward to the birth of her first baby. Kay is part of a large family and lives in Western Sydney where she has lived all of her life. Kay's parents came from the country but have raised their family in Sydney. After leaving school Kay did a retailing course and has worked as a shop assistant. Kay is attending the A.M.S. clinic on the recommendation of her sister who has attended the clinic herself. For Kay the life that her baby has is very important, she wants to ensure that the baby has everything needed, and is healthy. After the birth, the family will move south, so that Mark can take up the offer of a job playing football.

Sue is a 17 year old woman expecting her first baby, and lives in Western Sydney, at home with her parents and boyfriend. Originally from the country, the family has lived locally for all of Sue's life. Sue left school in Year 9 and has worked in sales jobs before going to Queensland to "...get away from (Suburb S) for a little while." Sue is attending the A.M.S. clinic on the advice of her mother. Sue hopes that the baby is a girl and is healthy.

Dianne is a 33 year old married woman who has three children, the last child is newborn. Dianne lived her early childhood in an inter-state city then moved to the country for a number of years before settling in Sydney. Dianne attended secretarial college after school and worked in the secretarial field until she had her first child and since then she has looked after her children full-time. Dianne said she wasn't going to have any more children, but is so enraputured with her new baby girl that she is thinking of having another baby.

Jenny is the mother of three boys, all of whom were born at the local hospital, and who grew up in and now lives in Western Sydney. Jenny is originally from a country area, interstate, left school at 15 years and has had some interesting work in her life. Included in her work history are dressmaking and tailoring, caring
for children in pre-schools and refuges, and being a health worker in the
community. She told me:

    I got involved in the medical centre at (suburb) at antenatal which I
love. Absolutely loved. I was involved at (hospital), we go out visit
women, take them into hospital, was in hospital with their deliveries
which was beautiful you know. I think it's an experience not being the
mother having a baby just being there supporting her you know which
was really good. Um, then I, we'd see them afterwards with the early
release program and um just visit them regularly then you'd see them
growing up.'

    Jenny seems to be a very warm and caring person, very involved with her
immediate family including sisters, their husbands and nieces and nephews, and is
interested in helping people as much as she can.

    Liz is a 22 year old Aboriginal woman who is the mother of two children and
expecting another. Liz had her first baby in hospital, her second at home and is
planning for the third to be born at home. She is attending the clinic at the A.M.S.
for the present. Liz was born in the country and has lived most of her life in
Western Sydney, attended school until year 11 and has since studied at TAFE and
University for a short while as well as working in various jobs. Liz is very interested
in her heritage, likes things to be as natural as possible, and enjoys the support of
her immediate family as well as parents, sisters and in-laws.

Participant protection

    This project was approved by the Human Ethics Review Committee of UWS
Nepean in November 1992. The ethics application was guided using the UWS,
Nepean Application For Ethics Clearance For Research Procedures Involving
Humans and the Guidelines on Ethical Matters in Aboriginal and
Torres Strait Islander Health Research (National Health and Medical Research Council (NH&MRC, 1991).

The ethical guidelines for working with Aboriginal and Torres Strait Islanders were developed because of the acknowledgment that research involving these groups of people requires an extra sensitivity in addition to the normal requirements covering human experimentation (NH&MRC, 1991).

Historically, research had often been carried out with Aboriginal and Torres Strait Islanders in an insensitive way, with an emphasis on the interest to science and white Australians, without concern for cultural responsibilities, and with lesser standards for the obtaining of consent, subsequently leading to exploitation (NH&MRC, 1991).

All of the informants in this project were volunteers whom I had approached personally at the antenatal clinic at the A.M.S. Initially I told the women about the project and provided them with a written information sheet (Appendix 2) which they read and then took home. On this sheet were my contact telephone numbers and the women were asked to read the information sheet (they could all read), and contact me if they had any questions about the project. Some of the women I approached in this way decided on the spot not to participate, and some women took the information and then decided not to participate. I respected their wishes and interviewed the women who were definitely willing, and who then signed a written consent form, of which they retained a copy and I retained a copy (Appendix 3).

In the Application for Ethics Clearance for Research Procedures Involving Humans for UWS Nepean, I have stated the following :-

- the data will be stored in locked cabinets in my office,
- the names of the informants will be changed to protect their privacy,
- access will be limited to my supervisory panel for the Masters degree and myself,
identifying data will be destroyed at the end of two years after the date of the report,

the original data will be kept by the researcher until an appropriate institution can be found in which to store the material, eg Australian Institute of Aboriginal Studies, State Archives of N.S.W. or an appropriate regional Aboriginal body,

access to the material will be limited to those people who have a valid research interest.

In order to protect my informants' interests, I have maintained confidentiality at every step of the research. The interviews have been conducted in a private room and the tapes have only been in my possession and that of the transcription typist who has understood and maintained confidentiality at all times. The informants' names have been changed during the coding process so that in any written reports the real names will not appear. During my time at the clinic, the informants or their information have not been discussed with anyone, prior to the informants entering the research, an information sheet has been provided which addresses the issue of confidentiality (Appendix 2).

The location

Interviews were conducted at private homes and at the Daruk A.M.S. at Mt. Druitt in Western Sydney. At the A.M.S. premises, the antenatal/postnatal clinic is conducted in a large room separate from the general waiting room. This room has a waiting area with lounges, coffee-making facilities television, video and library, and is where the Aboriginal health workers and midwives interview clients, do basic screening, and generally talk to the mothers and their other children. It is also the area where education sessions would be held. Consultations with doctors are held in consulting rooms which are separate to the large room. The interviews that were conducted at the clinic were held in a small, adjacent, private counselling room.
which was satisfactory for recording the interviews and for focussing on the issue at hand.

The interviews in private houses were conducted there at the request of the participating mothers and were often interrupted by their other children. However, the recordings were obtained and the transcripts were just a little more difficult because of the background noise and interruptions. I felt that it was important to accommodate the wishes of the women so that they were more comfortable for the interviews.

Every fortnight, a team of doctors and midwives from Nepean Hospital attend the A.M.S. clinic as an outreach service from the hospital. The women are seen by this team fortnightly, and on the other week are seen by the doctors, midwife and health worker from the A.M.S. The atmosphere between the two teams and the clients seemed to be friendly and co-operative. It seemed to me that the staff from the A.M.S. preferred to refer the women to Nepean Hospital rather than Blacktown Hospital which was the other local public maternity unit, probably because of the relationship of the outreach team from Nepean Hospital and the A.M.S.

Data collection processes and techniques

The process of gaining access to these women has been a long and arduous one, during which my patience has been tested. At times I believed that the outcome would be negative, meaning that I would not gain access to the population of Aboriginal women. I began the process by discussing the proposed research with some Aboriginal women from the local community, with whom I had worked before and established a good basic working relationship. They introduced me to an Aboriginal health worker who listened to my story and felt that this was a feasible and worthwhile study, and who also became interested in the study. Throughout the process of gaining access to the site and the participants, I have made it clear
that in addition to my own professional interest, this study is to lead to an academic
award for me and so everyone who I have had contact with is aware of that fact.
Much time elapsed at this point as I conducted the literature review and completed
other work. During this time however I was skirting around the outside of the urban
Aboriginal community, having the opportunity to meet one or two professional
people and elders, through a Public Health Conference in Alice Springs, and
through the opening of an Aboriginal Education Centre. I tentatively raised the idea
of my research with these people who understood the idea and the purpose of the
study and didn’t reject the idea, even though I am not Aboriginal.

The next step came with the presentation of my research proposal at a
university colloquium, where I came up against a lot of opposition because of my
non-Aboriginal background. This opposition nearly defeated me but I believed that I
had been building a trusting relationship with some Aboriginal people, I had never
pretended to be of Aboriginal descent, and would take that fact into account when
reporting the study. I had broached the subject of my non-Aboriginal background
with my Aboriginal contacts, who felt that in the context of where I was doing my
research, my relationship with them and my professional background, it would not
be a major problem. As I had lived and worked in the local area for many years and
anticipate continuing to do so, I believe that I was more acceptable to the local
community than maybe someone who would just be there for the period of the
research. I had built up a friendly relationship with my contacts, as evidenced by
one lady saying that I was just like her sister.

Gaining ethical clearance from the University became the next step as the
Ethics Committee would take notice of the advice of appropriate Aboriginal people
where the committee thought it was necessary. In order to gain this clearance I
familiarised myself with the Guidelines on Ethical Matters in Aboriginal and Torres
Strait Islander Health Research (NH & MRC, 1991). Having gained ethical approval
from the university, I took that as a positive sign and continued.
Throughout this time I was trying to make contact with the midwife who worked in the antenatal clinic at the medical service to talk over the project but was unable to meet with her at the time. Acting on the advice of my contacts, I wrote to the administrator of the medical service, outlining my research project and asking the permission of the board to conduct the project. I also asked for a meeting with the administrator in order to familiarise him further with my research. At the same time, I was invited to present my research at an Inter agency meeting at which all of the local Aboriginal community groups come together (Appendix 4). I was given ten minutes to present and the project was accepted overwhelmingly by the women attending that day. In fact, I had to excuse myself as some of the women started telling their stories in the meeting and the Chairman had to intervene. There were some elders from the local community present at that meeting which was, I believe, crucial to the approval of this project.

I gained the approval of the Board of the A.M.S., and was directed to work with the Aboriginal health worker and the midwife at the antenatal clinic.

Now that I had gained access to the site, I had to be accepted by these professionals, in particular the Aboriginal health worker as she was my entry into the clinic and gate-keeper to any participants. I met with her to familiarise her with the project, about which she was sceptical, as she thought that the women would be too shy to talk with me. I also felt that as I was an outsider (from the clinic) the staff probably thought that I shouldn't be doing the project. However, my relationship with the staff warmed as the weeks went by and I believe that any problems with communication never eventuated. I also think that the non-Aboriginal midwife wondered why I was the one doing the project, rather than herself. I took a very low profile when attending the clinic, trying not to intrude on any of the relationships that exist between health professional and client.

I attended the antenatal clinics which are conducted every Tuesday and Friday for five months. The mothers are usually picked up by car from home and so have a fairly long waiting period before they see the doctor. It was during this time
that I spoke to the mothers about my project, on an individual basis, as well as
engaging in the everyday conversation which was enjoyable for me as well as
building a trusting relationship with the women attending the clinic. Leininger (1985,
cited in Habermann-Little, 1991) states that once trust has been established with
informants, then the data will be more meaningful. Initially, the Aboriginal Health
Worker was introducing me to the women but as my confidence grew and I settled
in to the clinic I approached the women myself.

The women who identified themselves as being Aboriginal (some non-
Aboriginal women attend the clinic) were asked to participate in the project. They
were given an information sheet which told them about the project in writing (in
addition to my verbal introduction) and a copy of the consent form, both of these
forms were to be taken home to read and consider. The sample of six represent
those who volunteered to join the project and who made themselves available to be
interviewed. Apart from some women who never turned up to be interviewed, or
who changed their minds and decided not to be interviewed it was a very quiet time
at the clinic, with only a small number of mothers attending, so I had difficulty
increasing my sample. All of the women who participated in the project signed a
consent form of which I have retained a copy and the women have a copy.

In order to increase the number of women participating in the project I tried
snowball sampling as described by Minichiello et al. (1990). Using the informants
that I had contact with, as well as the Aboriginal health worker at the clinic, I tried to
gain access to other women who were friends or acquaintances and who fitted the
criteria. I was referred to the Aboriginal liaison officer at another local public
hospital who tried to help me but the contacts did not eventuate. I really needed
more time in the field, say another twelve months at least if I was to be able to
contact these other women. I think that a crucial point in gaining access to and the
trust of the women in my study was the intermediary i.e. the A.M.S.
I believe that this is the point where I may have come up against the fact that I am not an Aboriginal person as I have asked all of the Aboriginal people I know for contacts who may become part of my study, but to no avail.

**Data analysis**

Initially I intended to use a computer program to aid data analysis, but when I started to learn the program I did not feel comfortable using it, especially having to face the computer screen over a long period of time. I wanted to feel the stories of the women through the handling of the transcribed interviews, by reading out them over and over and by listening to the tapes. I photocopied multiple copies of the transcripts and kept a master copy filed away. Then I read each transcript, made reference notes on the transcripts and cut the copy according to the reference notes, which eventually formed the themes. As some of the topic crossed into each other, the multiple copies came in handy. This procedure helped me gather and order the data and also provided the advantage of being able to place data into more than one area. As I only had six interviews, through this process I became very familiar with the data and the context from where it emerged.

This process of data analysis encouraged me to immerse myself in the data, and revisited the interviews often, allowing for times of reflection which led to new insights when reading the data. The process of being able to step back from the data and reflect on it gave me time to consider the meaning and make my personal interpretation of the meaning. Time can also change the meaning (Riley, 1990) and discussions with my supervisors often led to clarification.
Leaving the field

My leaving of the research field has been a slow and gradual process. I was attending the antenatal clinic twice a week so I was keeping in contact with my informants through that attendance. As the bank of possible informants was drying up, and as I was trying to snowball sample, it was quite apparent to the women that the end of my visits was nigh. I was trying everything possible to increase the sample, and when appointments were not kept by possible informants, and no new women were attending the clinic I retreated to documenting the research. I had promised to send the article, *Borning: Pmere Laltyeke Anwerne Ampe Mpwaretyeke. Congress Alukura by the Grandmother's Law* to some of the women, which I did belatedly and I have written to all of the informants thanking them for their participation and with a summary of the research. The article is the benchmark publication about borning and the traditional ways and is written by Aboriginal women, and would be of interest to the women who wanted to increase their knowledge in the area. I also intend to produce a report for the Board of the A.M.S., regarding the outcomes of the research. I have been in contact with some of the informants and I expect to have further contact in the future.

The role of the researcher

Potential biases

During the data collection stage of this project, I attended an A.M.S. Antenatal Clinic every Tuesday and Friday. As a qualitative researcher I took note of the possible effect of "researcher bias on the site" as described by Miles and Huberman (1984, p. 233), where "the researcher disrupts or threatens ongoing social and institutional relationships" (p. 233) leading to informants possibly taking on another persona, presenting what they think the researcher may like to hear or even boycotting the study. Miles and Huberman (1984) describe three types of bias and
how to avoid them. I shall discuss each in turn before explaining how it was avoided in this study.

(1) "holistic fallacy: interpreting events as more patterned and congruent than they really are..." (p. 230). This can be avoided by spending as much time as you can in the field, so that you fit in as much as you can, making sure that the informants know exactly why you are there and what you are doing, and co-opting someone to pay attention to your influence at the site. I spent a period of six months attending the clinic twice a week during which I talked with all of the clients, whether they were in my study or not. Therefore, everyone knew why I was there and I believe that I was well accepted at the clinic.

(2) *elite bias*: overweighting data from articulate, well-informed, usually high-status informants and under representing data from intractable, less articulate, lower-status ones... (p. 230). This can be avoided by making sure that you spread your informants out and include all types of people, taking as seriously the less articulate informants. I included all of the volunteers who wanted to be part of my project.

(3) *going native*: losing one's perspective...being coopted into the perceptions and explanations of local informants" (p. 230). This can be avoided by concentrating on the research questions and not going off on a tangent. It is also important to try to consider why informants would mislead you if you feel that you are misled. Other measures include interviewing some informants away from the site and making sure that you keep your work in perspective. I believe that the amount of time I spent at the clinic gaining the trust of the women guarded against the possibility of being misled, and I was able to conduct some interviews in private homes instead of the clinic.
Avoiding bias

I believe that I have taken account of the possible effects of bias by instituting the following procedures during the data gathering stage. Firstly I took a very low profile, where I sat with the women attending the clinic and engaged in the everyday conversation that occurs during their waiting time, attending all clinic days possible, irrespective of new women attending or appointments for interviews. Because I am a midwife and because most of the women became comfortable with my presence, they frequently directed midwifery questions to me, which at times put me in an awkward situation. In the interests of my continuing relationship with the professionals at the clinic and because I was there as a researcher I always deflected the questions to the professionals even though I could have answered them. It was difficult at times because the natural reaction was to just answer the question which very nearly did at times before I remembered my place as a researcher, and the special relationship between the mothers and the midwives at the clinic.

Secondly, some of the interviews were conducted at private homes when the women felt comfortable about it, thus providing a more congenial social environment. The informants in this study were well informed about the purpose, method and communication of the results, both verbally and in writing, and I believe that I kept the project subordinate to the reasons for the women attending the clinic. I am also aware that in the beginning the Aboriginal Health Worker was sceptical about the research, probably because I was the one doing it, rather than someone from the medical service. I also detected some coolness from the non-Aboriginal midwife in the beginning, but I believe that as time passed both these professionals accepted me more. I believe that was due to the way I conducted myself at the clinic, as a researcher taking a low profile in the context.
Thirdly, during the conduct of this research I thought about my own biases related to birthing, for example the belief that breastfeeding is best for mother and baby and ought to be encouraged, that medical practitioners don't always do the best thing (in the interests of the mother), that midwives may provide a more appropriate service in most cases and that home-birth is not always the perfect answer. I hope that my awareness of these feelings and the time I've spent thinking about them have saved any problems of researcher bias in my interviewing and in my report.

Fourthly, an issue that has always been there for me and for others, for example my supervisors, those present at my colloquium, and maybe the workers at the A.M.S. and the informants, though it has never been voiced to me by the two latter groups, is the fact that I am not Aboriginal. My personal feelings about this are that this research may have been richer if carried out by an Aboriginal researcher who may have been able to interpret meaning differently or more confidently than I. I do not have an Aboriginal heritage and there may be a limitation on this research because of this. However, I see this research as a beginning, which an Aboriginal health worker or midwife may like to pick up and take further in the future, particularly in Western Sydney. I also take comfort from the publication edited by Diane Gosden called *Women's Talk* (1992) in which conversations with Aboriginal women from Redfern, Sydney were recorded. These conversations covered the areas of pregnancy, birth and motherhood and community, and the women involved had attended classes run by Aboriginal and non-Aboriginal health professionals, and were conducted by Diane Gosden from the physiotherapy department of King George V Hospital Sydney. The women in the book seem to be speaking freely and honestly from their own experiences and the record is a rich account of their stories. These conversations provided a base for me from which to structure my interviews.

In taking the role of the researcher, I had to refine my skills as a listener, learning to clarify unclear responses from the informants and making sure that there
was flexibility available to explore issues which came up from time to time, such as the treatment that Dianne received in hospital and which she was not happy about. Since I was trying to understand the experience of the informants in a rich and meaningful way I had to remain open and be an effective listener (Habermann-Little, 1991).

As a non-Aboriginal person brought up in the context of an Australian society which historically and collectively has not held Aboriginal people and their cultures in high regard, this research project has been a significant journey in my life. As a result of my employment situation and this research project, I have met and worked with Aboriginal people who do not reflect the non-Aboriginal stereotype of Aboriginal people. This project has caused me to wake up and look for myself at the many situations that Aboriginal people find themselves in today, in cities and towns and the homelands across Australia where they live and work, in traditional and non-traditional cultural contexts as well as a mix of both, and with the problems that are common to both Aboriginal and non-Aboriginal Australians today, such as the abuse of alcohol and other drugs and the shortage of paid work. On this journey I have been confronted with racism and prejudice, a feeling of hopelessness for some and, for others, excitement as I see Aboriginal people taking up the challenge of 'going on from here', reclaiming their cultural heritage and addressing the needs of their people, all of the time acknowledging the past but looking to the future. I have seen for myself evidence of the notion that was expressed by Gray et al. (1991) and by Bowden and Bunbury (1991) that the Aboriginal community is gaining strength from within itself:

"Aboriginal people are getting a lot stronger. They're feeling like their own people. They're uniting more. And they're doing a lot to rejuvenate the culture, just bring it to people's eyes", (Bowden & Bunbury, 1991, p. 16).

This journey has encouraged introspection on my behalf, examining my attitudes and beliefs and forming new opinions, while meeting Aboriginal people
from varying backgrounds and forming new friendships. Professionally, this journey has been difficult at times because I have had to deal with 'unfinished business' from my previous employment area and not give up because of it, even though at times, it has been very tempting to leave it. Of course, the whole experience has been positive and exciting in terms of the people I have met, especially the Aboriginal women. Another benefit has been the rewards to my family in terms of creating a positive environment for discussion and participation in Aboriginal culture.

Initial assumptions of the researcher

My assumptions when this study began arose from life experience, my experience as a midwife and from the impact that tertiary education has had on my life as a mature age student. In New South Wales, as in other parts of the world, women have been questioning the medicalisation of childbirth for many years, but in particular, in the 1970's, 1980's and continuing in the 1990's. My experience as a midwife has been mainly in a small district hospital with a maternity unit of 14 beds. This unit was targeted by the various groups concerned with changing childbirth practice in the 1980's, and, along with changing midwife attitudes of the time and the heavy push of community groups, nursing care of the women in the unit became very progressive, and women began to reclaim their own role in the birth of their child. I exclude medical care here, as my personal belief is that not much changed in the medical care of the clients (in this unit). My practical experience therefore, combined with my reading of the literature related to this changing midwifery practice over a long period of time, led me to believe that most women are becoming aware of the issues about natural childbirth and are therefore thinking about their choices involving labour, baby feeding practice and postnatal care. The topic of natural childbirth has received an airing in the popular press over the years as well as on television, especially when something goes wrong with

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homebirth. I therefore believed that all women, including urban Aboriginal women, were becoming more informed about birth choices.

Another assumption that I had related to Aboriginality. The year I began my study (1993) was the Year of Indigenous People and, along with the Federal Governments' belief in Reconciliation, the issues involved in being an Aboriginal person in today's society were at the forefront of awareness in Australian society. In that year, the popular press took up the issue and readers were again confronted with the history and present status of Aboriginal people. I assumed therefore that Aboriginal women gave additional thought to their Aboriginality, particularly in relation to birth and cultural practices.

The third assumption that I had was that the A.M.S. was providing a culturally sensitive, acceptable and accessible primary health care service to Aboriginal women residing in Western Sydney. In addition, I assumed that the service provided would have a particular emphasis on the areas identified as of particular concern in maternal and child health of Aboriginal people today, i.e. adequate and comprehensive antenatal care, postnatal support and education, information and encouragement with breastfeeding.

The report of my findings which follows shows how some of these assumptions were challenged during the period I conducted the research. In the next three chapters I present the stories of the women and my analysis of those stories in relation to what it meant to be Aboriginal and their experiences during pregnancy, childbirth and breastfeeding.

A bookmark with relevant details of each participant is provided to act as an aide-memoire for the reader.
CHAPTER FOUR: BEING ABORIGINAL

'It took a long time to get over that thing of black not being the colour of your skin'

(Bowden and Bunbury, Eds. 1990, p10)

In the pursuit of providing culturally appropriate services to Aboriginal women, it is important to understand what it means to be Aboriginal, the family support system, the effects of racism and the sources of Aboriginal cultural information (and lack thereof) for these Aboriginal women.

The women in this study are now based in a highly urbanised area of Sydney, having either been born and brought up in urban or country communities. Those who were brought up in the country have moved around, at different times, between country towns and the city. This also is true to a greater extent of their parents' generation, however, during the interviews the informants often were hazy about where the families originated. The women also came from families of mixed backgrounds, with Aboriginal and non-Aboriginal parents and grandparents. Interestingly the women themselves have also chosen partners of mixed backgrounds, Aboriginal, non-Aboriginal and European. As a consequence of the broad background of the group the individual experiences vary.
Pride

I want to say that I feel I'm regaining my Aboriginality. To me at the moment it means that I know where I'm from, I know who my people are, I'm starting to know who all my relations are and to meet them and get to know them as my aunts and uncles and cousins and my grandfather.

(Bowden and Bunbury, Eds. 1990, p16)

All the women knew of their Aboriginality and they all, without any prompt, stated their pride in being Aboriginal. Ways that the women expressed their Aboriginality include knowing that they were Aboriginal despite the presence of a white lifestyle:

LIZ: I always knew I was an Aboriginal person, yeah...my mother and my grandmother were mostly brought up in a white society.

JENNY: I was born into it.

The description of colour was another way the women described Aboriginality, as did some of the Aboriginal Australians in the book Being Aboriginal (Bowden and Bunbury, 1990). In the book, light colour is mentioned as the way that non-Aboriginal people discount Aboriginality. In other words, if you are not black-skinned then you are not Aboriginal. Maybe because of their experience in urban settings, and living in a non-traditional way, the women are expressing other people's thoughts about Aboriginality.

DIANNE: I've got Aboriginal in me but I'm also white.
KAY: It's good to be Aboriginal. I like it...I like being Aboriginal. I like my colour.

JOAN: I've never been white so I wouldn't know what it is like.

Sue talks about being Aboriginal as being brought up like "any other normal person" and Joan "doesn't see any difference really" with most of her friends being white. Having always known that she was Aboriginal means that she doesn't know what it means to be white. These women are experiencing a 'white lifestyle', and don't seem to be struggling between the two worlds, taking what they need from both. Dianne states that "the only Aboriginal to come out of me is since I've been with Paul". With Paul's encouragement, Dianne is making the effort to find out more about her heritage and together they will try to instil the values of both parents into the children.

The pride in being Aboriginal was really evidenced by the words of Jenny and Dianne who say:

JENNY: I was brought up to be an Aboriginal person and it means that I'm proud of what I am and I feel honoured that I can pass onto my children that they're Aboriginal and they should be proud that they're Aboriginal...and yes I'm proud of what I am.

DIANNE: I think it's special and I think it's something to be proud of. I don't think it's anything to be ashamed of...you've got a background, there's a history with being Aboriginal...it's good to be brought up to be proud of it.
We didn't have any history according to the white man. We're one of the poor old races that didn't have anything in writing so it's only hearsay. If you put it in writing it's history (Bowden and Bunbury, 1990, p18).

Dianne talks about the history associated with being Aboriginal as important and Joan also links her pride in being Aboriginal with the importance of being able to pass the heritage on through her children:

**JOAN:** Well, I'm proud of it. My kids are really proud of it...I don't see any differences really. Most of my friends are white...my hubby's white so I don't see any problems with it...I've never been white so I wouldn't know what it's like.

**SUE:** I always knew I was Aboriginal, like brought up like any other normal person. We've just got Aboriginal in you.

The pride that the women speak of indicates that they know within themselves what it means to be Aboriginal, even though they all have experienced life in a 'white way' with their present lifestyle and that of their forbears. They are intent on passing this pride on to their children, and ensuring that the children gain the benefits of being Aboriginal. The passage of the pride to the children is important to the mothers as most of them had an interrupted history from their own mothers who, in some instances, took the path of the white way for the sake of their white husbands, and who now have lost part of their cultural heritage:

**DIANNE:** My mother sort of grew up to more or less do what my father wanted.
LIZ: My mother and grandmother were mostly brought up in a white society except when they were younger like Mum was living in the bush when she was younger and then she knew how to speak the lingo.

The pride in being Aboriginal is echoed in *Being Aboriginal*,

As an Aboriginal person it will give me something to identify myself by to know that I do have a family. When I’m with other fellow Aboriginals I feel a certain bond, a certain magic. I feel like I’m part of their family. It’s a wonderful feeling, actually: a feeling of joy, a feeling of pride. (Bowden and Bunbury, 1990, p17).

**The effects of racism**

This pride in being Aboriginal also surfaces as a result of racism, as Jenny almost unconsciously points out:

JENNY: I was brought up to be an Aboriginal person and it means that I’m proud of what I am and I feel honoured that I can pass that on to my children; that they’re Aboriginal and they should be proud that they’re Aboriginal.

I think there’s so much racism around. It’s not heard of as much as when I was young, but it’s because it’s more out in the open now. But there is still racism there, and yes, I’m proud of what I am.

Jenny is making the link between the existence of racism against her people, her own pride in her heritage and her desire to protect her children from such racism by
instilling a similar pride in them. This highlights the importance of culturally specific care for Aboriginal people in the perinatal period.

As a practising midwife for many years, I was aware that there was information available about cultural mores for many other minority groups in Australia, as well as the existence of interpreters for people who required that assistance. Historically, Aboriginal women have not been catered for in mainstream health services around the period of childbirth, either by the provision of Aboriginal Liaison Officers, Aboriginal health workers or support people, interpreters or even culturally appropriate information. This situation is changing slowly, but after the improvements for people from a non-English speaking background. Liz and Joan have both experienced what they describe as prejudice or racism.

LIZ: That's always the way you know people are more sympathetic towards ...migrants than they are towards Aboriginals.

JOAN: Well in (town) there's a certain bit of prejudice...my son's Dad (grandfather) was really prejudiced...I was never allowed in the house when he was there...Just that in my street the neighbours some of them are.

Joan found and experienced prejudice in her home town, but says that she never encountered any prejudice from the nursing staff at the country hospital where she had her first two babies. Joan also says laughingly that she is not prejudiced herself as the fathers of her children are not Aboriginal! Even though Joan did not complete the statement about her neighbours, I think she was meaning that some neighbours looked down upon her.
JENNY: I think there's so much racism around. It's not heard of as much as when I was young but it's because it's more out in the open now but there is still racism there...I got called heaps of names.

Jenny has suffered for being an Aboriginal person, especially at high school where she says "that's when you more or less find out what you are from what you get called at school". Being a sportsperson helped Jenny's acceptance because she was representing the school.

Liz recounted the story of another women's experience at Hospital B.

LIZ: I don't know if it was to do with the baby but she was in and they didn't like all the relatives going up there and they said something about she's got to be kept clean 'cause of school sores...they reckon there was too many people going there. She just had a few things said you know? A few women have had trouble you know especially at Hospital B like you know sort of prejudice.

Dianne' experiences at Hospital A have her believing that she was discriminated against because of her Aboriginality.

DIANNE: Yes I do (believe that my Aboriginality had bearing on the situation) because I was in the bed and the doctor came to see a lady right next to me and he went down the hall...the doctor said he'd come back and he never came...they never rang up Aboriginal Medical Service to (tell them of my admission) and (midwife) had actually been in that ward that day, they never bothered to tell her...Well I just think that if the doctor is going to see a white person, that they should go.
Sounds terrible but I really mean it. I'm a little bit angry that I get treated like that.

Because Dianne has been attending the Aboriginal Medical Service she believes that the Aboriginal Medical Service should have been notified of her admission which, according the Aboriginal Health Worker, is the usual protocol. Dianne indicated that she believes her Aboriginality was a definite factor in what she believes was a discriminatory episode during her hospitalisation.

Dianne is also concerned because her husband and mother both believe that the children are going to have a hard time at school. Dianne herself believes that by bringing the children up to be proud of their Aboriginality they can "hold their heads high and say I'm OK".

Dianne's recent experience in the hospital has left her angry but with a firmer resolve to instil that pride of heritage in her children so that they will be able to stand up for themselves. Education for health professionals will go part of the way to address these problems, but if Dianne had been able to express her concerns, that would have raised the awareness of the staff at the time. Now, Dianne will be entering the same hospital for confinement, bringing that unresolved past experience with her. I hope that in recounting the experience to me during the interview (unrecorded section by request) Dianne was left feeling a little better.

Support Systems.

In Aboriginal and Islander families kinship networks and family structure are very important. It is almost unknown to have a nuclear family (Smallwood, 1991, p18).
Aboriginal societies have traditionally had a wider sense of family than Anglo-Australian society, with many more people defined as mothers, fathers, sisters and brothers etc. This kinship system governed most aspects of life, social interactions, economic, religious, judicial and cultural functions (Gray, Trompf and Houston cited in Reid and Trompf 1991). Langton (cited in Reid and Trompf 1991) found that amongst urban Aboriginal people some cultural practices and behaviours still exist, such as "methods of conflict resolution, funerary rites and matrifocality" (p99). Matrifocality is attributed to the "...woman focused family, in that mother, grandmother, aunts and other female relations provide a cultural core, remembering and passing on to their children the knowledge that provides them with an identity in a crowded, impersonal urban environment" (Langton cited in Reid and Trompf 1991). These kinship networks through the family can offer support, both emotional and economic, be a buffer between the family and the wider community in times of trouble and provide a sense of belonging where "Belonging is a pleasure and often a matter of defiant pride" (Langton cited in Reid and Trompf 1991).

The important people and the roles they play in the lives of the informants were described, for example, by Liz:

**LIZ:** My mother and my grandparents, sisters and brothers and cousins and aunties...mainly my family...all my relations. My mother's everything to me you know. She's the person I go to if I want advice 'cause I think she's led a pretty good life you know. She's learnt a lot you know and I've learnt a lot from her. I think she's a really good mother.

Liz nominates the members of her family as the important people in her life, especially her mother, who is her main support. Liz hasn't mentioned her husband here, only her family.
JENNY: Well it would have to be my family at the moment. They're a big important part in my life, my husband and my children and then my family itself which are my parents and sisters and cousins they're a really big part in our lives because we're very very close...On my husband's side he's an only child...so he feels really good walking into a big extended family. He feels really warm and good about it.

Jenny nominates her immediate family and then her extended family and believes that the family are very close and they make a point of seeing each other every weekend.

DIANNE: Dad was very close...He died about three years ago...I looked up at him. I suppose my mother...she rings up every week and everything...but I'm independent.

Dianne believes that her Dad was the most important person in her life, then her mother who Dianne has some difficulty with.

JOAN: My Dad. My Dad's the real Poppy type. He loves his grandchildren...he's the clucky grandfather. He wants his grandchildren around him all the time and my baby, the boy that's coming he's going to have my Dad's middle name so I think my Dad will spoil this one and he's the most important person in my life I think...and my kids they play a big part. Yeah, even though he's white, still my Dad.

Joan has nominated her Dad and qualified that with "even though he's white". Joan says her mother seems to disassociate somewhat from her and the grandchildren "she's lived her life", and they are not close.
Other women responded to my question about support as follows:

KAY: My parents and (partner).

SUE: Me Mum and Dad and (partner) now. They're always there like for me. They try and do anything for me.

The informants' fathers seem to have had a large influence in the lives of their daughters and so are nominated as the most important person and support. Jenny and Liz talk about their large extended families and the support that they offer and there is evidence of matrifocality in these families. The partners of these Aboriginal women do not seem to be the source of support, and therefore differ from the partners one generally expects to find among whites in Australian society today.

Although I have not explored child-rearing practices, a question is in my mind about the future support of the young mothers with their children given the lack of knowledge that is apparent in these interviews. With families being in the country or inter-state, when times get tough, who will be there for them, on the spot? One answer could be the Aboriginal Medical Service staff, in their own time, but there is an opportunity here for a culturally appropriate back-up service to be provided in collaboration with the Aboriginal community.

**Traditional Cultural Practices.**

Birthing and borning is a cultural process, at the heart of a culture, which has far-reaching consequences for the life of a society. Irrespective of the secret nature of some ceremonial matters in Aboriginal women's business, birthing and borning is a sacred process that must be considered with great care (Central Australian Aboriginal Congress, 1987 cited in Carter et al, 1987, p.7).
Carter et al (1987) found in their research in Central Australia, that Aboriginal people recognise and accept that today's obstetric care involves both the western way and traditional way, but that while they have had to accept the western way because of a lack of options and their own ignorance, western practitioners have not accepted any of the traditional ways. In parts of Australia, Aboriginal women are forced into leaving their communities, with all the problems that that brings, and going to the hospital to confine, thus placing many of these women into an alien environment. Because of the state of health of Aboriginal mothers and babies, this has been seen as necessary to protect the mother and baby during the birth process (and ante-natally for those with complications.). Little attention has been paid to alternatives, including the traditional cultural practices of Aboriginal women, until the research by Carter et al (1987). This Birthrights Research has led to a breakthrough in that Aboriginal women have been asked about their preferences in childbirth practices and are now involved in a 'self-help health care initiative' which should have a positive influence on maternal health and the high perinatal mortality rate (Carter et al 1987).

Some of the aims of the Congress Birthrights Research Program are that:-

- Aboriginal women will be able to have babies the Aboriginal way alongside the western way.

- Aboriginal women will be able to learn and know more about the Grandmother Alukara (sic) Law and the western way.

- Aboriginal women will no longer feel shamed about having babies. (Carter et al 1987 p2)

The knowledge about traditional cultural practices to do with having babies varied from not knowing anything about it to being interested. Here is how the informants
responded to the question of their knowledge about traditional cultural practices related to the birth:

**JOAN:** I wouldn't know anything about it. I haven't really thought about it actually...Just as long as I, I really hope my hubby's there because I want someone.

**KAY:** No. I don't know the traditional ways.

**SUE:** No.

Neither Joan, Kay or Sue knew about any traditional ways to do with birthing and the question provoked closed responses from them all. Moving along from that question I tried to find out if the question about traditional cultural practices would spur them on to asking female relatives what they knew about these practices. Kay responded that she may get around to talking to her Mum or Aunties later on. Sue thought that an Aunty of hers might know something about it because "she's right into it...she's got a lot of books...she talks about it to the school kids and what it's about and what it's like and...like Abstudy and all that sort of stuff". Sue wasn't sure if the talks her Aunty did at school included culture related to birth and motherhood.

Dianne showed an interest in traditional cultural practices, especially after she had her last baby.

**DIANNE:** Yeah, I've talked to (midwife ) about it...Especially after my birth she started talking about it, unreal! She's telling the other midwives ...at the hospital about it so I'm probably try to get my mind on...I was really interested in what she was saying...A lot of culture's been lost...unless you live in the Northern Territory a lot of it's just lost.
The midwife at the Aboriginal Medical Service had spoken to Dianne on a couple of occasions about traditional cultural practices and was delving further into the subject. Dianne was looking forward to finding out more about the practices herself and mentioned her experience in New Zealand where she noted that the Maori people had 'kept up with their traditions.'

Jenny had not thought about traditional practices when she had her babies.

**JENNY:** No, I didn't think none of it when I was... not until I got actually involved in working in the ante-natal after I'd had it... I would have liked to have visited an Aboriginal place up north to actually see what they actually do with their birthing because the women actually go out and have the babies you know with other women and that there... It is women's business, that's what you get told yeah it is women's business not men's.

Jenny had some information about traditional cultural practices from her work situation with Aboriginal people but hadn't been able to incorporate them into her own birthing experiences. However, Jenny was preparing for a traditional Aboriginal christening for her youngest son.

**JENNY:** My son could get christened the normal way but I thought no I'd like to do it the Aboriginal way... I'm going to have a fire on that day... (the fire) purifies I mean you walk through the fire and it purifies your body.

Jenny laments the loss of her cultural heritage.
JENNY: I mean you don't know about your cultural ways just growing up and learning it 'cause you missed out on it when you were young and I think it would be interesting in letting the young women today having a baby... I feel that if they were interested... it would be good if it was there for them to know about...they could expand...a big supporting centre more you know like for women having their babies like they just don't know what to do...That's where the woman Liaison officer could come in handy getting with (clinic) and working together to support that woman.

According to Jenny part of the solution to the loss of Aboriginal culture related to birth could be the provision of an Aboriginal Liaison Officer, who would work between the clinic and the hospital. She also mentions a supporting centre for Aboriginal mothers having babies where they would learn about pregnancy, birthing and motherhood. This centre, in my opinion, could support the initiatives of the Aboriginal Health Strategy (1989), particularly education and an increased rate of breastfeeding among Aboriginal mothers. This initiative would also provide the support that I have mentioned previously, for after the birth.

Liz has made some investigation into traditional cultural practices in relation to birth, partly as a result of her sister doing a child care course, during which she participated in a visit to a birthing cave. Liz described the cave that her sister visited as 'really lovely like there was water running through it. There was a nice grassy patch in there...really nice.' Liz has also talked to the midwife about traditional birthing practices.

LIZ: If I had my way you know if I had traditional, if my grandmother like done it traditionally I would have liked to you know done it like that. If she would have been able to...hand that down or something. I think
my grandmother was brought up by a white family cause her mother
died when she was young...it would be good if there was some
Aboriginal midwives around....I don't like having men doctors.

Even though traditional Aboriginal life seems to be far away from Liz's
experience, she identifies with some of the cultural mores reported in the literature
such as not having male attendants, her preference for an Aboriginal midwife and has
knowledge about the "smoking" rituals in Aboriginal life. Liz indicates to me that she
will be continuing her search for Aboriginal culture in the future.

My research into the women's knowledge of traditional cultural practices related
to birth has led to the conclusions that the women in this study do not generally have
knowledge of their culture in relation to birth, and sometimes do not know where they
can get that information within the family. However, the interest about traditional
cultural practices is there, and once these women identify the appropriate source,
attain the knowledge and sort it out in their own lives they will be a rich resource for the
clinic and the women attending the clinic in the future. This evidence of a lack of
knowledge about traditional cultural practices also reflects the deculturalisation of
urban Aboriginal people.

Sources of information.

The informants have had mixed experiences with their ability to obtain
information while in hospital, with Jenny, Liz and Joan being happy with their access to
information and Dianne having a negative experience with her last hospitalisation
which led to her taking extreme measures. The two primigravidas believed that they
would be able to access their required information by asking at the time:
JOAN: Just ask the nurse. They check on you anyway if there was anything that you needed or anything...you just ask if you needed anything and they'd get it for you. It was good.

Joan is happy about asking for anything that she wants as her past experience with nurses in hospital has been good. This is interesting as with her last two children, she has had problems breastfeeding, ultimately giving up, and says herself that she was 'silly' in not seeking out help. Joan is happy to put herself in the hands of the health professionals, accepting that they will do the right thing by her, and thus not considering what her own role could be. Joans' comfortableness with the status quo might go with how I describe her happy and positive nature and her preparedness to ask questions also comes from previous experience with nurses. This contrasts with Kay, who is not as confident about asking questions, and says "she feels that she will ask questions if she needs information"", and with Sue, who talks about being "shamed" to ask questions, and says that she wouldn't necessarily be more comfortable asking an Aboriginal person for information.

SUE: I'd ask, feel a bit ashamed asking. If I really want to know I'll ask. But if it's nothing really exciting you know, nothing I really need to know, I won't bother asking.

Sue indicates that she is only going to ask for information that she sees as important, which is a shame as she may miss out on a lot of information. It also means that if the nurses don't pick up on this, they may think she is doing better than she really is. Sue had told me that she wasn't very good at school and I wonder if her reluctance to ask questions is left over from then. Another concern of mine here is that Sue might ask for information from inappropriate people, thus not availing herself of genuinely useful information.
As these women were well advanced in their pregnancies, they were focussing on the baby and the impending birth, and it is usual that they wouldn't necessarily be thinking about what they needed to know after the birth.

Dianne is one of the women who seems to be interested in finding things out and her experience in hospital this last time denied her the opportunity to easily access information. Dianne eventually, during this admission, took things into her own hands, by leaving the hospital and seeking out help from the Aboriginal Medical Service. The information that Dianne and her husband required at the time related to her immediate care, so when that information was not forthcoming, Dianne sought other ways of obtaining it.

**DIANNE:** Then (husband) came in and he said, that was on the Thursday, well are you going to induce her or what you know. Oh no the doctors are very busy you know. We'll try to contact one. An hour later well, no the doctors are still very busy and I just wanted to come home and then I want you to ring (midwife) up and tell her what's going on. So I did...

When Dianne returned to the hospital she asked to see a doctor.

**DIANNE:** ...that night I said well is doctor coming to see me or not. Why do you want to see a doctor for they said to me. Well, my waters are broken. Oh ... it doesn't matter if your waters break because your waters just recycle and so you get new water every day, that's what they said to me. ...it might I don't know so you've got a hole there ....
When Dianne did seek information and services, sometimes she received an inappropriate response which made her angry. Dianne feels that once she contacted the Aboriginal Medical Service she did receive appropriate care from them, which led to her returning to the hospital.

**DIANNE:** ...when I got back to hospital then that I was told that I was going 'cause I did get induced on the Saturday because they couldn't let me go any further.'

As a result of Dianne's inability to access the information she needed, Dianne took the responsibility herself to find another way which was successful and probably influenced the outcome for her and her baby.

**DIANNE:** The only reason why I ended up having (the baby) on the Saturday is because(midwife) got, rang them up, no she wasn't informed. I came home and told her and then she rang up the hospital and said why, what's going on and then she also, then that's why she came and picked me up and got the doctor from the hospital to check me out at Aboriginal Medical Service, which seems a long way round about it if I was an inpatient at the hospital and when she found out she did the swab... I'm a little bit angry that I get treated like that.

Dianne did eventually receive the required information, which was about her immediate health status and that of the baby, and the planned treatment for them both. She had to be extremely resourceful and determined, and put herself out considerably in accessing the information and treatment. As a result she has lost confidence in the hospital and the staff employed there, she herself has become an expert in finding alternate ways to access information. Jenny was happy with the information she received in hospital as was Liz.
Conclusion

In summary, it has been seen that the women in this study have all been raised as Aboriginal people, mainly in urban settings, and are very proud of their heritage. They have experienced racism as children, and as adults, and all intend to instil in their children pride in their Aboriginality, as a defence against that racism. In spite of this, the support systems that these women have are not of the traditional type of Aboriginal families in so far as families being in close geographical proximity, and resemble the nuclear family that is part of our Australian society. In part, that is probably a reason why they do not have knowledge about the cultural traditions associated with pregnancy and birth.

As a midwife, I am concerned that the women have not sought information about the pregnancy, birth and baby, thus denying themselves any choices that they might have as a result of being better informed. The individual ways that each woman might use to gather information are also of concern because once they are in hospital, they will be at the mercy of the competing needs of other women. The short time during which they will have access to health professionals will probably not ensure that someone like Sue, who is not comfortable asking questions, receives adequate information. Therefore, it is important to find out what the experiences of these women have been while they are pregnant, around the time of birth and postnatally so that recommendations can be made which are appropriate. The experiences, as recounted to me, are recorded in the following chapter.
CHAPTER FIVE: EXPERIENCES DURING PREGNANCY AND CHILDBIRTH

Choice of Hospital

Although I have gathered the women's comments about their choice of hospital under this heading, in fact they seem to exercise very little choice. In reality the women in this study do not seem to have actively made an informed choice about which hospital they wish to confine in, it almost seems that there is an expectation from the clinic, that they will choose one local hospital over the other, and unusual if they choose the other. One explanation for this may be that one hospital, Hospital B, has extended its care to the Aboriginal Medical Service and the other Hospital A hasn't. Hospital B at the time of these interviews had appointed an Aboriginal Liaison Officer which the seemingly more popular Hospital B hadn't; however, there was an implication from the health professionals at the clinic that more work needed to be done at Hospital A. There are two public hospitals available to women in the local geographical area, Hospital B and Hospital A. Four of the women were going to Hospital B and one woman was planning a homebirth. One woman had given birth to all three of her children at Hospital B, another had her two children in city hospitals, one woman gave birth to her two other children in a country hospital and one woman had her first baby at another suburban hospital and her second was a homebirth.

In making her choice, Joan has taken the experience of other women into consideration as well as the nurses she has met. Speaking of Hospital B, she says:

JOAN: ...ladies that I've spoken to think it is a good hospital and all the nurses that I've spoken to they've been nice. They think the (sic)
Hospital B’s great, so other Aboriginal mothers that have been there I’ve never heard any complaints.

Kay seems to know that ‘they’ are sensitive to the culture, and she was born at the hospital she is attending.

KAY: ‘cause I was born in Hospital B...so I want my daughter or son to be born up there too...they are sensitive to the culture.

I find this an interesting comment from Kay, as previously, Kay has told me that she doesn’t really know anything about Aboriginal culture. The recommendation from the Aboriginal Medical Service has been accepted by Kay, who I believe, is not in a good position to be discerning, because of her disempowerment due to lack of knowledge.

Sue has based her choice of hospital on the word of the doctor and the midwife at the Aboriginal Medical Service, without question, which is indicative of her lack of knowledge, which renders her unable to make informed decisions.

SUE: The doctor told me about it over there Hospital B...and (midwife) was telling me about it.

Jenny appreciated the convenient location of the hospital, especially when she had her other children to consider.

JENNY: Well we live close to it and it was central and it wasn’t far to travel. Hospital B has become culturally sensitive with Aboriginal women in there and also migrant women too.
Jenny knows, because of her work, about the more positive shift of attitude at Hospital B towards migrant and Aboriginal women. Hospital A has since appointed an Aboriginal Liaison Officer.

These women accepted the word of mouth recommendations from a variety of people, and the regular presence at the clinic of some professionals from Hospital A seems to have swayed these women towards that hospital. The women do not have enough information to be critical about their choice of services, either antenatally, postnatally or for birth. During my interviews with these women and during the time I was at the clinic, I did not witness any critical questioning about how labours might be managed, postnatal care, how the role of families and support people can be accommodated or the care of the baby handled. In some of my interviews, early discharge was mentioned and one informant had actually been visited by the early discharge nurse in readiness for the postnatal period. It is interesting that the most imminent and critical event, the birth itself, was not talked about, yet how early a woman might be discharged was. I can only comment that the health professionals have not considered the needs of the women on an individual basis, and that getting women out of hospital is paramount!

Dianne had already given birth when this interview was conducted and chose to tell me of her experience at Hospital A. Dianne described the actual labour and birth in this way:

**DIANNE:** It was good. I spent a lot of time in the shower but it was the fact that I had all this support from (midwife, Aboriginal Medical Service) and (husband) that made it so much better ... you can suddenly go like that which is what happened so they just let me go...they didn't try to intervene and tell me how I was... it was great at the birth.
However, Diannes’ experience at the same hospital antenatally was a source of considerable upset to her:

**DIANNE:** I think Hospital B is a terrible hospital. I think it was great at the birth and I think it was great ...after...but before care is terrible.

Dianne explained to me that she had been in hospital for three days before she saw a doctor, and then only after some external intervention. Dianne considered that her Aboriginality has some bearing on her treatment:

**DIANNE:** Yes, I do because I was in the bed and the doctor came to see a lady right next to me and he went down the hall... the doctor said that he'd come back and he never came back ... It seems funny that they went to see the person next to me but they totally ignored me ...I just think that they should also make sure that if the doctor's going to go and see a white person, that they should go, sounds terrible but I really mean it. I'm a little bit angry that I get treated like that.

Dianne thought that because she was attending the Aboriginal Medical Service she was discriminated against by the staff (because it alerted them to her Aboriginal status). Dianne left the hospital, went to the clinic (Aboriginal Medical Service), where treatment was commenced and then she returned to the hospital. The concern of the professionals at the clinic led to appropriate treatment at the hospital. Dianne comments that this “was a long way round about it”, meaning that she had to leave the hospital to get some treatment.

Liz is also exercising her choice not to have her baby born in hospital.
LIZ: Just that I can make my own choices you know...I don't want...interfering...[like] when I had (first baby) how they pulled out the placenta when they didn't really have to. They could have waited...and that sort of really offended me.

Liz talked about having the baby at home which means that she won't have to worry about everyone else and can exercise her right to do things her way as well as having her family around straight away.

LIZ: When I was at home like, the midwife ...we did everything ourselves she just sat back sort of thing and watched and I really liked that you know 'cause we were sort of in charge and I could do what I liked...do things naturally.

These extracts show that some of the women are prepared to accept what is provided at Hospital B without question, that one informant was not completely happy with her recent experience, and one woman is not prepared to accept what she regards as racist treatment at all and has opted out of the hospital system.

Dianne and Liz both talk about having some control over the way their labours are managed and the role of professionals in that management. Both of the women appeared to appreciate being left in charge without interference from the professionals. Dianne and Liz would be a valuable asset to a program set up to empower and support urban Aboriginal women who are interested in childbirth choices, breastfeeding, and the pursuit of cultural information.

The mixed experiences and feelings expressed by the women may be a function of the fact documented by Pratt (1995) whereby for the majority of non-Aboriginal and Torres Strait Islander nurses 'the health of Australia’s indigenous people remains of secondary importance' (p.210). Once nurses and other professional health providers
become interested in the health of Aboriginal people and the provision of culturally appropriate care, it will be necessary for them to consider what their knowledge of Aboriginal culture is, and what that means in the delivery of care.

**Doctors**

Doctors are an integral part of maternity care at present and therefore they have an influence on that care and an impact on those people at the receiving end of that care. The women in this study were asked about their relationship with doctors during their pregnancies, both previous and present, in general terms so that the women would volunteer the information of their experience.

The doctors at the Aboriginal Medical Service are having an influence on the women attending that service at present as Joan explains:

**JOAN:** The doctors (at the Aboriginal Medical Service) are great, friendly actually... (a previous doctor) stitched me up wrong with my daughter and like I swore at her then.

Joan is happy with the doctors at present, and even though she had a problem with medical care for her last child, she doesn't bear a grudge against doctors. Joan is appreciative of the friendliness of the doctors.

Sue's experience has been different. Sue had previously been attending her local doctor for antenatal care and didn't like the service that was offered. She found that the waiting time was considerable and then when she saw the doctor, the consultation only lasted a short time.
SUE: 'she didn't really check me over or nothing,... didn't check the baby or me blood pressure or nothing like that...she was just in and out like. I used to wait there for an hour just to go in and see her and then I'd get in there I'd only be there for five minutes and back out again. Here...they do me weight and urine and check the baby and ask how I've been feeling like.'

Sue obviously appreciates the doctors asking about her general health for example, "[the doctors] ask how I've been feeling like".

Kay did not talk about the doctors as such, but mentions during the interview that she has asked the doctor about the pain of labour and she has accepted the doctor's explanation which suggests to me that the doctor's word is important to her and sufficient.

KAY: I've watched videos on it and I've asked my doctor what it's going to be like and the kind of pain...and they told me.'

Dianne gave birth to her other children at a hospital in the city, and was referred to a specialist because of complications. Dianne was happy with this doctor and her only complaint was the cost (she had to pay even though he missed the birth!). However, during her current pregnancy Dianne was hospitalised and had some trouble trying to see a doctor while in hospital:

DIANNE: I was in the bed and the doctor came to see a lady right next to me and he went down the hall and I said well what about me and this lady ran after the doctor ...the doctor said that he'd come back and he never came back then they just ignored us
Dianne was not impressed with this treatment which also reflected on the nursing staff and the hospital. She also believes that she received this 'treatment' due to the fact that she was an Aboriginal Medical Service patient, which alerted the staff to her Aboriginality. When Dianne’s baby was delivered she attributed the 'good birth' mostly to the support of the Aboriginal Medical Service midwife and to her husband.

Jenny attended the antenatal clinic at Hospital A and was happy with the doctors at that hospital, but wishes there had been an Aboriginal Medical Service available to her in the local area when she had her children. Jenny uses the Aboriginal Medical Service now for herself and her family and thinks the doctors there are 'really good'.

Liz, too, would rather go to the Aboriginal Medical Service in preference to the local doctor.

**LIZ:** This medical centre around the corner like it’s just around the corner from me but I try and avoid going there if I really have to and plus the doctor makes me feel uncomfortable. Oh well, he says he really gets up you if you don't make an appointment. When you make an appointment you have to wait anyway and usually if I've made an appointment like it seems everyone else goes before me. Yeah and I just don't like him. He makes me feel uncomfortable.

Generally, the previous experience of these women with doctors has been both positive and negative and has affected some women more than others. All of the women prefer the doctors at the Aboriginal Medical Service, regardless of their previous experiences, and describe the doctors in positive ways, using words like really good, good, nice and friendly. These descriptions of the doctors, eg friendly, nice etc., sum up the way that most of the women in this study think about the
maternity services offered. The women are not evaluating the services in a critical way. They do not seem to question what is offered to them, for example the lack of encouragement to breastfeed and skills in breastfeeding, their choices about the professionals roles during labour, information about choices regarding cultural aspects of care etc. Instead, within this group there are those who seem to be content as long as the professionals are 'nice' to them. It is not true of the whole group however, with Liz and Dianne being more discerning about their care.

According to the women, the doctors at the Aboriginal Medical Service treat them in a more acceptable way than do the local doctors, for example, in a more holistic manner, the women recognise this and appreciate it.

The women have displayed a lack of knowledge, some about maternity care, most about cultural aspects of maternal care, and they have not been empowered by the professionals to seek information and then apply it to their own situation. Clearly what is needed is the provision of appropriate information so that the women can evaluate what is offered in terms of their individual needs, and discuss choices and plans with the doctors at the Aboriginal Medical Service, with whom they feel so comfortable. If the women were well-informed, then the existing situation where the word of the doctor and nurses word is accepted in total (just because of their authority) would be more positively utilised.

Midwives

My observations at the Aboriginal Medical Service clinic, the discussions I had with the interviewed women and other women attending the clinic, lead me to believe that the women were very comfortable communicating with and being in the company of the midwives. The midwives who are at the clinic are either employed there or come
in each fortnight with the outreach team from Hospital A. The midwives were non
Aboriginal (as were the doctors) but were sympathetic to Aboriginal people. All nurses
know that clients or patients do generally feel comfortable with them and the general
public are supportive of nurses. Nurses are in the privileged position of being with
patients more than other health professionals, and quite often hear things, and/or are
asked to clarify the information that other health professionals give them. I can see
this reflected at the Aboriginal Medical Service, which puts nurses in a particularly
fortuitous position of influence with the women. The comments that have been made
by the women have mostly been positive about nurses:

**JENNY:** Yes both the maternity ward and the staff were just lovely. I was
actually with my last baby I was actually in hospital on and off...37
weeks...'cause I was very sick with diabetes and blood pressure so I
was called lady in waiting and the staff were just lovely.

**JOAN:** Staff up there are pretty good. Oh no, the nurses were lovely. They
just treated me just like they do the white mothers. They didn't like
shut your mouth you silly - you know nothing like that. No they were
great.

The nurses were notable here for the things that they didn't do such as verbal
abuse to Joan! Sometimes, health professionals try to put their own values on to other
people, and run the risk of alienating the very people they are trying to help. In Liz's
experience, this occurred with her previous homebirth midwife.

**LIZ:** I don't know, [she] made me feel guilty like you know because I
wasn't traditional like she sort of expected something traditional...we
haven't been brought up like that...It's not our fault like my husband
he was taken away and he was brought up in a white family...you
know people aren't interested in you if you're not traditional...and if you can't speak your own lingo.

Liz seemed to me to be struggling, to balance her life between her Aboriginal heritage and her urban lifestyle.

**LIZ:** And when tourists you know come out from other countries [they] only want to see traditional stuff...they don't see other Aboriginals getting on in the world...that's why I put [daughter] in a television agency when she was young...but we didn't get any reply back...I mean fair enough like they might show one Aboriginal kid.

This is a further example of Liz's pride in being Aboriginal. Liz's energy could be harnessed to make a difference to Aboriginal women in an urban setting by the establishment of a childbirth support group for Aboriginal women. This group would be run by Aboriginal women such as Liz and would provide peer support for pregnancy, childbirth and in particular, the establishment and maintenance of breastfeeding.

**Antenatal and postnatal care**

Liz is attending the Aboriginal Medical Service which is in the local area at present and previously she journeyed into the city to the Aboriginal Medical Service for her health care. She says that if the local centre was not available to her she would continue to travel into the city. The atmosphere of white medical centres is not comfortable for Liz:

**LIZ:** ...I don't like the atmosphere in white medical centres. It's just that no-one talks and sort of feel self conscious you know, don't wanna
make a noise and things like that ...I really like (Aboriginal Medical Service), like going there 'cause you get to talk to people... I don't have to worry about watching them (the children) someone will just keep an eye on them.'

Liz feels comfortable at the Aboriginal Medical Service because it is Aboriginal administered, and she is not comfortable at 'white' medical centres, where she feels 'self conscious'. At the Aboriginal Medical Service there is noise and everyone takes responsibility for the children compared to non-Aboriginal centres where mostly people don't talk and children can sometimes be seen as nuisances. Postnatally Liz will be at home and the midwife will attend each day. The people from the Aboriginal Medical Service will also call in regularly.

Jenny attended the clinic at (hospital) but says that she wished she could have attended a clinic like the Aboriginal Medical Service. As Jenny has worked there she knows what is available to the mothers and how it works.

Dianne had her first two children in the city and is very happy at the Aboriginal Medical Service. She finds her visits there enjoyable:

**DIANNE:** Oh, I really enjoyed going there. If I do have another one I will go there.

Sue was attending her own doctor which wasn't satisfactory for her, so, on the advice of her mother, she started attending the Aboriginal Medical Service.

**SUE:** Here ... they come and pick you up,...do me weight and urine and check the baby and ask how I've been feeling like.
Sue believes that the service at the Aboriginal Medical Service is more comprehensive than what she experienced with a local doctor. The professionals at the Aboriginal Medical Service are interested in how she is feeling as well as the medical checks and the access is very good as they arrange her transport which is convenient. This is an effective way of applying the primary health care approach to care, being flexible and adaptive to the needs of the client (Berland, 1991).

Kay is attending the Aboriginal Medical Service on the advice of her sister and enjoys the clinic, as she knows most of the people who attend the clinic and she 'feels really good' at the clinic.

**KAY:** I like coming here...I just feel really good here, I like it. I know most of them they come here.

After the baby is born Kay and her boyfriend will be moving to the country to stay with his sister. There is an opportunity for care to become fragmented for Kay and her baby here, because of the move to the country. This provides the Aboriginal Medical Service with an opportunity to ensure continuity of care by referring Kay to a local Aboriginal Medical Service (if available) or to the local community health service. Initially, Kay will require the support of the community nurse and early childhood nurse for the baby, and if she decides to breastfeed, in particular, the support of family and peers. This is a challenge for health services to ensure that accessible, appropriate and acceptable care continues for families like Kay's, who move around for various reasons.

Joan enjoys coming to the antenatal clinic for a number of reasons. The staff from the clinic pick Joan up from home and take her back home, thus saving her the trouble of public transport. At the clinic, Joan has met some other women, both
Aboriginal and non-Aboriginal, and enjoys the company and the atmosphere, which is conducive to making friends and having a laugh.

**JOAN:** I think it's great cause you get here and you can have a laugh as well with all the ladies and make friends. I think it's good.

After the baby is born, the staff from the A.M.S. will come out to visit Joan and her baby. Joan also believes that at the clinic the staff care. Joan thinks that the doctors are really friendly at the clinic, as they were in the country for her first two births.

Overall, the women are really happy with the care they receive at the Aboriginal Medical Service and feel really comfortable while they are at the clinic. The Aboriginal Medical Service provides an affordable, acceptable and accessible clinic for the women as they are transported to and from the clinic and the women are prepared to attend and accept the care offered. There can still be a problem with non-attendance at the clinic, one possible solution would be to see women in their home for routine checks, along the lines of the community health nurse, and outreach services.

**Antenatal Classes**

The National Aboriginal Health Strategy (1989) recommends antenatal classes be developed for Aboriginal women under the following guidelines:-

* the introduction of culturally appropriate and accessible ante natal classes for Aboriginal women;
* classes must be designed and presented by Aboriginal women (p.188);
These classes must include antenatal and postnatal education covering the areas of early antenatal and postnatal care, practices and procedures of that care, and information about birthing procedures such as induction of labour, anaesthetics, forceps deliveries and caesarean sections, episiotomies, the baby and complications etc. The working party of the National Aboriginal Health Strategy (1989) believes that 'improved antenatal and postnatal care can contribute to improvements in the health status of both mothers and children' (p.188). The working party also noted that:

It needs to be recognised that Aboriginal women find the 'white system' of dealing with obstetric care and the differing health personnel responsible for each phase of pregnancy confusing and, therefore, there needs to be some continuity between ante natal and post natal care, confinement and education (p188).

In 1989 the Final Report of the Ministerial Task Force on Obstetric Services in New South Wales noted that:

Parenting Education is recognised as a valid, important aspect of maternity care, contributing to healthy, planned pregnancy, informed participation in decision making during childbirth, and rewarding successful parenting (Shearman, 1989, p234).

Dr. Judith Lumley (C.E.A. Newsletter, Central Brisbane 1982, cited in Shearman, 1989) concluded that the benefits of attending prenatal classes included the provision of:

a powerful social support during pregnancy, improved meaning for the experience of pregnancy,...useful skills - relaxation and posture, [and] women can be taught to be more assertive and critical in dealing with those who provide health care services (p237).
This finding supports the establishment of prenatal classes that would be advantageous for the Aboriginal women in this study, because of the potential to become more critical when seeking childbirth services. These classes would follow the policy of the National Aboriginal Health Strategy (1989) which include being conducted by Aboriginal women. Shearman (1989) consequently recommended that antenatal clinics seize the opportunity to provide appropriate antenatal education to individuals or groups.

The women in this study talk about their experiences or knowledge of antenatal classes.

**LIZ:** We started to go to the ones at the hospital but we didn’t like them...They were mainly all um middle aged...and they were really loud...Everyone was singing out...and making jokes all the time...we felt a bit out of place so we stopped going...They didn’t have any Aboriginal input.

Liz and her husband were not at all comfortable at the classes which were mainstream hospital classes and so they dropped out. It seems that they were of a younger age group than the other participants and as both Liz and her husband have quieter natures, they found it difficult to cope. Liz felt that if there had been classes provided by Aboriginal people, or even targeted at Aboriginal people, she would have continued to attend.

**JENNY:** I did (attend) with my first one...but not with the others...I think that the antenatal classes are excellent for mums the first time. I think they’re really excellent because you don’t know what you’re in for
and make them be aware of what's to come, looking at the birth and stuff like that.

Jenny found the classes of benefit to her with the information they provided about the actual birth, and Dianne attended classes for her previous pregnancies.

**DIANNE:** I attended at the community health centre...they were good.

Kay and Sue who are expecting their first babies didn't really know about antenatal classes and Kay has asked her doctor about the birth and received some information.

**KAY:** I've watched videos on it and I've asked my doctor what it's going to be like and the kind of pain and they told me.

I think that this is an area of major breakdown in the service provided to these Aboriginal women. The National Aboriginal Health Strategy (1989) and the Shearman Report (1989) both acknowledge the role that antenatal or parenting classes have in today's society and yet here we have an antenatal clinic offering an acceptable, affordable and accessible clinic to a defined 'at risk' population and there is no real emphasis on education. Once while I was present at the clinic I witnessed an exchange of information about contraception, between a client and the midwife, at times a video was commenced, but with people constantly coming and going and with the presence of small children, I no-one could really concentrate on the subject matter of the video. There is, I believe, opportunity for informal talks with one woman or small groups, as the women who are transported to the clinic arrive very early and are often at the clinic for at least two or even three hours by the time they are taken home. Every fortnight an outreach team from the Hospital A is in attendance at the clinic, with the extra midwife available that day, so there is opportunity for some education. By
their own admission, the women enjoy their time at the clinic and the social opportunities offered there, so the target group is available and willing. It is such a pity when the staff are available, the venue is suitable, the time is available and the target group are waiting, and yet the opportunity is not taken up. The National Aboriginal Health Strategy (1989) goal of improving the health of mothers and babies by education is not being fully addressed in this setting. Even in a small way there is opportunity to address issues such as the promotion of breastfeeding, available without any need for extra resources.

Conclusion

In summing up this chapter, I find that there have been both positive and negative experiences with hospitals, doctors and midwives in the past but there is a positive anticipation towards the care and services for the future. The change in attitude at Hospital A has been noted, and an appreciation of the services provided by the Aboriginal Medical Service in the antenatal and postnatal periods is recorded. The area of antenatal education in the form of classes, one-to-one or small group presentation, is contentious. On the one hand we have the policy of the National Aboriginal Health Strategy (1989) encouraging accessible and appropriate classes run by Aboriginal women, and on the other an Aboriginal Medical Service not heeding this policy and not even taking existing opportunities for education which present regularly. My recommendations for this important area will be stipulated in the final chapter - conclusions and recommendations.
CHAPTER 6: BREASTFEEDING

The National Aboriginal Health Strategy (1989) promotes breastfeeding as 'the primary strategy to ensure adequate growth in the first 6 months of life' (p. 181) and describes a specific strategy, stressing that:

education programs emphasising the importance of antenatal and postnatal care for mother and baby should be developed.
This will include the development and distribution of resources that promote breastfeeding... (p. 181).

In a survey conducted by Fagan and Chambers (cited in Flower, 1987) between 30% and 40% of Aboriginal mothers breast fed their babies compared with 70% of the general population, 77% in 1989-90. Flower (1987) found that Aboriginal mothers have become the 'unwitting target of 'modern' practices and have changed from breast feeding to bottle feeding', as a result of the promotion of infant formulas. This is similar to what has happened in third world countries, where infant formulas have led to the malnourishment and death of millions of infants. Flower (1987) found the problems associated with bottle feeding of Aboriginal infants include:

- mothers who cannot read the label instructions for preparation of the formula
- the expense of the formula leading to weaker mixtures being made up
- the breakdown of the family unit leading to a lack of support from older women
- the perceived restriction of social life contributing to the decision not to breastfeed.

Flower (1987) believes that because of poor health status emanating from physical and social conditions, and lack of access to health services, it is vital to the health status of Aboriginal babies for them to be breastfed.
Other earlier studies in Western Australia, had found that the rate of breastfeeding among Aboriginal mothers depended on the integration of the women into white Australian society (Gracey, Murray, Hitchcock, Owles & Murphy, 1983). Women who were living in more traditional settings with strong tribal ties were all breastfeeding at birth, with 90% still breastfeeding at two years, compared to women who were living in and around country towns, with only 61% breastfeeding at birth, down to 49% at two years. In the more densely populated areas in the south-west of the state "no infants were breastfed over the age of twelve months, and over half had been weaned at six months (p. 32). The effects of urbanisation, westernisation and isolation from kin networks were identified by Cox in 1979, and in 1981, socio-economic status, as factors which destroyed the tradition (in North Queensland) of breastfeeding for the first six months. Even though since then, there has been national promotion of breastfeeding, the rates for Aboriginal women have fallen, leaving their babies at risk from the loss of the immunological properties of breast milk.

The women in this project had various responses to the subject of breastfeeding:

JOAN: I'm going to breast feed. I don't know if I'll lose any weight 'cause it's my third but I'll breastfeed and try to lose some weight.

Joan's major concern as expressed here seems to be to lose weight and breastfeeding may achieve that. There is no mention of the positive aspects of breastfeeding for the mother or the baby. This response could be indicative of a lack of knowledge about the benefits of breastfeeding, or the lack of a suitable role model.

Kay doesn't seem to have made up her mind about breastfeeding yet and mentions the health aspect for the baby, as well as it being possibly easier to breastfeed:
KAY: But they say that it's a lot healthier breastfeeding the baby and it's a lot easier I suppose. I don't know. I haven't really decided on that yet...I just...nothing's really stopping me. If it's a lot healthier for the baby well then...you lose a lot of weight breastfeeding.

Like Joan, the possibility of losing weight when breastfeeding is mentioned, with a weak indication that she may know that it is healthier for the baby. Kay also doesn't have the appropriate information to help her make the best decision for her or the baby.

Sue's attitude to breastfeeding is ambivalent:

SUE: I don't know. A lot of girls have told me it hurts and you get really sore, but I don't know. I want to try it...I'm going to try it for a week or so if it hurts too much I'm just going to put her on the bottle but I do wanna try.

The emphasis here seems to be a negative one for example, the information that Sue has received about breastfeeding hurting and making you really sore has led to her decision to try breastfeeding for one week and then put the baby on the bottle. There is no mention of the positive aspects of breastfeeding either for the baby or mother. This is another example of a lack of appropriate, relevant information which will help Sue make an informed decision. At the moment Sue is basing her plan to try breastfeeding for one week on information from "a lot of girls" which makes me wonder what their information is. This situation is a poor reflection on the health professionals whom Sue has encountered so far during this pregnancy.

Dianne is a breastfeeding mother and identifies some of the aspects of breastfeeding, such as the learning for the mother and the baby, the complexities
such as how long and often to feed, and the benefits to the mother and baby such as the closeness, comfort and security and antibodies to the baby.

**DIANNE:** I never really have stopped. You need somebody. It's not that simple when you start off. The baby learning and it's the mother learning. It's a whole new experience and people don't know how often you've got to feed, how long, how anything and all this just matters I mean I just feed them whenever they feel hungry it doesn't matter I don't look at the time. It benefits the mother and the baby like I think even the closeness of baby needs the comfort and security it gives them as well as the antibodies in it and all that.

Dianne is also aware that the mother needs someone for support when establishing breastfeeding.

Jenny tried to breastfeed but was unsuccessful and acknowledges that it is good and natural. Jenny also mentions the belief that it bonds the mother closer to the baby, however, Jenny achieved that bond without breastfeeding.

One of the primary strategies of the National Aboriginal Health Strategy (1989) is to promote breastfeeding so that the growth and development of babies is adequate in the first six months of life. This report suggests that education programs run by Aboriginal women are the most appropriate way to achieve this strategy.

**JENNY:** I tried to breastfeed...I wanted to do it because I think it's something that is really naturally and I think it's really good...They say it bonds you closer to the baby but I felt that anyway being on the bottle you know.

Liz supports breastfeeding because her grandmother and mother did, and while she doesn't talk about the benefits of breastfeeding she mentions that the
thought of bottle feeding makes her sick. Liz does make the point that breastfeeding ties you down.

**LIZ:** Yeah and because my grandmothers did and my mother.
Like I never thought about bottle feeding...I hate the thought of it...the thought of having to give them a bottle makes me sick...But it makes you pretty tied down too you know.

These responses from the mothers about their intention to breastfeed raises the issue of their knowledge about breastfeeding. The responses vary from not being sure about whether to breastfeed, through not having thought about it to a definite intention to breastfeed, this last response coming from the multiparas. The benefits to the mother and baby (expressed by the informants) include it being healthier, natural and good for the baby, while being easier and leading to weight loss for the mother, even though there is hurting and soreness to contend with. Overall there is a lack of knowledge about the benefits of breastfeeding to both the mother and the baby, particularly from the primiparas and even though the multiparas were not able to articulate all of the benefits they seem to know that breastfeeding is good.

This evidence suggests that the women in this study have not received appropriate, comprehensive maternal and child care as stated in the National Aboriginal Health Strategy (1989): "health services must develop protocols for antenatal care, ensuring that women receive comprehensive examinations and investigation, and one to one advice and counselling breastfeeding..." (p.182).
Previous experience of breastfeeding

Four of the mothers interviewed had previously breastfed, two successfully and two not successfully, although all of them seemed to have wanted to be successful at the time. Joan and Jenny both tried to breastfeed but it didn't work out for them. Dianne told me about her successful experiences:

**DIANNE:** I never really have stopped. I started with (first baby)...I was feeding (first baby) when I fell pregnant with the other one and so I...fed until...third birthday...I was feeding both of them...I was feeding the little one until I had (third baby) all through my pregnancy...and now I'm feeding (third baby).

Liz also succeeded with breastfeeding:

**LIZ:** I fed (first baby) till she was two and I plan on feeding (second baby) you know at least until he's one.

The mothers who had previous children all tried to breastfeed. They had positive and negative experiences and it is interesting to note that the ones who were not able to successfully breastfeed kept trying with subsequent babies. It is interesting that all of these women did try to breastfeed from their first babies whereas my two other informants who are expecting their first babies are not sure about whether they will even try. The mothers who tried to breastfeed are more positive about breastfeeding than the two primiparas which leads me to believe that with the provision of appropriate information, and encouragement by health professionals, aided by breastfeeding peers, the primiparous women might be swayed towards breastfeeding.

The Nursing Mothers' Association of Australia (NMAA) recognised the need for the promotion of breastfeeding among Aboriginal women (and support from Aboriginal men for breastfeeding), and set up outreach programs for this purpose.
(Law, Anderson, Travers & Larcombe, 1988). NMAA recognised that the community itself was the key to success and trained women from each community "to help other mothers to breast-feed and to give support, hold discussion meetings, go out to communities and talk with mothers and offer counselling in specific breastfeeding problems" (Law et al., 1988, p. 37). The outreach programs were conducted in the northern regions of New South Wales and Queensland and "While all involved with the program recognise that this work must continue and that processes will evolve and develop, there are clear indications that there is a growing awareness of breastfeeding among the Aboriginal communities" (Law et al., 1988, p. 38). As some of these programs were funded by governments using the Wage Pause Program and the Community Employment Program, they are an excellent example of intersectoral collaboration found in the Primary Health Care approach to health care.

Had this model been available to the following women, their stories may have been different. Two of these mothers were successful and two were unsuccessful in their attempts to breastfeed. Joan and Jenny describe their experiences:

**JOAN:** I only breastfed (first baby) for about a week um but I stopped. I breastfed (second baby) for two weeks...but I stopped because it was killing me it was so sore. I mustn't have been doing it properly or something. That's the only reason I stopped there. I could have went and got some cream and that but I didn't. I was silly, I stopped.

Joan had cracked nipples and needed some help, both in positioning her baby correctly and in treating the nipples. Joan was not sure of any help that was available to her at the time and, in retrospect, thinks she 'was silly'. Joan was a teenager at the time and the services did not meet her needs even though I would have thought that a health professional would have been looking out for her because of her age and her problems with breastfeeding.
Jenny also needed advice, assistance and care in her pursuit of successful breastfeeding, both antenatally and postnatally:

**JENNY:** I had heaps of milk and that there but after I had them I just lost it. I tried to breastfeed and I was actually raw because it just hurt so much and I come home and I wanted to do it...It just hurt me too much you know I mean I was forever bleeding my nipples and that I did all the preparation beforehand and it just...hurt me too much...with my second one I tried it and I thought well I'm not going to go through the pain again you know.

I wonder if the services that existed at the time (seven years ago) were extended to Jenny. Certainly, the women that I have interviewed for this project have not been aware of the various services that exist in order to support new mothers for example, Clinical Nurse Consultants - Lactation. These consultants are available to staff and patients, both as inpatients and outpatient, and are employed by Area Health Services. This advice could be provided to Aboriginal women during their visits to the clinic, at antenatal classes or in a resource pack. Another strategy could include the lactation consultant visiting the clinic every two to three months to provide one-to one counselling or group sessions.

**Counselling for breastfeeding**

The experience of the women in this study in relation to breastfeeding is varied, with two women being primigravidas and the other four being multiparas. Of the four multigravidas, only two have successfully breastfed their babies, even though all four women attempted breastfeeding. All of the women except one are well advanced in their pregnancy and none of the women expecting their first baby or those who had problems with breastfeeding their previous babies has discussed
breastfeeding with a health professional. The information or example that the primigravidae have about breastfeeding has come from family and friends:

**KAY:** Mum, she breastfed us. She thinks we'd be a lot healthier.

Kay's mother breastfed her children and Kay quotes her Mum even though Kay herself has not made up her mind about breastfeeding. Sue mentions that she has taken notice of what the 'girls' have told her about breastfeeding:

**SUE:** A lot of girls have told me it hurts and you get really sore.

Similarly, the multiparas have not had any discussions with professionals about breastfeeding and the problems they have experienced in the past. This subject should have come up on as a result of the initial nursing assessment. A section of the nursing assessment document should be designated to the promotion of breastfeeding and could follow the steps of the nursing process. This would provide detailed information covering initial assessment, planning for breastfeeding, individualised implementation strategies and evaluation. The evaluation phase would then provide outcomes data.

One of the informants pointed out to me during her interview, that she believed that some of the women attending the clinic were not comfortable talking to the professionals until they got to know them:

**DIANNE:** ...some people are a bit scared to talk openly to (name) you know...I mean until they get to know them...I think if they went to some sort of class or something even though they're not asking questions 'cause some of them are very young and they need some sort of to know what's going to happen at the birth and all this.

With the promotion of breastfeeding being part of the National Aboriginal Health Strategy (1989) and *Goals and Targets For Australia's Health in the Year*
2000 and Beyond (Nutbeam et al., 1993), specialist breastfeeding services are available locally, but these women are missing out on the up-to-date information and care provided by these specialists.

There is an urgent need to address the promotion of breastfeeding with strategies such as education, peer role models and support for breastfeeding mothers at home. The health professionals need to gain the confidence of the women in order to fully utilise the services offered. The women in this study would have benefited from the provision of information about breastfeeding and one-to-one counselling about up-to-date methods for preparation for breastfeeding and discussions about their past experiences.

At the time of this research the issue of whether women breastfeed or not seems to be ad hoc and breastfeeding was not discussed openly during my visits to the clinic.

Anecdotally I have been told of a breastfeeding specialist nurse noticing that one key to teenage mothers breastfeeding successfully is the presence of peer role models. This is an activity that could be instituted easily as the facilities are available at the clinic, and the benefits may be enormous.

One example of support for young mothers has been occurring at Yuendumu, out of Alice Springs, as told by Lottie Napangardi Robertson (Central Australian Rural Practitioners' Association Newsletter, 1991):

Visits to the schools was one of the things we would do, teach the girls about nutrition before becoming pregnant and after birth, for child and mother or even for the whole family. I would get the older ladies to be involved in teaching the young mothers and the senior girls the traditional ways, or even tell stories of their life...or get them to talk about women in labour...In the future I would like to see more young mothers getting the whole family to come together...and talk about all those things they would like to know about their child's health (p. 18).
This project is providing encouragement to mothers, particularly those with failure to thrive babies, and is satisfying a need of young mothers who are trying to raise a young baby, by providing community support. These principles could be useful in the urban setting and within the group of women who have participated in this project, there is an untapped resource which could be a starting point.

The targets set for increasing the rate of breastfeeding in the Australian community by the year 2000 include the priority areas of:

- Babies up to 2 months - 90%
- Babies up to 3 months -
  - fully breastfed 60%
  - partially breastfed 80%
- Babies up to 6 months -
  - fully breastfed 50%
  - partially breastfed 80%

(Nutbeam et al., 1993).

With the rate of fall of breastfeeding amongst Aboriginal women over the last decade or so, there is a lot of scope available for innovative programs tailored to particular communities, urban and non-urban.
Conclusion

In this chapter I have explored the personal breastfeeding histories of the participants and their future plans for breastfeeding. Experiences have varied, from Dianne's positive experiences, to Jenny who tried unsuccessfully to breastfeed after each of three babies, to Sue, who does not have a firm commitment and is relying on information from non-professional people. In addition, none of the women have received counselling about breastfeeding during this pregnancy. The stories in this chapter lead me to fear for the future of these unborn babies who are being born into families with lower socio-economic status, and who are targeted by government agencies charged with trying to improve the health status of this group. The governmental targets aimed at improving the health of all Australians are not going to be easily attained because of the gap between the rates of breastfeeding among non-Aboriginal and Aboriginal women and the complacency of health services towards the promotion of breastfeeding. Recommendations follow in the final chapter - summary and conclusions.
CHAPTER 7: SUMMARY AND CONCLUSIONS.

The aim of this study was to interview Aboriginal women living in Western Sydney, to specifically hear about their experiences of maternity services. I was also interested in why the women had chosen the particular ante-natal service they attended, and whether traditional cultural practices related to birthing had any influence on the women for their own pregnancies and deliveries.

I interviewed six Aboriginal women who all lived in Western Sydney and who were pregnant at the time or who had already given birth. The interviews were taped, then transcribed for analysis. Participants were shown their transcripts, before analysis commenced. Using a phenomenological approach, I analysed the interviews, to gain insight into the world of the Aboriginal women who were living in an urban area and receiving maternity care from both mainstream and culturally specific providers. Analysis of the interviews by listening to the tapes and reading the transcripts over and over led me to categorise the parts that stood out for me into the themes of 'being Aboriginal' (Chapter 4), 'the perinatal experience' (Chapter 5), and 'breastfeeding' (Chapter 6). Whenever I was 'bogged down', I would listen to one of the interviews which would re-create the excitement I felt during the interview sessions, and remind me of the warmth I felt when I was with the women, as well as acknowledging the worthwhileness of the project. This analysis led to the themes of 'being Aboriginal', 'the perinatal experience' and 'breastfeeding'. These themes led me to consider the experiences of these women in relation to the recommendations of the Shearman Report (1989), and to ask 'has there been any change for urban Aboriginal women in Western Sydney since the release of the report?'

While the intention of the writer is not to fall into “the trap of constructing a long list of what nurses should and must do” (Lawler, 1994, p.10) the results of this study do have implications for midwives and other health professionals in their delivery of culturally appropriate care for Aboriginal women who live in Western Sydney. Because of the small number of women who participated in this study, the recommendations
cannot be generalised across the total population, but I would be pleased if this work
led midwives to pause, and consider, their practice in terms of the primary health care
principles of acceptable, accessible and affordable care. Changes in practice can be
the result of imagination, legalisation, funding and infrastructure, either on their own or
collectively.

Studying the experiences of urban Aboriginal women from Western Sydney, has
been a journey of discovery for myself and in some ways for my daughters. As I have
mentioned previously, my own personal experiences with Aboriginal people had been
very limited, certainly, my daughters had not knowingly interacted with Aboriginal
people, and through this work, we have all increased our experiences to include
Aboriginal people into our network of friends and acquaintances, as well as taking part
in some aspects of Aboriginal cultural events when able.

As a midwife, I have been through the pangs of guilt, those of being a part of a
structure which ignored the needs and desires of our own indigenous people, while
being very concerned about people from other cultures, and of latterly being part of a
group who had some insights, but was not able to mobilise that insight into anything
positive.

This project has allowed me to examine the experiences of urban Aboriginal
women in Western Sydney, in the light of my own practice and experience and with
that which is recorded in the literature. At times, this has been a painful and difficult
experience, but eventually an enlightening one, allowing me to consider what I have
learnt, sit back and think about it, and then recommend actions which nurses may
choose to implement into their practice. The recommendations could also form the
basis of policy for health services which have Aboriginal women as clients.

The interviews with six Aboriginal women from Western Sydney, I was able to
elucidate the knowledge they had of traditional Aboriginal ways of birthing, and the
importance of those ways to the women in the present lives. Through talking to the
women and others at the clinic, and by my regular attendance at the clinic, I was able
to consider the effect that the Shearman Report (1989) was having on the care of
these women, particularly the care provided by the mainstream visiting service. My findings, and consequent recommendations have therefore been formed from three aspects of this work. Firstly through interviewing six Aboriginal women who reside in urban Western Sydney, I was given access to their experiences and the thoughts that they had formed as a result of those experiences, upon which I have based the recommendations. Secondly, because of my experience as a midwife and my previous exposure to the Shearman Report (1989) I was able to evaluate the situation at the clinic and verify my thoughts with the women who were the recipients of the service provided by the mainstream team. Thirdly, my reading in the area of traditional Aboriginal birthing culture and the scant literature about Aboriginal woman living in urban areas and their use of mainstream health services has provided me with the opportunity to explore the issues and my recommendations with the women.

Recommendations

1. Establishment of a discrete health unit for urban Aboriginal women in Western Sydney

The women I have interviewed have all been proud of their Aboriginality and are interested in cultural information surrounding birth. At the moment they are not sure where they can gain access to this information in an acceptable way, or explore the choices available to them about childbirth or breastfeeding. These women, and others like them, would benefit from the following:

1.1. Establishment of a centre within the unit for Aboriginal mothers having babies where they would learn about pregnancy, birthing and motherhood would support the initiatives of the National Aboriginal Health Strategy (1989), particularly education, as well as providing support for after the birth.

1.2. Provision of peer support with women like Dianne, Liz and Jenny who would bring knowledge, experience and a guiding hand to new mothers.
1.3. *Building on the positive relationship that already exists between the women and the doctors at the A.M.S.* to encourage further use of preventive and health promoting services.

1.4. *Home outreach services* such as antenatal and postnatal care by midwives and Aboriginal health workers would complement the service and ensure that mothers were provided with necessary care during pregnancy and the postnatal period. A culturally appropriate back-up service for mothers, in collaboration with the Aboriginal community, would complement this outreach service and build on community links and strengths.

1.5. *Employment of Aboriginal Liaison Officers (ALO)*, who would work between the unit and the hospital and would ensure continuity of culturally acceptable care and the valuable link for ongoing support through networks, especially for mothers, like Kay, who move to other locations after the birth. The ALO would also provide the cultural link between health professionals and Aboriginal women, addressing the most important issue of racism amongst health professionals.

2. **Provision of culturally acceptable education about pregnancy and childbirth**

2.1. *Culturally appropriate antenatal classes*, as recommended by the National Aboriginal Health Strategy (1989), would be conducted by Aboriginal health workers and would access the positive energies of Aboriginal women like Liz, Jenny and Dianne. Clearly, what is needed is the provision of appropriate information so that the women can evaluate what is offered in terms of their individual needs, and discuss choices and plans with the doctors at the Aboriginal Medical Service (A.M.S.), with whom they feel so comfortable.

2.2. The classes would provide education to Aboriginal women about pregnancy and birth in a culturally acceptable way which would enable the women to think carefully about any possible choices they might have and to exercise those
choices so that their birth experience was more self-directed and not totally controlled by other health professionals. At present we have, on the one hand, the policy of the National Aboriginal Health Strategy (1989) encouraging accessible and appropriate classes run by Aboriginal women, and on the other an A.M.S. not heeding this policy and not even taking existing opportunities for education which present regularly. The classes would also establish supportive networks for the women which would continue after the birth of the baby.

2.3. Inclusion of mothers and aunts in the educational process so that they are able to support the family and provide parenting skills, along with ensuring the link of Aboriginality continues.

3. Promotion of breastfeeding

3.1. Encouragement of breastfeeding starting with the antenatal classes which would provide education about breastfeeding.

3.2. Provision of one-to one counselling about breastfeeding as part of the assessment procedure at the antenatal clinic, and ensuring that ongoing information and time is available for mothers to explore the issue further at the clinic.

3.3. A support group for breastfeeding mothers. The group would consist of breastfeeding mothers, peers, mothers and aunts and supportive women who would be available for new mothers. The role of providing education would be expanded in this forum by visits from breastfeeding specialists such as Lactation Consultants. Perhaps an Aboriginal branch of the Nursing Mothers Association would be an appropriate strategy, incorporating Aboriginal culture into the branch.

Overall, the women are really happy with the care they receive at the A.M.S. and feel really comfortable while they are at the clinic, but they are not discerning about the care offered, being content to accept without question the status quo. The A.M.S.
provides an affordable, acceptable and accessible clinic for the women as they are transported to and from the clinic and the women are, in the main, prepared to attend and accept the care offered. So, while the acceptance of the service by the women is a definite strength, the service is not taking advantage of this by addressing the Australian health target of increasing the rate of breastfeeding.

4. **Education for non-Aboriginal health professionals**

   Education programs would include the following:
   * consultation with the Aboriginal community
   * Aboriginal people leading and contributing to sessions
   * cultural awareness
   * the issue of racism
   * reflection on how individual health professionals might incorporate culturally appropriate care into their practice.

**Structural issues arising from my recommendations**

1. **Infrastructure**

   The infrastructure for my recommendations already exists in the form of the antenatal and postnatal clinic running twice weekly at the A.M.S. This clinic and physical clinic areas could be formed into the recommended centre, in which most of the activities would take place. The health professionals, both Aboriginal and non-Aboriginal are there, along with the visiting team from Nepean Hospital, so the expertise required is available.

   Accommodation for antenatal classes may have to be found, or imaginative thinking about use of existing resources may provide the answer at no additional cost. In addition, venues for support groups are conducive to flexible community input.
2. Community support

The contact that I have had with Aboriginal people during this project leads me to believe that there is community support for the A.M.S. The extra support required for the centre, I believe, would be easily tapped, starting with some of the women in my project and their own contacts. Most of the supporting roles mentioned would be voluntary.

3. Funding

Most of the positions that feature in my recommendations are already in existence, but may need to have more time allocated to them. In essence, from my observations, the existing services could be tightened up e.g. when the outreach team from Nepean Hospital is at the A.M.S., better use could be made of the extra staff available during quieter times. Additional costs would be incurred for classes and for setting up support groups. An Aboriginal community development worker would be the appropriate position to facilitate the process of consultation and implementation. Some appropriate teaching equipment is already available. Additional funding would be obtained from government grants which address the health of Aboriginal women and children, applied for by the community development worker, the midwives and the community and area health service allocation.

4. New Footsteps

There have been some changes in Western Sydney since the Shearman Report (1989) such as provision of an outreach service from Nepean Hospital to the Aboriginal Health Service, and the provision of Aboriginal Liaison Officers at Nepean and Blacktown Hospitals, with additional similar positions currently being advertised in the Western Sydney Area Health Service. My recommendations build on these beginnings.
The pride in their Aboriginality the women spoke of and their interest in their cultural heritage is the source of energy to be tapped in developing a culturally appropriate maternity service. By forming partnerships, Aboriginal and non-Aboriginal nurses, health professionals, health workers and the community of interested women, mothers and grandmothers, can work together to provide care which is acceptable to urban Aboriginal women and break down racist and racial discriminatory behaviours amongst health providers.

There is still much work to be done in ensuring that urban Aboriginal women have access to culturally acceptable maternity services, and encouraging midwives and other health providers to be advocates for Aboriginal women in their search for these services. The inclusion of the women in the whole process, as in the Congress Alukura project, is integral to any success.

The dissemination of the findings of this project, by conference presentation and publication, will be a beginning step in Western Sydney, and I envisage an Aboriginal midwife or health worker taking the research further, and gathering the community with her to create change. The first step could be a gathering of the women involved in this project, where the recommendations are discussed, priorities developed, and plans made for implementation.
REFERENCE LIST


Lawler, J. (1994). *Guidelines for structuring a treatise based on qualitative research.* Draft manuscript, University of Sydney at Sydney.


APPENDIX 1

INTERVIEW SCHEDULE

RELEVANCE TO CULTURE

VALUE TO WOMEN

ACCESSIBILITY

AFFORDABILITY

BACKGROUND

Name. Age, No. of children?
Where are you from?
Other places of residence (the country, city, etc)?
Mother came from?
Can you tell me a bit about your life?
Were you brought up as an Aboriginal person?
Who are the important people in your life?
What roles do they play in your life?
Do you have any other children?
Where were they born (city, country, hospital, home)?
Who will be supporting you at this birth?
What does being Aboriginal mean to you?
Thinking about this baby (babies) and the birth, what do the traditional Aboriginal ways of bearing mean to you? (I've read about bearing being women's business, that men don't attend the birth, Aboriginal birth attendants)?
Why did you choose to come here to Daruk?
Why did you choose to go to Nepean Hospital/Blacktown Hospital?
BIRTH EXPERIENCES

Previous experience (births, etc.)?

Do you think that your being Aboriginal had any bearing on this?

So, what are the important things for you in having this baby, especially in terms of your Aboriginality?

SERVICES

Support (family, visitors, staff)?

Information in hospital. How did, will, are you going to get information in the hospital?

Are there any problems in getting info from the hospital?

How do you think they could be fixed?

Classes?

Breastfeeding. What do you feel about breastfeeding? Are there any ways that would make it better for you?

Environment (physical)?

Environment (emotional)?

Midwives?

Doctors?

Other hospital people?

Lactation Consultant?

Aboriginal Liaison Person?

Traditional, Cultural aspects. You were talking before about your culture, how do you think that maternity services could be more sensitive to your culture?

A.M.S. Has it made a difference to you?

Are there any other areas you would like to talk about today?

Thank you.
APPENDIX 2

INFORMATION FOR WOMEN INVOLVED IN THE RESEARCH PROJECT

Researcher
Barbara Beale

Telephone
(047) 36-0382 (W)
(047) 53-1061 (H)

Purpose
This project aims to understand the factors that influence Aboriginal women, living in Western Sydney, when choosing a hospital in which to have their babies. The researcher is also interested in what influence the traditional ways of bringing have on you. The results of this project will have some influence on the delivery of maternity health care services to Aboriginal women living in Western Sydney.

Procedure
This research project will be carried out by one or two interviews with you. The interviews will be taped using a tape recorder and you will have control of the recorder, you may turn it off if you choose. The interviews will then be typed onto the computer. This data is then looked at to find important points.

Ethical Considerations
Participation is entirely voluntary and you may leave the project at any time. Privacy and confidentiality will be maintained at all times.

Your name will be substituted by a false name when the data is entered into the computer to maintain confidentiality.

The researcher will be available by phone if you wish to call.

Use of Data
The tapes will be kept till the end of the project.
APPENDIX 3

FACTORs INFLUENCING URBAN ABORIGINAL WOMEN WHEN SELECTING HOSPITAL FOR CONFINEMENT

CONSENT FORM

I have been asked to participate in the above research project and I give my consent by participating in an interview. I understand that:

1. The research project will be carried out as described in the Information Sheet, a copy of which I have kept.

2. If I do not volunteer, or decide to withdraw, my decision will be accepted.

3. My consent to participate is voluntary and I may withdraw from the research at any time. I do not have to give a reason for the withdrawal of my consent.

4. I have read and understood the Information Sheet and had all my questions answered to my satisfaction.

_________________________________

Signature
APPENDIX 4

INTER AGENCY HANDOUT

WHAT ARE THE FACTORS THAT INFLUENCE ABORIGINAL WOMEN RESIDING IN WESTERN SYDNEY WHEN CHOOSING HOSPITALS IN WHICH TO CONFINE

RESEARCH AIMS

This research project aims to understand the factors that influence Aboriginal women residing in Western Sydney when choosing the place of birth for confinement. I aim to find out why these women prefer to use services other than those available locally. I am also interested in how much influence the traditional ways of birthing have on these urban Aboriginal women.

METHOD

The method to be used in this research project will be qualitative using in-depth interviewing, using a phenomenological approach. This method has been chosen in order to capture the richness of the informants' experience using their own words, in order to understand the decisions made in relation to the research topic. In depth interviewing during qualitative research also gives the researcher the opportunity to involve the informants in the research and the Aboriginal women will be involved in this project to its end.

The informants will be Aboriginal women residing in Western Sydney who are receiving antenatal care from Daruk Aboriginal Medical Service or other providers. The interviews will be recorded using a tape recorder and transcribed onto the computer.

SIGNIFICANCE
This research has implications for local mainstream health services which at present do not cater for the local Aboriginal people. I would hope that the findings in this research would be picked up by the local health authorities and utilised to increase the cultural appropriateness of existing services. I would also hope that this research will have psycho-social implications for health care providers with attitudinal changes occurring during the delivery of such services to Aboriginal people. As there is such a gap in research involving urban Aboriginal people, this research may lead to other researchers picking up where this work finishes.

Barbara Beale

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(047) 53.1060 (Home)
MATERNITY SERVICES FOR URBAN ABORIGINAL WOMEN:
Experiences of six women in Western Sydney.

B. L. Beale

Master of Nursing (Honours)
1996
University of Western Sydney, Nepean
CERTIFICATE OF ORIGINALITY

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the award of any other degree or diploma of a university or other institute of higher learning, except where due acknowledgement is made in the text.

(Signed)  

Barbara Beale
Summary

The use of mainstream maternity services by urban Aboriginal women is an important issue for health professionals, especially in the context of the recommended policies contained in the Shearman Report (1989). Aboriginal mothers are much more likely to die in childbirth than are non-Aboriginal mothers and their excessive risk does not appear to have changed over the last two decades. The infant mortality rate is three times higher than for non-Aboriginal infants. It is important that Aboriginal women receive appropriate care from mainstream services which is culturally acceptable to them. Searches of the literature revealed a dearth of information about urban Aboriginal women and their interaction with maternity services. Therefore, this project aimed to discover the cultural needs of urban Aboriginal women who use mainstream maternity services.

Six Aboriginal women who were attending the ante-natal clinic at Daruk Aboriginal Medical Service were interviewed. Analysis of the interviews showed 1) the women were proud of their Aboriginality, 2) traditional cultural mores related to childbirth had been lost, 3) breastfeeding had not been discussed fully with the women and was not actively promoted and 4) experiences of racism were reported. Three of the women in particular, had a positive energy towards their culture and 'women's business' which would be invaluable in setting up the recommendations of this thesis.

The thesis includes the following recommendations and strategies for their implementation:

1. establishment of a discrete Aboriginal women's health unit in Western Sydney,
2. provision of culturally acceptable education about pregnancy and childbirth,
3. promotion of breastfeeding,
4. education and encouragement for non-Aboriginal health professionals.
ACKNOWLEDGEMENTS

I would like to thank the following people for their unfailing support:

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EXPLANATION OF TERMS

Borning- 'Borning, determined by the Law and the Dreamtime, is firmly situated in a tradition of belief about life and death, the relation of people to their origins and the rights and responsibilities of people to kin and country. Borning has a holistic, purposeful and sacred character, and these dimensions of life are carefully woven and directed in the borning process. Borning is a symbolic and progressive happening that encapsulates spirit, country and Dreaming. A social and spiritual identity and not merely a physical organism comes into being in a cycle of past, present and future relationships.' (Carter, Hussen, Abbott, Liddle, Wighton, McCormack, Duncan and Nathan, 1987, p8).

Antepartum, antenatal, prenatal - Time between conception and onset of labour; usually used to describe the period during which a woman is pregnant.

Gestation- the number of weeks since the first day of the last menstrual period.

Term- the normal duration of pregnancy.

Intrapartum - time from onset of labour until the birth of the infant and placenta.

Postpartum, postnatal - time from birth until the woman's body returns to an essentially prepregnant condition.

Gravida - any pregnancy, regardless of duration, including present pregnancy.

Primigravida - a woman who is pregnant for the first time.

Multigravida - a woman who is in her second or any subsequent pregnancy.

Primipara - a woman who has had one birth at more than 20 weeks' gestation, regardless of whether the infant is born alive or dead.
Multipara - a woman who has had two or more births at more than 20 weeks' gestation.

Obstetric terms (except those already referenced) are taken from Olds, London and Ladewig, 1992, p 317.