

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

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## THESIS SUMMARY

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

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

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

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

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

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

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

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

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

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

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To my extended family who continue to remind me that life is for living, and that it's about the quality of life not how long you live.

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

## DECLARATION

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

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

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*Renaë Kirkham*

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*Date*

## TERMINOLOGY

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

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

## INTRODUCTION

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Aboriginal and Torres Strait Islander peoples (hereafter referred to as Aboriginal peoples) are the original inhabitants of Australia, but are yet to be recognised as such by the Australian Constitution. During 2011, 2.5 per cent (548,639) of the total Australian population identified as being of Aboriginal or Torres Strait Islander descent (Australian Bureau of Statistics, 2012). Relative to other Australians, Aboriginal peoples continue to experience social, economic and health disadvantage. Lower life expectancy is one indicator of this disadvantage; currently the estimated life expectancy of this population is at least ten years less than the non-Aboriginal population. High infant mortality is a key driver of this inequality (Australian Bureau of Statistics, 2002).

In 2011, 6 per cent (17,621) of the total registered births (301,617) in Australia were Aboriginal (at least one parent identified as being of Aboriginal or Torres Strait Islander origin) (Australian Bureau of Statistics, 2012). Aboriginal women, on average, commence childbearing at younger ages and have more children than other Australian women. For example, in 2011 the total fertility rate among Aboriginal women was 2,740 births per 1,000 compared to 1,884 per 1,000 among non-Aboriginal women (MacRae et al., 2013). Furthermore, there is a high rate of teenage fertility among Aboriginal women (79 babies per 1,000 women) compared to that of all other Australian women (17 babies per 1,000 women) (Australian Institute of Health and Welfare, 2011). There are disproportionately high rates of adverse maternal and infant outcomes for Aboriginal mothers and babies. The rate of Aboriginal perinatal mortality is higher than the rate in the non-Aboriginal population (13 per 1,000 births compared with 9 per 1,000 between 2004-2008) (Australian Institute of Health and Welfare, 2011). This is also seen in the Aboriginal infant mortality rate, which is almost double that of other Australian babies (7.8 per 1,000 live-births compared to 4.0 per 1,000, respectively), despite having declined since 2006 (Australian Institute of Health and Welfare, 2011).

In 2010, 13.5 per cent of babies born to Aboriginal mothers were born preterm (<37 weeks gestation), occurring at almost twice the rate than for other Australian mothers (8 per cent) (Li, Zeki, Hilder, & Sullivan, 2012). The rate of low birth

weight (< 2,500 grams) among Aboriginal babies was also double the rate for other babies (12 per cent compared with 6 per cent in 2010), and there is evidence that this gap is widening (Chan, Scott, Nguyen, & Sage, 2011; Scheil, Scott, Catcheside, & Sage, 2012). These morbidities have both immediate consequences for health (i.e. higher risk of death, increased hospitalisation) as well as long-term sequelae (including poor development in childhood as well as chronic disease in later life).

In South Australia (SA), 3.2 per cent of the total births in 2010 were to Aboriginal mothers (Scheil et al., 2012). The outcomes for Aboriginal women in SA are similar to the national data for Aboriginal mothers. In 2012, the perinatal mortality rate among SA Aboriginal women was 9.5 per 1,000 births, compared with the rate of 8.1 per 1,000 births for non-Aboriginal women. While this is the lowest rate recorded, and much less than the 2007 figures (27.1 vs. 9.0 per 1,000 births respectively) (Chan, Scott, Nguyen, & Sage, 2008), fluctuations may have occurred due to small numbers (Scheil et al., 2012). Furthermore, twice the numbers of Aboriginal babies in comparison to non-Aboriginal babies born in 2010 were of low birth weight. In fact, Scheil et al. (2012) reported that 16.3 per cent of babies born to Aboriginal women in SA were of low birth weight, compared with 6.9 per cent for non-Aboriginal women.

The high rate of perinatal mortality and morbidity for the Aboriginal population is of particular concern as it is recognised internationally as an indicator of the quality of maternity care and maternal health status in pregnancy (Lander, 2006). This suggests that existing maternity services are not adequately meeting the needs of Aboriginal mothers and babies.

Good healthcare for women in pregnancy provides an opportunity to improve birth outcomes (Carroli et al., 2001). Aboriginal women have been found to access antenatal care differently to non-Aboriginal women. They are less likely to present in the first trimester and on average have fewer antenatal visits (Middleton, 2009; Rumbold et al., 2011). There are a range of factors influencing the poorer utilisation of antenatal care among Aboriginal women, including services that are culturally inappropriate, healthcare providers who are insensitive to their needs, difficulty

accessing transport to attend visits as well as cost (Bar-Zeev, Barclay, Kruske, & Kildea, 2013; Kildea, Kruske, Barclay, & Tracy, 2010; Kildea & Wardaguga, 2009). There is evidence that programs specifically designed to meet the needs of Aboriginal women improve maternal and perinatal outcomes (Herceg, 2005; Middleton, 2009). Such programs in South Australia include the *Anangu Bibi Regional Family Birthing Program* and the *Aboriginal Regional Family Birthing Program*.

This study focuses on the *Anangu Bibi Birthing Program* in Port Augusta. Port Augusta is situated at the top of Spencer Gulf and is the country of the Bungarla nation. It is a traditional meeting place for at least 32 different Aboriginal language groups. It has a population of 13,658 with 2,358 (17.3 per cent) identifying as Aboriginal (Australian Bureau of Statistics, 2011). Health services are available at the Port Augusta Hospital, a secondary level hospital that has 80 beds and an Aboriginal occupancy rate of 50 per cent. There are also two Aboriginal community controlled health services. In 2010, of the 257 births at the Port Augusta hospital 89 (34%) were to Aboriginal families.

The *Anangu Bibi Birthing Program* was developed in response to poor perinatal outcomes documented in the region for Aboriginal families. A detailed description of the program is presented in Chapter 3. Since its establishment, the program has cared for approximately 80 per cent of mothers of Aboriginal babies who present to the Port Augusta Hospital or other local health providers.

An initial evaluation of the program undertaken in 2007 found that the program was highly valued by local women (Stamp et al., 2008). A comprehensive evaluation assessing the trends in perinatal outcomes since the establishment of the program is currently underway.

The Aboriginal Maternal Infant Care (AMIC) worker role was developed specifically for the *Anangu Bibi Birthing Program*, which is based on a model of care that involves AMIC workers working in partnership with midwives and other healthcare providers to deliver culturally appropriate care. The program adopts a holistic approach to the health and wellbeing of women and their families. While all roles are



vital, AMIC workers have been widely recognised as being critical to the success of the program.

The overarching aim of this study was to seek an in-depth understanding of the experience of the AMIC workers in order to support them in their ongoing role in caring for Aboriginal women during and after pregnancy.

### **Overview**

In this thesis I, as the researcher, applied a critical approach to explore the constructions and implications of the roles of the AMIC workers. Using a theoretical framework that privileges Aboriginal women's voices, I explored the many complexities inherent within their roles, the space in which they work and the extensive obligations they have as individuals to family, community and clients. I present an in-depth analysis of aspects of AMIC workers' personal, community and work life that impact on their ability to fulfil their professional roles. I explore the caring role (someone who remains sensitive to a diverse range of client needs) as a response to the poor health of Aboriginal women and babies, and describe the complex nature of this work. The dominance of the medical model and the ways in which this model shapes the approach to maternal healthcare, the preference for clinically-informed care and decision-making, and the roles of the healthcare workers are also explored. Interwoven throughout these discussions, along with a dedicated chapter exploring the notion of the ideal worker, are examples of how AMIC workers do not conform to the inherent expectations of the ideal worker. I examine the ways in which these expectations are invisibly embedded within the healthcare system and discuss the misfit of this social construction with the role and extensive obligations of the AMIC workers. A major consequence of this misfit is the potential for AMIC workers to experience excessive emotional labour. I explore this and the ways in which emotional work perpetuates itself as a result of the many obligations and responsibilities the AMIC workers have. Partnerships between the program midwives and others within the setting who are supportive of the AMIC worker role are explored as being the most successful strategy for overcoming many of these complex aspects facing AMIC workers. To contextualise the ways in which these constructs and expectations impact on AMIC workers, in the following section I draw upon the narrative of one AMIC worker who participated in this study.

I interviewed this AMIC worker in late 2010. The interview was rescheduled five times because of unforeseen commitments that she had, including sorry business (bereavement which often involves entire communities with funeral and cultural practices). She is a middle-aged woman and has worked in the role for a number of years (I will not disclose specific details for confidentiality reasons). She is a mother, a grandmother and a well-respected member of the local Aboriginal community. Her obligations extend beyond her immediate family, and she has many caring responsibilities to other members of her extended families. She described a ‘typical day’ as an AMIC worker:

*I'd bring [clients] into the clinic to see [the Dr] and the midwife as well [...] I would do [the client's] antenatal check on her. So blood pressure and checking fundal height and doing a palp heartbeat, and then recording [...] that all and just giving [clients] one to one education and going through the care plan that Country Health have put out for antenatal care. So [...] a lot of it is education, one to one. So a lot of it can be in the car as well, talking in the car to the [clients] [...] and then taking them back and just follow ups if they need appointments to the scans, taking them to the scans.*

She touches on a discourse that signifies the importance of the social model of health, a model that is not typically given priority within a mainstream health organisation. While this AMIC worker obviously engages in some of the clinical monitoring of the client, she has no intention of becoming a midwife because to her ‘*it's more about going out into the community and the connections that you have*’ highlighting the significance of the relationships she has developed with other Aboriginal women. One of the main challenges she identified with her role is working in the hospital. Predominantly, the issue stems from:

*... wondering how this midwife is going to, what is she going to think of you. I always get that feeling where, most of them are really good anyway, but you just have some [midwives] that think, oh you know, they don't even bother to say hello to you. And it makes you feel, you know, like they're worth more than you.*

These comments stem from a culture of clinical dominance and traditional views about who should be involved in providing clinical care to clients. It also has underlying references to discrimination. Despite being trained in clinical aspects of maternal and infant care she believes that, *'some of [the midwives] just think we are transport people.'* This demonstrates a challenge the AMIC workers face with regard to a lack of understanding and respect for the role.

Aside from the inherent challenges she faces in relation to existing medical hierarchies and her subsequent acceptance within the workplace, there are also emotionally demanding aspects of her role arising from clients expectations that she will be of assistance at any time of day or night:

*I'm having a shower and the phone's ringing again, "come on you better hurry up, you better hurry up!" So I go in my own car over there [to client's house] and visit and "no, no, long way to go yet". So yeah, you know it's ... yeah, that after hours, before hour's stuff.*

Furthermore, she described a situation highlighting the emotional attachment and subsequent consequences of working with clients with complex needs. This quote also explains that some of the women she works with are relatives:

*... this is very deep, one of my cousin's girls that came down from [a remote community in the North of the state], she wasn't on the program, but um ... we were up at the hospital and she came in and she was in labour plus she had the swine flu, and she came into the labour ward, all ready, and the Obstetrician was saying "yep that baby is dead already" then I had to [...] 'cause she was family, so it was like I had two hats on. I had to um ... you know be the health professional there, and um ... then I also had to take my hat off and put on my family hat [...] advocate for her, because she ended up going down to Adelaide and six weeks after she died. So that was very, yeah ... experience that was one of the worst. [...] You had to be really strong like that.*

Not only does this illustrate the depth of the relationships she has with clients, and her responsibilities to the wider community, but also demonstrates her requirement to have a dual advocacy role. Events of this tragic nature happen far too often in many Aboriginal communities, and inevitably have a strong emotional impact. The emotional impact from such situations is an important matter that this thesis demonstrates is largely unrecognised by Australian healthcare services. This AMIC worker describes how she deals with such situations:

*You can have your downfall and you feel you know, like ohhh crap, but you still go up on a high then because something else has happened. Like maybe if you've had to go to a baby's stillborn funeral, and then you feel so down. And then next week you might have you know, like a birth. So that brings you back up again.*

This description was given in response to a question I asked inquiring into whether or not she thought AMIC workers are resilient. She believes there are some protective factors against 'burnout', including a connection to clients and their families that increases the positive impact of births and the good experiences and outcomes that follow. In the times when things are not going well, she comments that she is able to go to colleagues within the birthing program for support. She believes that the AMIC workers:

*... wouldn't be able to do it without the midwives and the doctors. And I think they wouldn't be able to do it without us because of the cultural knowledge and background.*

This demonstrates the importance of partnerships within this setting, and acknowledges that mutual respect for each other within the birthing program is critical to the success of the model. Despite all of the complexities she faces within her role, this AMIC worker believes a measure of the program's success is the increase in early engagement with antenatal care among local Aboriginal women. It is this that she describes as being the best thing about being an AMIC worker:

*And they're coming early, like we're getting some at six weeks, eight weeks, so you know, it makes you think that you're doing good and also you get your girl on the program and then we've had a girl that's been on our program three times, so three babies she has had on our program, so that's good because it makes you think, oh well we must be doing something right.*

The themes identified in this narrative, which are common to many of the interviews with AMIC workers and other participants of the study, are identified throughout the AMIC worker interviews, and are further explored in discussion with the other participants of the study. The complex ways in which these themes are interlinked forms the main exploration of my thesis.

### **Thesis Structure**

I have structured this thesis according to the five main themes that have been described throughout this AMIC worker's narrative, and identified in the wider literature. Each theme is explored in a separate chapter. Each chapter comprises a literature review, followed by an in-depth analysis of the data, and a discussion of the findings in the context of the wider literature. I have written these chapters in such a way as to honour the voices of the AMIC workers, by allowing their perspectives and opinions to remain the focus of the analyses chapters.

In Chapter 1 I locate this research within a social constructionist framework that privileges Aboriginal voices and perspectives. Important aspects of conducting research with Aboriginal people are discussed and my own positioning as a non-Aboriginal researcher is described. The research processes I engaged with are also explained, including the methods I used for data collection, and analyses, and how I ensured that the research remained rigorous.

Chapter 2 focuses on the construction of the AMIC worker role as a caring role, to address local needs and preferences for care. This chapter also explores the nature of the role beyond clinical activities, the extent of relationships between AMIC workers and clients, and the level of understanding of the role among other professionals working in this setting.

Chapter 3 examines the impact of medicalisation on the delivery of maternal and infant healthcare in this setting. Through the analyses I explore the differences in construction of risk between Western and Aboriginal worldviews, the dominance of the medical model over other approaches to health and wellbeing, and the subsequent compromises and challenges that arise for AMIC workers sitting at the interface between two very different knowledge systems.

Chapter 4 explores the concept of the ideal worker and I consider how this construct is an outdated and unrealistic expectation of this particular workplace. I review the common expectation of the ideal worker as being able to separate their private and public spheres of life. I then discuss the constraints that AMIC workers have in fulfilling this expectation, and its relevance (or lack thereof) to this role.

This line of argument continues in Chapter 5, where I consider how AMIC workers are affected by different types of emotional work. I present an in-depth analysis of the nature of the emotional work they engage in, and discuss the potential consequences of this for AMIC workers and the sustainability of the wider program.

Chapter 6 explores how partnerships between AMIC workers and program midwives act as a buffer against the challenges faced by each role that are inherent to the system and when working cross-culturally. Discourses around the importance of mutual respect and using partnerships as a strategy to overcoming challenges (including difficulties negotiating the health system and gaining wider recognition for the importance of the role) and unrealistic workloads are also explored.

In Chapter 7 I conclude the thesis by discussing the complexities that are involved in the AMIC worker role and the pathways of associated conflicts (largely a misunderstanding of the role by other professionals within the maternity setting). Furthermore, I consider the implications of this study for our understanding of the dominance of Western ideas about health, how these ideas are often invisible to those working within the health system, and how AMIC workers negotiate these differences. I also consider how these concepts often compromise aspects of the AMIC worker role and how an illumination of the challenges they cause may be helpful in supporting the ongoing sustainability of the role. Through deepening this

understanding I bring together the findings that have emerged from the research, along with the incorporated feedback from the AMIC workers, and propose recommendations for providing more support and recognition of the AMIC worker role, and also the wider sustainability of the program. I conclude with a discussion of directions for future research.

## CHAPTER 1: METHODOLOGY

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In this chapter, the dominant questions driving my PhD research, the conceptual framework underpinning it, and the specific methods used will be outlined. Also detailed in this chapter are the underlying values of the research, ethical considerations for working with Aboriginal people, potential benefits for participants and the wider community and potential limitations of the research methodology.

The overarching aim of the study was to seek an in-depth understanding of the role of Aboriginal Maternal Infant Care (AMIC) workers in order to support their ongoing contribution to the care of Aboriginal women during and after pregnancy.

Specifically, the study aimed to increase understanding of the role of the AMIC worker and explore the ways in which they manage the differences between a Western medicalised approach to maternity care and of Aboriginal understanding of reproductive health.

I proposed a series of questions that required exploration in order to address the study's aims. Firstly, looking at what the roles involve and how the AMIC workers find paths that: (a) meet the needs of women; (b) respond to the health service; and (c) align with their roles and responsibilities within the community. In particular, I considered how the AMIC workers deal with 'between world' negotiations and the tensions that exist within them. Additionally, I was interested in exploring the AMIC workers' perspectives on 'keys to success' and their understandings of resilience and sustainability within a working environment in order to identify effective ways of supporting AMIC workers in their work.

Literature on the main concepts that are explored in this thesis, including the effects of medicalisation, the ideal worker and emotional labour, reflect Western thought. This thesis will demonstrate that foregrounding Aboriginal perspectives in relation to these concepts improves our understanding of the way they exist for or impact upon Aboriginal people. Much of the theoretical development around these concepts has been driven by feminist perspectives, which have challenged gender-neutral interpretations of the health system and work organisations. While these analyses



highlight the importance of deconstructing gendered structures and processes and provide useful building blocks in developing such understandings, I am focusing on Aboriginal perspectives that have been less visible. I accept that gender is a highly relational social category and therefore this focus will have gendered components. As such, I am being deliberate in foregrounding Aboriginal perspectives and have given them preference in the analysis of the overall ideas and concepts presented, but accept that there will be gendered and class processes at work. By taking this perspective I am contributing to feminist understandings of medicalisation, emotional labour and the ideal worker concept through demonstrating the need to expand these concepts to incorporate different meanings and effects for women, beyond the white Western woman.

### **Conceptual approach**

This research was guided by a social constructionist epistemological perspective, an appropriate approach to cross-cultural research (Liamputtong, 2010). It thereby adopted the position that our known realities are socially constructed and language constituted (Burr, 1995, 1998). When considering the contexts of different cultures, this notion of knowledge being socially constructed is extremely important. As articulated by *Crotty*, constructionism's focus is on 'the collective generation [and transmission] of meaning' and 'emphasises the hold our culture has on us: it shapes the way in which we see things and gives us a quite definite view of the world' (Crotty, 1998, p. 58). Consequently, it is appropriate that this approach has guided the exploration of the roles of the AMIC workers, within the context of culture, history, policy and experiences.

The theoretical perspective 'interpretivism' is located within the social constructionist epistemology and 'looks for culturally derived and historically situated interpretation of the social life-world' (Crotty, 1998, p. 67). As cross-cultural interactions are inherent in the *Anangu Bibi Regional Family Birthing Program*, such an approach has allowed for different knowledge systems to be explored. An understanding of different worldviews can be gained through the exploration of the range of views and interpretations of people involved or affected. A better understanding of the knowledge systems and structural factors affecting the roles of the AMIC workers has been gained from the application of this paradigm to this research project.

I acknowledge that there are many relational aspects associated with the AMIC role, which could be interpreted through a gendered lens, however I have chosen to privilege Aboriginal knowledge and experiences for the reasons that are described in the following section.

**A decolonising research methodology**

The superior position European colonists and scientists assumed over Aboriginal societies has not only damaged Aboriginal cultures globally, but also silenced Aboriginal voices (Smith, 1999). As such, Aboriginal people have become suspicious and distrustful of Western researchers and their objectives (Smith, 1999). Research can be understood in historic terms as being a metaphor of colonialism (Prior, 2007). Historically, research has been used to both instigate and support repressive policies that negatively impact upon Aboriginal people. As a result, more recently, colonised Aboriginal people have begun voicing their concerns about research and challenging the assumptions and authority of research that continues to colonise and position Aboriginal people as the ‘problem’ (Smith, 1999).

There is a legacy of exploitative, disempowering research practices involving Aboriginal groups in Australia (Thomas, 2004). Power dynamics can exist within research processes, particularly in cross-cultural research, or research involving minority groups (Smith, 1999). Linda Tuhiwai Smith, a Maori academic, used the following lines in the opening of her text *Decolonising Methodologies* (1999, p. 1):

*... the term ‘research’ is inextricably linked to European imperialism and colonialism. The word itself, ‘research’, is probably one of the dirtiest words in the indigenous world’s vocabulary.*

Decolonising research processes require critical and reflexive views, whereby the primary research focus is not on the aims of the researcher, rather on the agenda of the Aboriginal people. It advocates for engaging relationships between the researcher and those involved in the research (i.e. study participants), which are based on trust and co-operation (Prior, 2007). Furthermore, it has been argued that the aim of the decolonising research movement has been to evoke discourse (Tyler 1986 as cited in Prior, 2007), through meaningful and respectful relationships and associated

collaborative processes (Prior, 2007). As such, both the method and outcome of decolonised research should be in line with the epistemologies and cultural views of Indigenous people (Smith, 1999).

Lester-Irabinna Rigney, a researcher from the Narungga, Kurna and Ngarrindejeri nations of South Australia, focuses on Indigenist research and its aims to decolonise Western approaches to research. He described Indigenist research as that which is conducted by and predominantly with Aboriginal Australians, as a way of establishing power and overcoming oppression (Rigney, 1997). The three main principles of Indigenist research include resistance as an emancipatory imperative, political integrity and privileging Aboriginal voices. Rigney developed Indigenist research through the following strategy:

*... my people's interests, experiences and knowledges must be at the centre of research methodologies and the construction of knowledge about us. Incorporating these aspects in research, we can shift the construction of knowledge to one which does not compromise Indigenous identity and Indigenous principles of freedom from racism, independence and unity (Rigney, 1997, p. 637).*

While I am not an Aboriginal researcher, I have developed and maintained strong relationships and processes to allow this research to be informed by Aboriginal people and to privilege Aboriginal voices and perspectives. I describe my positioning a little later in the thesis.

Karen Martin, a Noonuccal woman and researcher from Minjerripah (North Stradbroke Island, Queensland), expanded on Rigney's Indigenist research principles and questioned the position of resistance, claiming that her 'belief as an Aboriginal researcher is that [she] actively use[s] the strength of [her] Aboriginal heritage and do[es] not position [her]self in a reactive stance of resisting or opposing Western research frameworks and ideologies' (Martin, 2003, p. 205). Martin believes that Aboriginal research will continue to be merely Western research conducted by Aboriginal researchers unless it 'centralises the core structure of Aboriginal ontology' (Martin, 2003, p. 205). Aboriginal ontology includes worldviews that encompass aspects of Aboriginal culture and experiences that have influenced current ways of

knowing (Martin, 2003). Research with Aboriginal people should therefore be culturally safe and culturally respectful of this ontology, recognising the inherent differences from Western ontologies.

While research has produced extensive knowledge highlighting the gaps between Aboriginal and non-Aboriginal health and welfare, it has also been recognised that simply knowing about these disparities does not translate into improved outcomes (Prior, 2007). Therefore we enter into an ethical dilemma regarding the ways in which research results are produced and used. For example, it has been argued that research informing the 'Close the Gap' campaign produces more damaging discourses around Aboriginal health and wellbeing, with unrealistic expectations set around reducing the disparities (Black & Richards, 2009). It has been recommended that for Aboriginal research to be ethical the researcher is required to decolonise the research (Coram, 2011), and also perform research that encourages the production of meaningful and useful outcomes for Aboriginal people (NHMRC, 2002, 2006). Simply put, as Aboriginal friends and colleagues warned me in the early stages of my PhD candidature, it is important not to conduct research for research's sake.

Another dimension of this discussion has been raised by Kowal (2011) who describes the stigma of white privilege in Australia. White anti-racists are described as people who are concerned about Aboriginal disadvantage and have the ultimate goal of helping Aboriginal people until their help is no longer required. As such, they believe that all research concerning Aboriginal people should be led and undertaken by Aboriginal researchers. As put by Kowal (2011, p. 315) white anti-racists who work in Aboriginal health research in the Northern Territory have a 'highly ambivalent attitude toward their own agency [which] is rarely discussed in the academic or popular literature, yet it is crucial to understanding the limits and possibilities of post-colonial justice.' My own engagement with these discourses is discussed further below.

A critical reflexive view of the way in which research with Aboriginal people is conducted has recently emerged (Nicholls, 2009). Reflexive practice may involve continually cross-checking with the Aboriginal people involved in the research that they are supportive of the research aims and processes. I was reassured frequently by

the AMIC workers interviewed in this study that this work was not only in line with many of the values they held as AMIC workers, but the potential recognition it may afford AMIC workers and the program was appreciated. For example, when I asked one AMIC worker how she believes the AMIC worker role could be better acknowledged, she responded by saying *'Oh Renae people like you. People like you; you know you're going to do this study and you're going to put it out there.'* There were other instances of this form of reassurance, including when one AMIC worker advocated strongly for me and this research at management levels (specifically when I was seeking approval to interview clients of the program). She told me that after watching me work, and having been interviewed herself, she felt very safe with what she named my 'gentle' approach, and wanted to support the ongoing processes of the research. While this is not claiming that all people share these same views about this research, I believe it highlights the level of acceptance and support this research was given by at least some of the local Aboriginal community and the women involved.

I established an Aboriginal Reference Group to assist with appropriate research processes (including dissemination of results) and accurate interpretation of the results. This group included local AMIC workers and community representatives. I frequently checked in with the Aboriginal Reference Group and individuals involved in this research around the appropriateness of my research processes and aims, and received no negative feedback about the research or its processes at any stage. My approach will be elaborated on in the section entitled 'Research Design'. I believe this affirms my commitment to undertake respectful work, which was recognised by others involved in this research.

As a non-Aboriginal woman, I understand that there are constraints on both the way the research was conceptualised and how it was undertaken and interpreted. Prior to commencing my PhD I had frequent conversations with a local Aboriginal elder, with whom I had a long standing relationship: this elder constantly reminded me that Aboriginal knowledges should inform research with Aboriginal people, and that other epistemologies developed through a Western lens were not adequate. These discussions, supported by relevant literature as described above, contributed to my decision around the most appropriate theoretical framework to inform this research.

As discussed by Laycock and colleagues (Laycock, Walker, Harrison, & Brands, 2011), good quality research within the Aboriginal context is linked to productive and trusting relationships between the researchers and others involved in the research processes. Ian Anderson also described the importance of the quality of the relationships and subsequent trust established between the researcher and the research participants (Anderson, 1996). As such, throughout the entire research process it has been critical that trust was developed and maintained with the local Aboriginal communities. I was constantly mindful that the research needed to be respectful of Aboriginal knowledges and values.

Furthermore, I understand that as a non-Aboriginal woman conducting research with Aboriginal women, research that has attempted to privilege an Aboriginal conceptual framework, there are inherent differences in the ways in which we experience and interact with the world and how we construct meanings of this. I acknowledge that being part of the privileged white majority influences my understandings and interactions with the world. These differences not only influence cultural beliefs, but are also related to social and material processes that influence experiences. I also understand that not being a mother myself and discussing in-depth aspects of women's business and maternity care, is a possible limitation of my understanding of these aspects of women's lives. However, I believe my positioning within the local community has given me a deeper insight into local Aboriginal worldviews and allowed me to develop a greater understanding of culture and everyday life for the women involved in my study. I also understand that as a non-Aboriginal woman there is information regarding Aboriginal culture that I am not privy to, which I both respect and appreciate. While this may be considered by some as a constraint upon my research, I understand that the information that was shared with me is important because it is that which women feel comfortable disclosing and have given permission to be shared with a wider audience. I attempted to overcome these limitations by continually checking meaning and my interpretation of findings through consultation with the Aboriginal Reference Group and other community members.

#### ***Establishing meaningful relationships***

As described, establishing meaningful relationships has been critical to the development of this study and as such it is important to describe the foundation on

which my relationships have been built. I was born and grew up in Port Augusta, and have developed relationships with many Aboriginal people within the town from a young age through school, family and community events. My work, both PhD and other, has been motivated by witnessing the health disparity between Aboriginal and non-Aboriginal people while growing up in Port Augusta. One important experience that had a strong impact upon me and helped to deepen my understanding of the poor treatment of Aboriginal people and unacceptable differences between the two populations; was during a vocational placement in psychology offered by the Spencer Gulf Rural Health School, with the Social and Emotional Wellbeing Team at Pika Wiya, the local Aboriginal Health Service in Port Augusta. It was during those six weeks, in the final months of 2006, that I repeatedly felt ashamed of my ignorance as a non-Aboriginal person of the dire situation that had always existed right in front of me, but one that I had (shamelessly) not recognised. I had spent my childhood growing up with Aboriginal children, playing in the scrub, playing sports, picking peaches, going through school, all the while learning about the world through a very Western lens, and going home at the end of each day to very different lives. The retrospective ignorance with which I had lived these experiences remains unsettling to me. It was during my time on placement that I made the conscious decision to start what I believe will be a lifelong journey of working with and learning from Aboriginal people.

As a result I have been passionate about being involved with a number of different initiatives aimed at addressing inequality and empowering Aboriginal individuals and groups. Some of these initiatives include working with local Aboriginal youth at the Port Augusta Youth Centre for a number of years, being involved in numerous cultural awareness field trips (from 2009-2012) taking various healthcare professionals to the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands (in the north of South Australia) as well as being involved in local events and health organisations. Furthermore, I have recently been closely engaged in a project with the Centre for Regional Engagement, University of South Australia, which introduces secondary students from Mimili Anangu School (located in the APY Lands) to tertiary education pathways. This has involved regular trips to the lands to further establish relationships: core to my role in this project has been an understanding of the importance of maintaining cultural values and links. My involvement with these

initiatives has given me a strong understanding of the diversity of cultural practices, beliefs, as well as circumstances and issues facing Aboriginal people in contemporary society.

Developing respectful relationships with the local community has been critical to building trust and maintaining meaningful relationships. In particular, the relationships I established or further developed with the staff of the *Anangu Bibi Birthing Program* were critical to how I was accepted and viewed by these women. While I did not personally know any of the AMIC workers prior to commencing my PhD, I did have well-established relationships with some of the program midwives, ward midwives and medical practitioners. I believe that some of these relationships assisted with the development of my relationships with the AMIC workers, and the extent to which they felt they could trust me.

My mother is a nurse at the Port Augusta Hospital and a nurse tutor at Pika Wiya Health Service, and she is known to most of the staff I interviewed in this study. I am confident this influenced the willingness participants had to be involved in this research, along with the ease in which we were able to interact. I spent a lot of time visiting my mum and her students at the Pika Wiya Learning Centre throughout the course of my PhD. It is important to note that the AMIC workers also receive their formal training in this facility. I believe that the relationships I continue to form with members of the local Aboriginal community through this safe learning environment assist with the further promotion and recognition of the AMIC worker role. They also continue to deepen my insights into life for Aboriginal people in this community.

My sister became pregnant during 2010/2011, and as a result of my mum's relationship with the AMIC training program she was instrumental in organising for my sister to be a 'dummy/volunteer patient' for the AMIC workers' antenatal training sessions. Not only did these experiences contribute to my unique experience of establishing quite personal relationships with some of the AMIC workers, it also gave them a deeper insight into my family and the nature of my family relationships. My niece continues to be the topic of many conversations and was often used as a reference for me during client interviews when discussing different aspects of maternity care.



Also of importance was that I spent the first two and a half years of my PhD journey working from the Spencer Gulf Rural Health School offices, which were based in the Port Augusta Hospital. Not only did this give me ease of access to the ward environment, but it also meant that I often crossed paths with program staff, and at the time of interviews participants were able to easily get back to the ward in the case of an emergency (which happened only once), and I was able to be called up to the ward at very short notice (particularly for meetings or to conduct client interviews). I believe this also contributed to the establishment and maintenance of relationships, along with the transparency of my research processes.

I believe there is enough evidence through my acceptance by members of the community and program to demonstrate that my research is not tokenistic. Other evidence of this includes my invitation from the *Aboriginal Regional Family Birthing Program* to make an information booklet about the program to be distributed across the state, the willingness of all AMIC workers to be involved in my research as well as approval given by the program's State-Wide Steering Committee to interview clients. This was allowed after I had demonstrated my approach to interviewing program staff.

#### **Consultation with stakeholders**

This project was preceded by consultation with members of the local Aboriginal community, members of the *Anangu Bibi Regional Family Birthing Program* and appropriate staff from the Port Augusta Hospital and Country Health SA. Firstly, Aboriginal people employed by Pika Wiya Health Service were consulted around ideas of the research topic, and its potential benefit to community. Preliminary research ideas were then established, and members and key stakeholders of the birthing program and staff from the Port Augusta Hospital were consulted around the research ideas and objectives. A one-page brief, summarising the research proposal, was circulated to members of the State-Wide Steering Committee prior to a meeting early in 2010, which I attended with one of my supervisors to present my research proposal and answer any questions and concerns. All subsequent interactions and responses from the Committee were positive. Following permission from the Committee to undertake research, I received approval from the Aboriginal Health

Council of South Australia's Aboriginal Health Research Ethics Committee and The University of Adelaide's Ethics Committee (Human Research Ethics Committee, The University of Adelaide - Project Number H-018-2010; The Aboriginal Health Research Ethics Committee, The Aboriginal Health Council of South Australia-Reference Number 04-10-325).

Approval to interview clients of the program was not gained until 2011, after I reapproached the State-Wide Steering Committee to do so. Following their permission, I applied for ethics approval through both aforementioned ethics committees, which I was granted.

#### **Aboriginal Reference Group**

The establishment of an Aboriginal Reference Group for the project helped to ensure the project remained culturally safe, respectful, relevant and appropriate. Specifically, the purpose of the Aboriginal Reference Group was to: provide an Aboriginal view on how to run the study appropriately; to ensure I remained respectful to individuals, families and the community throughout the entire research process; to guide and inform the study to assist in shared understandings of the project, open and trustful communication, and community support; and to ensure the study was completed in good time, so that results can contribute to knowledge and be distributed widely.

The Aboriginal Reference Group consisted of seven Aboriginal women who had been recommended to me by senior Aboriginal women involved in the *Anangu Bibi Birthing Program*, and others from the Aboriginal Health Service. These women were invited through either personal meetings, phone conversations or via email. Three meetings were held in 2010 when the project was being established, and another one in 2013 to discuss and confirm the accuracy of my interpretation of findings, and consult with the group around appropriate methods of dissemination. Two women attended all meetings, and one other attended one of the meetings in 2010. While meeting times that were convenient for all women were attempted, many of these women had extensive commitments and obligations and were therefore unable to attend. Apologies were mostly given for absences. Despite members not being required to make it to every meeting, they were given the choice to end their

involvement with the group at any time. All group members remained in the group, and received regular updates about the research, along with the minutes of meetings.

Through the relationship I established with one member of the Aboriginal Reference Group, I was invited to attend a cultural awareness weekend at Iga Warta in the Flinders Ranges being held for program midwives from metropolitan Adelaide after the expansion of the program to metropolitan areas in South Australia. This was an invaluable experience, which deepened my knowledge regarding aspects of Adnyamathanha culture. It also gave me insights into the depth of cultural knowledge and understanding of many of these midwives, along with the processes involved in cultural awareness training given to *Anangu Bibi Birthing Program* staff.

I was also able to check the accuracy of my interpretations and appropriateness of the conduct of my work through opportunistic conversations with both members of the Aboriginal Reference Group and other women in community, for example during workshops or team meetings. This allowed me to continually assess boundaries of the research and assisted in maintaining respectful research processes.

#### **Recognition of participants**

Consultation with the Aboriginal Reference Group assisted in determining the most suitable form of reimbursement for participants. All participants were given a voucher to a nominated department store in the town. Aboriginal Reference Group members were also reimbursed appropriately for their time. I believe this was important to demonstrate that I valued their time and contribution, as many had other commitments including substantial family obligations.

#### **Framework for working in an Aboriginal setting**

Throughout my PhD I have gained knowledge about the impact of historical and contemporary political processes on the way Aboriginal people access and engage with services. I am very aware that in many communities, there continues to be widespread distrust of mainstream institutions. I am also aware that Aboriginal people have been the subject of an intense amount of research, and that this research has often been of little or no benefit to community members, and has sometimes been exploitative. Therefore, in order to overcome the ongoing legacy of these past practices, there is a strong need for researchers to build trust and respect and

undertake meaningful engagement with community members. These processes require a substantial investment of time, as well as the formation of partnerships to identify solutions that are tailored to local needs and promote respect for culture. I have attempted to keep these values central to the research processes of this PhD and the way I conduct myself when engaging with Aboriginal people.

There are a number of guidelines for working respectfully with Aboriginal and Torres Strait Islander people. The National Health and Medical Research Council defined six core values in its report *Keeping Research on Track: A guide for Aboriginal and Torres Strait Islander Peoples about Health Research Ethics* (2006). These principles are based on Aboriginal and Torres Strait Islander understandings of health and research (Tjikalyi & Garrow, 1998) and focus on the Aboriginal and Torres Strait Islander values of spirit and integrity, reciprocity, respect, equality, survival and protection and respect. This is an exemplary model for a decolonising research paradigm (Prior, 2007). This research keeps Aboriginal knowledge, leadership, values and worldviews central to its processes.

As such, this project aligns with these priorities and values and aimed to address the six main values, which were further described in the NHMRC Report *Road Map II: A Strategic Framework for Improving the Health of Aboriginal and Torres Strait Islander People through Research* (2010b). Here I detail how my research is consistent with each of these main values.

### **Spirit and Integrity**

Spirit and integrity is the value that over time binds the other five values together. This research remained respectful of spirit and integrity in several ways. Firstly, it remained respectful of the principles of capacity building and empowerment, promoting resilience (in AMIC workers), promoting optimum service delivery and focusing on urban Aboriginal populations and urban health. Promoting resilience was a central aim of the research, and was achieved by recognising the success stories and providing positive feedback to the program around identified strengths. This research was specifically fed back to program managers to promote optimum service delivery. Capacity building and empowerment were promoted by the research, through professional development opportunities (such as co-presenting at a national

conference and being involved in a publication) offered to AMIC workers throughout the research process, along with promoting further value of the AMIC role both within the program and to a wider audience. Furthermore, I remained flexible with interview times, meetings and other engagement with community to allow for community events. Throughout the research process I also understood the obligation I have to the spirit and integrity of communities and as such maintained a project that was consistent with community values.

### **Reciprocity**

This research aimed to promote empowerment, resilience and increase sustainability of AMIC workers by strengthening and gaining a wider understanding of and appreciation for the AMIC worker role. Specifically, through the process of dissemination a wider audience (both locally and nationally) have had the opportunity to learn more about the value of the role. With regard to the sustainability of the role in the context of the program, a better understanding of the AMIC role and associated challenges has been gained, and moves made to overcome some of these challenges. The formation of the Aboriginal Reference Group, which included AMIC workers and community representatives, enabled some members to learn more about the research process. This group was formed after consultation with the State-Wide Steering Committee responsible for overseeing the program and the local program steering committees. Appropriate representatives from the community and program who are involved in the care of Aboriginal women during pregnancy were invited to be part of this group in addition to Aboriginal women with experience in engaging in research. The purpose of the Aboriginal Reference Group was to provide advice in regards to; appropriate research processes, interpretation of findings, publication protocols and dissemination of results to communities and the wider public.

Through my engagement with the *Aboriginal Regional Family Birthing Program's* State-Wide Steering Committee, I worked in collaboration with the program to develop an information booklet ('Aboriginal Women Caring for Aboriginal Women: Aboriginal Family Birthing Program') that was distributed across South Australia as the program expanded. Furthermore, I co-authored a paper with an AMIC worker that was published in 2010 (Stuart-Butler, Kirkham. The Aboriginal Maternal Infant Care Story. *Aboriginal & Islander Health Worker Journal* 2010; 34: 9-11.). I also sought

and won a scholarship that enabled a member of my Aboriginal Reference Group to attend the Public Health Association of Australia's 2013 conference on Complex Needs and Social Inclusion. This provided her with a professional development opportunity as she co-presented with me. I felt it was important that my research be presented for the first time in partnership with an AMIC worker.

### **Respect**

This project was designed to contribute to shared understandings of the role of the AMIC workers. It also aimed to give these workers a voice, and increase awareness of their roles, opinions and knowledges. In line with theories around decolonising methodologies I had Aboriginal input into the manner in which the research questions and research processes were shaped. Additionally, I worked closely with relevant stakeholders, including community members, government departments (in particular Country Health SA), the local Aboriginal community controlled Health Service (Pika Wiya), and the *Aboriginal Regional Family Birthing Program's* State-Wide Steering Committee to ensure the project remained respectful of community needs.

Additionally, I adhered to rules about cultural safety and appropriateness as guided by the Aboriginal Reference Group.

### **Equality**

Equitable access to antenatal care that is culturally safe and appropriate is the right of all Aboriginal women in Australia. The *Anangu Bibi Birthing Program* is designed to support this right, and this project aimed to contribute further to the understanding of why and how Aboriginal women are able to feel comfortable in accessing care from AMIC workers and therefore promote optimum service delivery. This research provides further justification and support to the continuation of the program and highlights the appropriateness of the service in engaging women who may have otherwise not felt comfortable accessing antenatal care. Furthermore, the knowledge and wisdom of all participants involved in the study was valued and has been represented appropriately throughout the analyses and writing.

### **Survival and Protection**

It is envisaged that the research will benefit the *Anangu Bibi Birthing Program*, proposing the views and opinions of the AMIC workers will be incorporated into protocols for program delivery. The research findings also provide evidence to support the case for ongoing funding, which is currently relevant considering recent

funding cuts to the program. At all times, the research remained conscious and sensitive to the fact that Aboriginal knowledge is owned by the informants themselves. All participants were provided with a copy of their interview and findings, and interpretations were cross-checked with participants once transcriptions were complete. Furthermore, the research highlights the many different cultural groups involved with the program, contributing to the cultural and social bonds that exist between families and groups within the region. This further contributes to the survival and protection of local Aboriginal knowledges.

### **Responsibility**

Through valuing the roles of individuals and AMIC workers, and being accountable to the project's Aboriginal Reference Group and community, I aimed to do no harm to individuals or communities. By including Aboriginal people in the reference group, this project aimed to contribute to building Aboriginal research capacity and engagement within the community. Furthermore, the purpose of the research was in line with the needs identified by local Aboriginal people, and adopted a very transparent research process. Timely publications from the research will be made to further support the program.

## **Research Design**

### **Participants**

#### **Data collection: In-depth interviews**

I undertook in-depth interviews with: (a) six AMIC workers; (b) six program midwives; (c) eleven clients of the *Anangu Bibi Birthing Program*; (d) five ward midwives and (e) two medical practitioners who work with AMIC workers to gain a better understanding about the roles of the AMIC workers. It was necessary to explore the views of these five parties to assess the varying perceptions of the complexities the AMIC workers face within their roles.

#### **Sampling and recruitment processes**

All participants were selected using purposive sampling techniques (Patton, 2002). Purposive sampling is the most appropriate method for this research because it allowed me to focus on recruiting individuals who have had involvement in the

*Anangu Bibi Birthing Program* and could provide information that cannot be obtained elsewhere. As described by Patton (2002) purposive sampling is both useful and powerful because it allows for information rich cases to be selected for in-depth study, enabling rich understandings and insights of the data to be gained (Liamputtong, 2013). Additionally, purposive sampling was appropriate because of the small number of individuals who have been involved in the *Anangu Bibi Birthing Program*, as either staff or clients.

Access to potential healthcare providers was discussed with the State-Wide Steering Committee (the regional management group consisting of key stakeholders and staff), the local Program Steering Committees (responsible for individual sites such as Port Augusta) and the individual health services. They determined the most appropriate process to access potential participants of the study, which would be least disruptive to staff members' work schedules and commitments. I was given a list of the program staff by the program manager and given permission to contact them via email to arrange a time most convenient to them, including the option to attend the interview during work hours. Furthermore, any clients of the program who the Steering Committee or health service felt to be inappropriate to interview were not invited to take part. While the Steering Committee initially had some concerns around confidentiality and overburdening clients with interviews (the Aboriginal Family Study in South Australia was due to commence interviews with clients of the *Anangu Bibi Birthing Program* at the same time), they gave me permission to conduct these interviews 18 months into my study. I was then required to seek further ethics approval from both the University of Adelaide and the Aboriginal Health Council of South Australia. Program staff then selected clients of the *Anangu Bibi Birthing Program* to participate, the staff invited participants according to how appropriate they believed the participants were for the study (i.e. many of the clients are very shy and often have complex situations they are dealing with). In this way, purposive sampling was appropriate because it reduced the chances of my research being a burden or having a negative effect on clients who may have been vulnerable. While this may be considered a potential bias of my research, it is more important to me and my understanding of ethical practice in Aboriginal research that I respect and understand that clients priorities are not in line with my research, and that they may not feel comfortable engaging in in-depth conversations about their experiences with



the program and program staff. Furthermore, access to clients of the program was dependent on the Steering Committees decision that program staff would select appropriate clients. In this way, this aspect of participant recruitment was beyond my control.

Prior to recruiting participants, I consulted with my Aboriginal Reference Group on the most appropriate methods of doing so. After I gained permission from the Steering Committee to conduct the research, I was required to request permission to conduct the research through the Port Augusta Anangu Bibi Management Group and the CEO of the Port Augusta Hospital. I was advised to provide a cover letter outlining the aims of my research, a copy of The University of Adelaide's Ethics Proposal, as well as a support letter from the Country SA Aboriginal Family Birthing Steering Committee. Following the circulation of these documents, I was granted permission to undertake interviews with AMIC workers, program midwives, ward midwives and medical practitioners. I approached all staff that worked in the program through email, and was able to recruit all AMIC workers and program midwives, with no invitation declined. However, ward midwives were selected by the head of the maternity ward, and providing they were willing to participate were released from the ward at scheduled times. These midwives were selected according to their perceived level of involvement and understanding of the *Anangu Bibi Birthing Program*. Furthermore, hospital management thought that some staff on the ward would not be willing to participate in the study because of the lack of value they have of the program. I did not approach these individuals, as I was advised not to. Going against this advice would have been disrespectful to those who supported the access to and recruitment of study participants. Clients were recruited following permission from the Steering Committee and appropriate Ethics bodies, and were selected by the *Anangu Bibi Birthing Program* staff according to individual circumstances and characteristics, and then their details were passed on to me. I recruited the two medical practitioners following the analyses of all other data based on which medical practitioners the participants had spoken about most frequently. I invited these participants to be involved in the study by making phone contact.

All participants were given the option of meeting at a mutually convenient time and space. AMIC workers and program midwives were all interviewed in my office at the

hospital. Some clients and ward midwives were also interviewed in this space. I conducted interviews with seven clients, one ward midwife and one medical practitioner, on the maternity ward or associated space, in a private room that was allocated by the program. Some interviews were conducted away from the hospital: five in the homes of participants (two clients, two ward midwives and one medical practitioner); one client at the Early Years Parenting Centre; and one program midwife at another place of employment.

Information about the study was provided to participants through the hand out of information sheets (Appendix A) and word of mouth dissemination from the State-Wide Steering Committee and local committees and health service. In some cases staff made the first initial contact with potential participants. Formation of, and consultation with members of, the Aboriginal Reference Group further highlighted effective ways of providing appropriate information about the study to potential participants.

Written consent to participate in the study was gained from participants after they read the information sheet with details of the study. They then had the opportunity to discuss any aspects of the research with me. The information sheet provided details around what the study results would be used for, confidentiality, and guidance on where to seek further information or where to lodge any complaints or concerns. The signed consent form was received before the interview was conducted. Participants were also clearly advised that they were able to withdraw from the interview or study at any time. See Appendix B for a copy of the consent form.

Advice on the appropriateness of the questions and topics that were broached was guided by the project Aboriginal Reference Group. A semi-structured interview schedule was developed that encouraged free narrative and enabled the opportunity for rich storytelling (Appendix C). By employing a flexible interview schedule, participants were encouraged to lead the conversation and topics they felt important were also explored. This technique allowed for additional questions. To ensure that I was ascertaining the correct meaning behind each response, I continually cross-checked my own understanding throughout the interview and then again after the interview by providing a copy of the transcript to participants. Each interview was

between 20 minutes to 2 hours in duration, with an average duration of approximately 50 minutes, and was audio-recorded with the consent of the participant. I conducted all of the interviews, and then transcribed and coded the content of the interview using the qualitative analysis program NVivo (version 9).

I digitally recorded most interviews to allow for an accurate reproduction and record of participants' expressed beliefs and experiences (Judd, Smith, & Kidder, 1991). This also allowed me to engage fully with the participant and the conversation without being distracted by scribing the interview. Two clients did not give permission to digitally record the interviews, and two of the recorded interviews failed. In these instances, I engaged in a rigorous journaling process during the interview (for the clients who I could not record) and afterwards (for all four of these interviews) to document all that I could from the interview. While this was still an effective way of recording data, it was not as rigorous as having the digital file to cross-check accuracy. All participants were given the option of receiving a copy of their interview transcript, however only the program staff requested transcripts.

The interview questions covered the following key areas:

- Perceptions on the role of the AMIC workers;
- Perceptions on how the AMIC workers juggle the complexities of their daily work;
- Perceptions on how the AMIC workers commit to this profession whilst adhering to cultural protocols and maintaining close relationships with community;
- Perceptions on how the role has changed since the inception of program.

(See Appendix C for a general interview schedule.)

### AMIC Workers

I undertook these interviews during 2010 and 2011. AMIC workers varied in the time they had been involved in the *Anangu Bibi Birthing Program*, along with previous work histories and life experiences. Three of the AMIC workers had been working in the program for 12 months or less, one for three years and another two for six years. All AMIC workers were trained and working in Aboriginal Healthcare prior to their involvement with the program. The participants were aged between 22 and 44, with their average age being 38 years and 2 months at the time of interviews. At the time of interviews, all of the AMIC workers had children themselves, ranging from one to six

children. Two of the AMIC workers had grandchildren at the time of interview. All AMIC workers lived in Port Augusta at the time of interviews and had families living in the region as well as extended family in other regions of South Australia and Australia. All AMIC workers identify as Aboriginal women. All AMIC workers in the program agreed to participate in the study (n=6).

### Program Midwives

Interviews with program midwives were conducted in 2010 and 2011. One program midwife had past experience working specifically in Aboriginal health, while the other five had experience working with Aboriginal clients within the hospital setting. Six program midwives were interviewed, one of whom is no longer involved in the program. Program midwives varied in the time they had been working in the program. Two had been involved since the program started in 2004, one joined the team not long after, and three had been working in the program for 12 months or less. Four of the program midwives had been practicing midwives for a minimum of ten years prior to their engagement with the program, another finished her midwifery training in 2002 and the most recent to join the program had completed her training only months prior. Five of the midwives had previous experience of working in the Port Augusta Hospital prior to their engagement with the program. Program midwives were aged between 29 and 56 with an average age of 45 years and 5 months. Five of the six program midwives had children themselves, ranging from one to four children. All were Caucasian and born in Australia, and four of them had lived in the region for many years. All program midwives working in the program agreed to participate in the study.

### Clients

I interviewed ten clients of the program within two months of 2011. Clients were aged between 21 and 42 and their average age was 30 years and 7 months (clients under the age of 18 were not invited to participate). At the time of interview, one client was in labour with her first child (she was having contractions and had asked to be involved in the study while her labour was progressing – she was referred to me by the program), two clients had one child and were pregnant at the time of interview (28 weeks and 12 weeks), two other clients had one child (aged five months and six weeks), three clients had two children (with their youngest being eight and six months

old), one client had four children (her youngest being eight months old) and another client had six children (her youngest being only three days old). Nine clients identified as being of Aboriginal descent, and one client had children of Aboriginal descent (that is their father identified as an Aboriginal man). At the time of interviews, seven women were in relationships with the father of their youngest child, while three clients were not. All clients were residing in Port Augusta and had family from a range of areas across South Australia. One client described herself as '*Pitjantjatjara. So I'm like Northern Territory*', whereas others identified primarily with Aboriginal groups across South Australia.

### Ward Midwives

Five ward midwives were interviewed for this study in two months of 2011. Ward midwives varied in their experience of being midwives, along with the time they had worked on the maternity ward in the Port Augusta Hospital. While one ward midwife had been practicing as a midwife for over 25 years, the others had been for seven years, four years, 18 and 12 months. All midwives had been working on the maternity ward at Port Augusta Hospital for a minimum of 12 months. Ward midwives were aged between 23 and 59, with an average age of 42 years and 8 months. At the time of interviews, two had no children, while one had two children and two had four children. All women are Caucasian, and only one was born outside of Australia.

### Medical Practitioners

Two medical practitioners were interviewed for this study early in 2013. I decided to include them in the study at this late stage of the research because I felt their input would add another layer to data analysis and contribute to a deeper understanding of the analyses. Both medical practitioners are specialists in fields related to the program (neither their specialty nor sex will be named in this study for confidentiality reasons), have an average age of 56 years, have practiced in their fields for 25 and 30 years, and have both worked in the Port Augusta Hospital long term.

### **Data Analysis and Interpretation**

The specific methodology I used is discourse analysis. As put by Crotty, 'in discourse the beliefs, norms and values that are taken for granted in everyday interaction are expressly thematised and subjected to critique' (Crotty, 1998, p. 144) . Discourse

analysis involves the extensive analysis of language and allowed the main themes of my thesis to emerge along with an understanding of how the themes exist and the ways they are interlinked. For example, while medicalisation emerged from my data as a major theme, it does not exist in isolation from the other dominant discourses, including the ideal worker and emotional labour. Discourse analysis highlighted an Aboriginal cultural dimension to the way these constructs affected the AMIC workers, with extensive family and community relationships and subsequent obligations being interwoven throughout all themes.

The analyses of interview data began in conjunction with the data collection stage. The interview data was transcribed verbatim (including as many features of the talk as possible) and uploaded into NVivo. The coding system allowed the emergent coding structure to be constantly reviewed and developed as the sets of interview data were analysed. All interviews were read and re-read for meanings throughout the entire coding process.

Analysis began with initial coding of data, which as defined by Charmaz (2006, p. 43), is ‘the process of defining what the data are about.’ I labelled pieces of the data in ways that described and summarised each piece, a process in line with Holloway and Wheeler’s (2010, p. 286) description of coding as ‘marking sections of data and giving them labels or names.’ I used ‘in vivo’ coding for some of these initial codes to assist in maintaining meaning attributed to data by the participants, as suggested by (Charmaz, 2006). Following this first stage of coding, I used the scheme of meanings, that is the way participants made sense of their world, as recommended by (Liamputtong, 2013) as appropriate for understanding meanings and subsequent actions.

The analysis and interpretation of the data developed further in the process of writing, as also described by Charmaz (2000). The re-drafting of arguments and the writing up of concepts allowed the data to be re-examined numerous times. This process allowed me to reorientate my interaction with the literature, and to move between the data and literature as necessary. While it would be optimal to have reached saturation, I argue that for this research saturation was not possible because of resource constraints and the limited number of interviews that were possible (i.e. small numbers of possible

participants). Saturation is when additional information does not contribute to the generation of new understanding (Liamputtong, 2013). Consequently, the analysis was largely informed by the emergent patterns of the data and contributed to a deeper understanding of pre-existing theoretical constructs. These main theoretical constructs include medicalisation, the ideal worker construct and emotional labour.

#### **Storage and Access of Research Data**

Individuals and communities were not identified publicly. All transcription and consent data was stored separately (including audio-files and interview transcripts). The data was stored in a locked filing cabinet located in relevant office space at the University of Adelaide and was accessible to only my supervisors and myself. Project information will be stored for a minimum of five years, in accordance with the data storage policies at the University of Adelaide, after which time the interviews and transcripts will be destroyed.

#### **Ownership of the Data**

The Aboriginal knowledge collected about Aboriginal lives and experiences is owned by the individuals themselves. This study did not ask about and has not claimed ownership over any sacred Aboriginal knowledge.

#### **Reporting Process**

Cross-checking of accuracy of data interpretation was made with the interviewee and the Aboriginal Reference Group. I also provided the Reference Group with regular updates on the progress of the study. More recently I discussed the appropriate forms of dissemination with the Reference Group and after their approval of a two page brief, I presented the results to the staff involved in both the local and state-wide program (that is AMIC workers and program midwives who work in different sites across the state), and at two public forums, one at the University of Adelaide Campus in Port Augusta and the other at the Pika Wiya Health Service (to which ward midwives were invited). I have also presented my findings and recommendations to the State-Wide Steering Committee. All feedback has been positive and recommendations were further developed according to follow up discussions. Feedback is also being given to the community and other relevant bodies, through members of the Reference Group.

## **Ethical issues that need addressing**

### **Potential risks**

This study involved interviews with healthcare providers and clients of the *Anangu Bibi Birthing Program*. During the interviews I did not ask participants about sacred knowledge, rather investigated how they align traditional or even contemporary cultural views with the modern healthcare system. The main ethical implications of my work related to maintaining the privacy and confidentiality of participants, and minimising the potential for participants to feel discomfort during the interview.

All information from participants was collected and reported as de-identified, with the exception of being able to decipher their role in the program (whether it be midwife, AMIC worker, client or medical practitioner). However, there is the possibility that interview content may distinguish a participant in its raw form (as a result of close community networks and low numbers of AMIC workers) and as such extra care has been taken with presentation of data in publications and public forums. If the research has identified specific information that has the potential to identify an individual participant, prior to publication or presentation of that information, I negotiated with that individual about the use and disclosure of their information.

At the time of the interview, the clients of the program had the option of having an Aboriginal woman who is familiar with the project attend the interview, or to bring a friend of their own choice to assist with making the participant feel comfortable and confident in the relevance of the project. Only one client chose to be accompanied during the interview.

### **Protocol for adverse events**

In the event that any participant felt discomfort or distress, as a result of any negative recollections caused by the interview process, participants were provided with information on available support services. Such support services included Pika Wiya's Social and Emotional Wellbeing Team, Child and Youth Health Indigenous Cultural Consultants, the Aboriginal Health Unit, United Care Wesley, Red Cross' Social and Emotional Wellbeing Team and Lifeline for any immediate concerns. Additionally, participants were given the opportunity to withdraw from the study at any time. To date none have withdrawn.



**Research rigour**

Within experimental and positivistic research methodologies, the quality of research is frequently assessed by the concepts of validity and reliability. Validity is a concept assessed by positivistic research paradigms to ascertain whether or not research is a good representation of the 'truth' (Liamputtong & Ezzy, 2005, p. 33). Reliability is the degree to which another researcher can replicate the research results (Liamputtong & Ezzy, 2005). The origins of these concepts make them unfitting for qualitative research, as they fail to account for the contextual, individual and interpretative factors associated with this line of inquiry. As such, a more appropriate concept has been developed to assess the quality and credibility of qualitative research. Rigour is the concept that is able to provide reasoning and justification for appropriate methods to assess particular research questions (Liamputtong & Ezzy, 2005). Clear documentation of decisions made throughout the research process, along with interpretations of results and findings are important aspects of rigorous research. Rigour therefore requires that throughout the research process integrity, authenticity, openness and equality is both established and maintained (Liamputtong & Ezzy, 2005).

I have maintained rigour throughout this research in a number of ways. First, by remaining open throughout the interview process for additional information (which may not necessarily have been guided by the research questions) to be raised by participants, and by establishing a safe interview environment where participants felt comfortable expressing their opinions and experiences, rich and deep understandings of participants' experiences and descriptions were gained. This has been described as being an important factor in maintaining rigour because it is more likely that accurate information of participants' perceptions and understandings of their realities will be gained (Liamputtong & Ezzy, 2005). Additionally, the richness of the data that is presented throughout the thesis provides further evidence of rigour within this research because it demonstrates an in-depth understanding of the complexities of both the public and private aspects of the AMIC workers lives. As described by Ezzy (2013) and Hansen (2006), rigorous research is affirmed through efforts to explore participant's social realities, in the form of rich descriptions. My earlier discussions around the importance of establishing and maintaining relationships with participants

and the local community have also attributed to the extent to which this research can be considered rigorous.

### **Reflexivity and Transparency**

In line with good practice in constructionist research, throughout the research process I have been very conscious of the potential impact assumptions can have on both the research process and results. This is an important process in maintaining rigour in qualitative research, in particular it is referring to the process of reflexivity which requires the researcher to reflect on their influence on the research (Hansen, 2006; Guba & Lincoln, 2005). As such, this research has been conducted with reflexivity at the fore, with constant examination of my position as researcher within the research, and the effects this has had on the way the research processes were formed and engaged with. Practical steps that were employed to ensure reflexivity throughout the research included keeping a journal, undergoing constant review with self, supervisors and the Aboriginal Reference Group, as well as remaining open to feedback along the way.

Furthermore, in order to remain true to the data and research process, I endeavoured to be transparent to enable others to make their own judgements around the quality and rigour of the research. Steps undertaken to achieve this included good documentation, use of carefully contextualised quotes, and an audit trail. The Reference Group and joint presentations with an AMIC worker (at staff training and a national conference) also contributed to the manner in which this research remained reflexive and transparent.

Additionally, as recommendations emerged from the data I informed the local program's Steering Committee. For example, a common problem expressed by many participants was associated with the inappropriate space the program was allocated within the hospital. I wrote a letter to the Steering Committee to offer support for this issue to be addressed. While I am not sure whether or not this had any influence on Hospital Management's decision to relocate the program to a more appropriate space within the maternity ward, it demonstrates the reflexive processes I attempted to maintain throughout the research. This was part of a study process that I engaged with throughout the duration of this research, which I believe further respected the

maintenance of trust and relationships I had with the program and associated individuals.

Journaling has been an important way in which this research has been able to remain reflexive, not only with the research processes, but also with my own positioning within the research and the development of my own understanding of Aboriginal culture and issues affecting Aboriginal people in contemporary society. This can perhaps be understood as an instance of highlighting my understanding of how I may be affected by the stigma of white privilege, which Kowal suggests may require ‘reflexive anti-racism’ for effective management (Kowal, 2011, p. 326). While I could include examples of journaling that document reflections and critical thought processes around interpretations of data and my positioning within the research process directly, I believe it is important to share the following extracts as examples of the growth of my understandings around Aboriginal societies. I believe they highlight some of my experiences and the subsequent growth of my knowledge and understandings that are critical to accurate interpretation of the research data.

As such, this first extract is from a journal entry I wrote on the 14<sup>th</sup> of September 2009, following my first field trip to the APY Lands:

*‘I had an unbelievable week in the lands, and am not too sure what my overall thoughts are about the way things are up there (conditions are shocking). I do know that I was surprised when I did not walk away feeling totally helpless and devastated for the people up there- I feel as though the connection the people have to family and culture is so strong that a great sense of happiness and strength exists amongst the people- as if through all of the hardships they have managed to cling on to that (like a survival technique). In conversation with an Aboriginal lady on the trip, she said that the shock will come when talking to people who label and speak about the community people as a single unit and who fail to recognise any of the issues and complexities they face. I am really not looking forward to those conversations.*

*We did a lot of cultural activity, watched an Inmar one night (traditional cultural dance) and visited the schools (did a language class in a middle school classroom) and art centres in two communities (Mimili and Fregon). So I learnt far more than I*

*could have reading cultural books at my desk, or even talking to people about the circumstances and situations.*

*When it came to women's business, I didn't feel it right to talk about birthing or things of that nature, without knowing the women personally. But at an observation level, it was amazing to see the women pass around the young babies with no hesitation (the kinship system in action) and not seeing a single baby cry. They all seemed so happy and loved! (Not meaning to say that I didn't think they would be, but the conditions in which the community lives are so shocking to me, that it is unbelievable to see that it seems they put the conditions behind them and still manage to focus on the importance of their families and relationships). Also, it was interesting to see how strong the babies are - holding their heads and bodies up at what seemed a younger age than what we see with non-Aboriginal babies. So I had many learnings from this trip when it came to bubs and families, amongst other things.'*

Through reflexive consideration of this journal entry I now understand that some of the ways in which I have discussed some big themes can be interpreted as being quite paternalistic, and in some ways contrary to the ideals of a white anti-racist. However, I believe this extract is important in demonstrating some of the realisations I had at this early stage of my PhD in regards to remote Aboriginal communities, and the types of thinking I engaged with early on. It really touches on the importance of learning about culture through engagement rather than through existing literature. I believe my knowledge around many of the aspects raised in this extract has since deepened significantly. Furthermore, attending a cultural awareness field trip at Iga Warta in the Flinders Ranges with program midwives from across the state, also heightened my awareness around cultural views of the local Aboriginal group, the Adnyamathanha people, along with some of the perceptions and assumptions non-Aboriginal people have about Aboriginal people's lives and histories.

*7<sup>th</sup> June 2010: It was a great weekend for relationship building and learning. It opened up a lot for me in my learnings around kinship systems and the histories and cultural practices of Adnyamathanha people. I think of great significance is that I am now welcome by family to Iga Warta, and that I was referred to on a number of occasions over the weekend as being family. I am starting to understand what it feels like to live the experience. Working with Aboriginal people is not and cannot be constrained to 9-5, it is something that you need to be prepared to live and breathe*

*around the clock. Relationships, respect, trust and flexibility are what are key. Experiential learning is what I think is required to understand this complexity. I am hopeful that some of the midwives are willing to engage in long term partnerships with the Aboriginal people they work with, and in doing so create more sensitive and receptive environments for the Aboriginal clients they are required to work with.*

This extract demonstrates my growing understanding of the history and culture of Adnyamathanha people as well as my positioning within society and relationships to members of this group. It is evident that I perceived my relationships with this group to strengthen on this trip, and maintain that my increased level of understanding of their culture has been integral to my interactions with Adnyamathanha people. I worked closely with women from this group not only throughout my research, but also in my work at the youth centre, and my engagement with the Pika Wiya Health Centre. Furthermore, my grandmother lives next door to an Adnyamathanha elder who has a strong voice within the community, and who was responsible for my being invited on this trip. Understanding that these relationships are not isolated to the research process is an important factor to remaining reflexive and transparent.

My journal entry from the last cultural awareness field trip to the APY lands, demonstrates many of the learnings that I have had throughout the PhD process and through the establishment and maintenance of various relationships. I believe this extract contrasts with the depth of understanding evident in my first journal from these field trips, and as such am using it as evidence of my personal growth and increased understanding of the many complexities within Aboriginal life and societies.

*17<sup>th</sup> April 2012: I guess my biggest learning had to do with knowing that the information we hold about the way of life in communities such as the APY lands is very special and unless people are open enough to listen (remembering we have two ears and one mouth) and be respectful of these knowledges I don't think they have the right to know. It is what we do with this knowledge, and how we do it that we need to be incredibly mindful and careful of. When visiting these communities we are enriched with new experiences and insights constantly. I believe that after visiting and being privy to these experiences we have the moral responsibility to stand up and advocate for the rights of these people and their land. On this trip I wasn't so much*

*focused on birthing or healthcare practices as I have been on other trips, but more so focused on a holistic approach that I think is becoming clearer to me. Holistic yet political. Again the more I know the less I know ... and I think that stands more so for politics than the way of life in community. [Mentor] always says he has done his job if we come away from the trip with more questions than answers. For some reason I have come away a bit numb this time- numb because solutions to many of the problems are there, but the people who have the power to change them don't care ... and the most innocent people suffer. Maybe it has sparked a new fire in my belly? Maybe.*

This is really touching on the moral obligation I came to understand and believe that I have as a researcher and member of society. It is these values and perceptions that I have both brought with me and established throughout this research process and the other activities I have engaged with outside of my research work. These factors are all critical to the accuracy of my interpretations of the research data.

### **Conclusion**

Throughout this chapter I have provided an explanation of the research design and methodological approach used within this study. The important aspects of conducting ethical and meaningful research with Aboriginal people have been described in-depth and the manner in which this research has maintained appropriate processes and data interpretation discussed. The influence of my positioning within the research and the wider community has also been described as a critical aspect to the information disclosed to me, along with my understandings and interpretations of the data and phenomena being investigated. As such, a key aim of the research methodology has been to give priority to Aboriginal perspectives within an exploration of the construction of aspects of the AMIC worker role. An in-depth exploration of these findings is focused on in the following chapters of this thesis.

## CHAPTER 2: CARING ROLE

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Poor health among contemporary Aboriginal Australians is an ongoing legacy of colonisation, and reflects the history of oppression, racism and lack of cultural recognition brought about by settlement (Aboriginal & Torres Strait Islander Social Justice Commissioner, 2005; Paradies, Harris, & Anderson, 2008).

Following European settlement of Australia, the Aboriginal population suffered greatly from direct contact with Europeans and the introduction of disease. It is estimated that during the nineteenth century, the Aboriginal population had decreased to approximately one quarter as a result of European settlement (Altman & Sanders, 1995). Following this initial devastation, Aboriginal people were largely excluded from society, although patronising attempts were made for their inclusion. For example the introduction of policies such as the Assimilation Policy which encouraged Aboriginal people to lose their Aboriginal identity and to assimilate into mainstream culture, adopting the same values and ways of living as other Australians. It was only in the 1967 Referendum, more than one hundred and fifty years after colonisation, that Aboriginal Australians were recognised as being Australian citizens, with their own culture and beliefs. The poor treatment of Aboriginal Australians since colonisation is still reflected in the general mistrust Aboriginals have of mainstream institutions.

Social exclusion and economic marginalisation are strongly linked to poor health. Therefore, for the health status of the Aboriginal population to improve, government policies must continue to address and minimise social inequalities. As put by Raftery (2006, p. 47) ‘it is only when we acknowledge that the ‘appalling state of Aboriginal health’ is a result of non-Aboriginal policies and practices that we will be in a position to respond appropriately’.

It has been argued that past health policies have been misguided in relation to Aboriginal health largely due to a lack of inclusion of Aboriginal concerns and ideas about health and the design of the health system (Anderson, 2003). This underrepresentation is a result of Aboriginal people feeling excluded from and disengaged with Australian policies and health systems (which feed each other). In relation to maternal healthcare, the disengagement of Aboriginal women in

birthing services may contribute to poor data collection and understanding of their experiences with such services. These factors can be considered a reflection of the history of colonisation, dispossession and marginalisation.

The path to achieving political and social equality has been a slow one. Ten years after the Referendum the adoption of the 'Self-Determination Policy', through the Whitlam Government, was a significant milestone in the Aboriginal people's ongoing struggle for equality, and encouraged a positive reclaiming of a separate Aboriginal identity (Raftery, 2006). The 'Self-Determination Policy' acknowledged the need and right Aboriginal people have to determine their own lives (Jenkins, 2002) and recognised the significance of cultural identity (Australian Law Reform Commission, 1986; Hon RI Viner MHR Minister for Aboriginal Affairs, 24 November 1978). This policy emerged from an increasing recognition of the need for rights for Aboriginal people in Australia, and the ongoing control that previous governments had implemented over almost all aspects of the lives of Aboriginal people (Jenkins, 2002).

With the Referendum result came the official recognition and authority of the right to develop services specifically for Aboriginal people in response to the urgent need to make services more accessible. The opportunity to develop Aboriginal organisations, specifically Aboriginal community controlled services also emerged, stemming from the belief that Aboriginal people have the right to self-determination. Community controlled services are those that allow Aboriginal communities to determine protocols and procedures that are then instigated and followed by an elected board of representatives. Primary healthcare services were among the first types of organisations to implement this approach. The first of these was established in 1971 at Redfern, Sydney, known then as the Aboriginal Medical Service Redfern. This model was unique and innovative because of its focus on a holistic view of health, prevention and social justice, as well as the employment and subsequent empowerment of Aboriginal people. This model was viewed as a mechanism for community development. Since then, the number of community controlled health services has grown substantially, there are now over 150 Aboriginal Community Controlled Health Services currently operating around Australia (National Aboriginal Community Controlled Health Organisation, 2013).



The common philosophy underpinning all of these services is the provision of culturally appropriate alternatives to mainstream health services, with a focus on prevention as well as empowerment of Aboriginal peoples.

Differences in understandings of health and wellbeing contribute to the poor utilisation of healthcare. While health for non-Aboriginal people is generally conceived from a biomedical lens, it has been recognised that for Aboriginal people, health is not merely the absence of disease or physical wellbeing; rather it incorporates a whole-of-life view (NHMRC, 2010b). Understandings of what constitutes appropriate healthcare are dependent upon these views.

The effective dispersion of appropriate health information can perhaps also be considered an important factor in obtaining better health outcomes. Until recently, ethnocentric views have dominated healthcare and presumed that a Western biomedical system was best for all. From the end of the nineteenth century, a focus on individual, biological and behavioural explanations of health and illness have been dominant. The limitations with this view of health are that it fails to take sufficient account of culture, and external factors and determinants of health. As such, ethnocentric views have more recently been challenged by growing evidence of the complexities of socio-economic inequalities and their subsequent relationship to poor health and illness (Raftery, 2006). It therefore seems appropriate that the latter approach to health is more widely adopted. This has been recognised as essential to improving all areas of Aboriginal health, including maternal and infant health. With respect to maternity care, this will be discussed in detail in later chapters.

### **Determinants of maternal and infant health in the short and long term**

Poor perinatal outcomes are associated with a range of factors present both prior to and within pregnancy. Many of these risk factors are disproportionately high among Aboriginal women. Some of the main risk factors in women prior to pregnancy include: age, where women are classified as being ‘at risk’ of poor outcomes when they are considered to be in an undesirable age group for pregnancy (either adolescent and still growing, or between ages 40-49 years); short

pregnancy interval (less than two years between pregnancies); and having more than four children (Fathalla, 1990). Of Aboriginal women who gave birth in 2010 in South Australia, 17.8 per cent were less than 20 years, compared with only 4 per cent of non-Aboriginal women who had babies that year (Scheil et al., 2012).

Several factors are known to contribute to low birth weight, including maternal smoking, poor nutrition, alcohol intake and health during pregnancy (all of which are disproportionately high among Aboriginal women), along with parity (Ashdown-Lambert, 2005; Baghurst, Brown, Robinson, Sutherland, & Yelland, 2011; Sayers & Powers, 1997). Smoking has been found to have strong associations with preterm birth and low birth weight (U.S. Department of Health and Human Services, 2004) and in 2010 a larger proportion of Aboriginal women were found to be smoking at their first antenatal visit (52.8 per cent) when compared to non-Aboriginal women (12.2 per cent) (Scheil et al., 2012). Further, poor nutrition and health status (i.e. obesity and gestational diabetes) within pregnancy are also linked to poorer birth outcomes (U.S. Department of Health and Human Services, 2004).

Low birth weight babies are at greater risk of poor health and development after birth (Goldenberg & Culhane, 2007). Furthermore, an association has been found between low birth weight and chronic illness later in life, including cardiovascular disease, type II diabetes and renal disease (Australian Bureau of Statistics, 2011; Barker, 1998). Such illnesses are found to be disproportionately high amongst Australia's Aboriginal population (Australian Institute of Health and Welfare, 2011), and are thought to stem partly from the effects of poor growth during fetal life and early infancy (Barker, 1998; Barker, Osmond, Forsén, Kajantie, & Eriksson, 2005). Interestingly, fetal malnutrition may not result in low birth weight but still contribute to poor adult health (Roseboom et al., 2001), highlighting the importance of adequate maternal care during pregnancy. Additionally, the largest Aboriginal cohort study to date has demonstrated this relationship among Aboriginal people in the Northern Territory. Specifically, that the highest risk of chronic non-communicable disease is reported for Aboriginal people who were born small and became relatively larger in later life (Sayers, Mott, & Singh, 2011).

Unfortunately, mainstream birthing services are not suited to many Aboriginal women, and their needs are often not met (Kildea, Stapleton, Murphy, Low, & Gibbons, 2012; Watson, Hodson, Johnson, & Kemp, 2002). This in turn can lead to low antenatal attendance late presentation at first antenatal visit, and only presenting to mainstream services for medical emergencies and childbirth (Campbell, 2000). It is well documented that mainstream services can foster traumatic experiences for Aboriginal patients, often at times that are traumatic enough (Campbell, 2000). In addition, poorer treatment outcomes are experienced by Aboriginal patients in Australia as a result of insufficient communication between doctor and patient, along with various systematic problems (Cass et al., 2002; Cunningham, 2002).

### **Factors affecting the provision of care in pregnancy and childbirth for Aboriginal women**

#### **The privatisation of maternity care**

The privatisation of maternal and infant healthcare in Australia does not improve health outcomes from women or babies (Roberts, Tracy & Peat, 2000; Shorten & Shorten, 2004; Tracy, Wang, Black, Tracy & Sullivan, 2007; Guilliland, Tracy & Thorgood, 2010). Health reforms occurred in many high income countries during the 1970s (Benoit, Zadoroznyj, Hallgrimsdottir, Treloar, & Taylor, 2010) with the aim of improving the efficiency and effectiveness of healthcare systems. However it has been argued that the neoliberal market approach taken by some countries, including Australia, has failed to overcome issues associated with medical dominance and highlighted the extent to which it is embedded within institutions (Willis, 2006).

Benoit, Zadoroznyj, Hallgrimsdottir, Treloar and Taylor (2010) argues that while reforms in Australia were intended to increase public choice and democratise healthcare, they have in fact continued to perpetuate inequalities in access to care. Medical practitioners in Australia are mostly privately or self-employed and are not restricted to limits on their service fees (Benoit et al., 2010). With the Medicare system, in place since 1984, subsidies are available to members for various medical services and procedures. However, clients are responsible for the payment of any excess charges made by the medical profession. It has been argued that the nature of this democratic market has resulted in medical professionals effectively ‘naming’

their price, in which case specialised care has become unaffordable for many people with low income status (Benoit et al., 2010). Private obstetricians are among the highest earning medical specialists and as such are predominantly available to high income women only (Benoit et al., 2010).

Reviews of maternity care services in Australia have shown that women have limited maternity care choices, and when choice is available it is limited to low risk women (Department of Health and Aging, 2009). Women who access the private healthcare system are more likely to be seen by obstetricians, and the dominance of obstetricians in the private system has resulted in inefficient usage, as they have become 'overused' in the private sector, fulfilling more of a birth attendant role for women who are classified as low risk during pregnancy (Benoit et al., 2010). As such, obstetricians are often not serving the population they were once intended for (i.e. medically complicated pregnancies), contributing to health inequalities in access to specialist care in Australia's minority populations. Specifically, the medicalisation of childbirth has been argued to disadvantage Aboriginal people (Benoit, Carroll, & Westfall, 2007).

#### **Access to services**

Improving health outcomes for Aboriginal mothers and babies is a priority of the Australian Government and an essential part of closing the gap between Aboriginal and non-Aboriginal mortality rates (Australian Government, 2015; Kildea, Kruske, Barclay & Tracy, 2010). Nationally, Aboriginal women utilise care in pregnancy less frequently than other Australian women (de Costa & Child, 1996; Mackerras, 1998; Powell & Dugdale, 1999) and present later.

This is also seen in South Australia, for example of the 652 Aboriginal women recorded in the South Australian Pregnancy Outcome Data in 2010, only 54 per cent presented for antenatal care within the first 14 weeks of pregnancy, compared with 81 per cent of non-Aboriginal women. Similarly, 64 per cent of Aboriginal women attended a minimum of seven antenatal visits, compared to 88 per cent of non-Aboriginal women (Scheil et al., 2012). This is in part likely to reflect both poorer access to care and dissatisfaction with models of maternity care available.

Differences in access to healthcare are confounded by location. For example, it is recognised that a decrease in Aboriginal life expectancy increases with remoteness (Australian Institute of Health and Welfare, 2005; Bryant, 2009). This is partly due to difficulties in access to appropriate medical staff and midwifery services. There is a chronic shortage of general practitioners, obstetricians and midwives in rural and remote areas which has led to the closure of over 120 smaller maternity units over Australia in the last ten years (Rural Health Education Foundation, 2009). Given that two thirds of Australia's Aboriginal population live in regional and remote areas (Australian Bureau of Statistics, 2010), the shortage of maternal healthcare services in rural and remote areas affects Aboriginal people disproportionately.

Even when services are available in rural and remote areas, there are often profound issues with disengagement from the services by Aboriginal peoples. Reasons behind Aboriginal women's reluctance to access mainstream birthing services are fostered by the cultural barriers, lack of cultural safety, miscommunication, feelings of isolation and philosophical orientation (Kildea & Van Wagner, 2012). The mismatch between medicalised care and needs of Aboriginal women is explored in Chapter 4.

### **Aboriginal women caring for Aboriginal women**

Mainstream services in Australia have begun employing Aboriginal health workers and liaison officers to assist in overcoming barriers to care (NHMRC, 1997). However, within this framework barriers are still evident, with many communication, conceptual and cultural difficulties existing between Aboriginal and non-Aboriginal personnel working within mainstream settings (Kildea & Wardaguga, 2009). It is therefore essential that access to high quality, appropriate care before and during pregnancy be improved to produce better health outcomes for Aboriginal women and babies.

Birthing in traditional Aboriginal culture was always viewed as 'women's business' (Jones, 2011). Senior female family members prepared for and attended the births, provided physical and emotional support for the birthing woman and most importantly removed fear from the birthing process (Ireland, Wulili Narjic, Belton, &

Kildea, 2011; Jones, 2011). Senior women in Aboriginal communities were considered the most appropriate people to attend to women during pregnancy, childbirth and the postpartum period, because they were well respected and held the necessary special cultural knowledge about birthing rituals related to belonging to family and country (Callaghan, 2001). The significance of the place of childbirth, along with who cares for them still has strong spiritual meaning for many Aboriginal women today (Kildea, 2006; Kildea & Wardaguga, 2009), which is described in more detail in the Medicalisation Chapter. This knowledge is known as 'Grandmother's Law' (Carter et al., 1987; Congress Alukura and Nganampa Health Council Inc, 2008).

Simmonds et al. (2012) found that the traditional role of the support person is still important, however this has been adapted to suit contemporary needs of Aboriginal women. Forms of support include accompanying a woman to the clinic for antenatal appointments, speaking on her behalf, caring for other children, sharing traditional knowledge, offering reassurance and in some cases accompanying her to town (in this case hundreds of kilometres from home) for antenatal care or to await the birth. Simmonds et al. (2012) noted that while women's priorities of support were dependent on their age, all women believed support was important.

Aboriginal women's preference for female kin to support them during their pregnancy (particularly in terms of accompanying them to antenatal check-ups) has been well documented (Simmonds et al., 2012; Watson et al., 2002). This is particularly important for overcoming some communication barriers associated with both language difficulties and lack of confidence in negotiating clinical interactions. For example, young Aboriginal women often do not seek clarification from the healthcare professional during appointments (Simmonds et al., 2012; Watson et al., 2002). Consistent with maintaining the principles of Grandmother's Law it is clear that it is still important and a strong preference of many Aboriginal women in Australia to be supported by another Aboriginal woman (or someone known to them) throughout their pregnancy care.

### **The importance of local workers in other maternity settings**

It is accepted that in many settings access to a trained professional or attendant can improve pregnancy and birth outcomes (World Health Organization, 1992). In developing countries, traditional birth attendants (TBA) are important providers of maternity care and have been defined as a person who assists the mother during childbirth (World Health Organization, 1992). TBAs are typically female and continue to deliver two thirds of the worlds' babies (World Health Organization, 1992). The benefits of TBAs are associated with their positioning within and accessibility to community; making them culturally acceptable, available when required and able to offer other valued aspects of care to women and their families (including domestic duties such as cooking and cleaning). Even when medical personnel are available, cultural, financial and personal factors affecting families and the community reduce the utilisation of such services (Kamal, 1998). In some countries, limited transport or means of communication prevent women from accessing any other form of maternity support (UNFPA 1995-1996 as cited in Kamal, 1998). However, a review of the training and utilisation of TBAs in more than 70 countries, showed limited examples of their successful utilisation (Kamal, 1998).

The training of TBAs in developing countries as a strategy for improving maternal-child outcomes has been a priority (World Health Organization, 1992). In Pakistan, their training and integration into healthcare systems has reduced perinatal mortality (Jokhio, Winter, & Cheng, 2005). While the training given in this context was largely around biological aspects of the pregnancy and birth (including recognising physical complications and obstructed labour), it also included learning about referral processes for women to public health services (which was suggested to improve their confidence).

Widely accepted objectives of training TBAs includes improving links between healthcare services and the community, increasing the number of TBA-attended births and improving TBAs maternity care skills (Sibley, Sipe, & Barry, 2012). A significant positive association between the effectiveness of TBAs training and their knowledge of the need and timing for antenatal care visits has been demonstrated, highlighting the importance of their role in influencing women's use

of antenatal care services. This was found to be true when TBAs are respected and active within the community and when their services include health promotion activities (Sibley, Sipe, & Koblinsky, 2004).

Similarly, doulas are understood to provide physical, emotional and informational support to women during labour and delivery (and like TBAs are generally female) (Maher, Crawford-Carr, & Neidigh, 2012). They have also been found to be associated with positive birth outcomes (including being more likely to have a spontaneous vaginal delivery, less likely to have a caesarean section, self-reported positive birth experience and increased satisfaction with care received) (Hodnett, Gates, Hofmeyr, Sakala, & Weston, 2012). As such, doulas can provide supportive care that alleviates the negative psychological consequences of interventions that disrupt the normal physiological processes of labour (Maher et al., 2012). Another important benefit of the role of doulas within the maternity care setting includes overcoming communication barriers between staff and patient's, which can lead to poor patient outcomes (Timmins, 2002). Patient's adherence to healthcare advice can also be compromised when language barriers are experienced (Wilson, Chen, Grumbach, Wang, & Fernandez, 2005).

In a recent pilot study, the introduction of an interpreter/doula program in the maternity setting of an urban hospital in the Midwestern United States (that has a large population of Spanish-speaking patients) was assessed. The program was implemented in an attempt to overcome issues associated with interpreter lag time, having multiple interpreters and disrupted continuity of care. The interpreter/doula role was designed to assist the maternity staff by overcoming communication issues, providing maternity care support to women (during the labour and postnatally, including lactation support and postpartum education), as well as addressing other needs (such as paperwork and providing patients with other needed supplies). It was found that timely, competent care in a range of maternity situations could be offered by interpreter/doulas, that they were cost-effective and increased patient and staff satisfaction (Maher et al., 2012). This model was recommended across cultures and settings (Maher et al., 2012).



Additionally, a study in Peru found that the inclusion of family and TBAs in the delivery process (along with other culturally appropriate features including local language and equipment to support vertical deliveries) increased the numbers of women accessing maternity services (Gabrysch et al., 2009). The TBAs also informed the health service employees of pregnancies and births, sought their help and referred clients to the service. This did not occur prior to the project. These changes reflected an improvement in relationships between staff and saw an increase of participant use of a service that integrated local needs. This project highlighted some of the benefits of integrating modern medical and traditional approaches to care in pregnancy and childbirth (Gabrysch et al., 2009).

### **The Anangu Bibi Regional Family Birthing Program**

The *Anangu Bibi Regional Family Birthing Program* was preceded by extensive consultation with women in the Northern region of South Australia, who strongly voiced their desire for a continuum of care birthing model, which is holistic, allows for extended visiting time, is responsive to the needs of clients and is culturally appropriate. Women participating in the consultation expressed the desire for consistency in who cares for them, access to a midwife at all stages of pregnancy care, and the opportunity to engage in a less formal antenatal education process (Stamp, Champion et al. 2007). As a result, Port Augusta has been running the *Anangu Bibi Birthing Program* since 2004, which involves the partnership of a doctor, midwife, Aboriginal Maternal Infant Care (AMIC) worker and Aboriginal client, to provide culturally safe care and service. Rather than adopting an Aboriginal health worker role in this program that focuses on general aspects of health, a specialised AMIC worker role has been tailored to this specific midwifery setting. Largely the AMIC worker is seen to be the cultural broker of the partnership, but also brings to the setting many clinical skills and vital cultural knowledge. One of the philosophies of the program is that it provides AMIC worker led primary care. Mutual respect for each role in the program is considered critical to the success of the model.

Additionally, Whyalla has been running a variation of the program, out of its hospital and Aboriginal health service, and involves maternal healthcare not only for the Aboriginal women of the region, but also for non-Aboriginal teenage

mothers. Justification for this comes from Whyalla's high rate of teenage pregnancy (McGregor Tan Research, 2006). Both programs are receiving wide acceptance among local women as a result of over ten years of consultation (Stamp et al., 2007).

For both programs, there is a required assessment criterion that women must meet to be eligible for care. This includes the presence of one or more of the following risk factors: young maternal age, engaging in substance use, being socially disadvantaged, and having a history of medical complications. The programs have been developed to improve pregnancy outcomes by targeting specific areas of women's health. They aim to improve access to antenatal care and ensure it is culturally safe, to modify substance use behaviours, treat medical conditions, identify potential risks early in pregnancy, and make timely referrals to improve access to healthcare (Stamp et al., 2007).

The 2007 evaluation of the program '*The First 50 Births*' aimed to gain participants' views and experiences of the program, collect information about behaviours that may affect birth outcomes, obtain information about the establishment and implementation of the program, explore the relationships between AMIC workers and program midwives, as well as to provide demographic information about participants' as well as perinatal outcomes (Stamp et al., 2007). The evaluation drew on seven data sets including interviews with stakeholders, AMIC workers and midwives, focus groups with program clients, the new mothers' questionnaire, supplementary birth records, purpose-designed program database and summary data of birth outcomes from the SA Pregnancy Outcome Unit (Chan, Scott, Nguyen, & Sage, 2006).

Evaluation of different aspects of these programs has, to date, reflected more positive outcomes than initially expected. The implementation of the programs has seen possible improvements (inconclusive because of missing data) in antenatal attendance (15.6 per cent of women had fewer than seven visits), and a possible reduction in harmful behaviours (such as smoking; n=13 at first antenatal visit, n=11 at postnatal visit) (Stamp et al., 2007). It is recognised by those within the

program that without the AMIC workers many of the clients would not feel comfortable accessing the maternal services.

The qualitative findings from interviews of the initial evaluation found that intercultural partnerships between AMIC workers and midwives exist, are mutually satisfying and encourage opportunities of two-way learning. Although the program claims it is 'AMIC-led', the exploration of the partnership model revealed that this may be inappropriately named in light of the emerging two-way partnership. Further strengthening of these relationships was described as being vital to the programs' sustainability. AMIC workers were also found to have obligations to the program, the community and their families. The evaluation claimed that the '*AMIC worker's social, cultural and community knowledge crucial to women's attendance and program success*', and noted that '*as the AMIC worker is pivotal to the success of the program we recommend that the role be further acknowledged, resourced and developed*' (Stamp et al., 2007). This draws attention to the importance of the AMIC workers and provides some description of the role. However the complexity of the role of the AMIC worker has not been fully described (nor defined). One key issue that was identified as a priority for further research was exploring the way AMIC workers often needed to balance their clinical, cultural roles together with family and community responsibilities (Stamp et al., 2007).

Additionally, a study investigating the views of AMIC workers and program midwives was undertaken to explore roles, the partnership and the program (Stamp et al., 2008). Semi-structured interviews were undertaken with five AMIC workers and four of the five program midwives employed in the program at the time. This study found that the development of a partnership took commitment and time, resistance from hospital staff and structural barriers with hierarchy are challenging, and that 'skill sharing and two-way learning' bring about mutual respect. The main themes that emerged from interview data with the AMIC workers, that were associated with their role, were found to be interconnected and included the importance of clinical work, social and emotional support, using appropriate language with women and advocating for Aboriginal women within the hospital

setting. Mutually equivalent roles were considered critical to the development of partnerships with the program midwives.

Additionally, themes that emerged from interviews with the program midwives included the challenges associated with setting up the program, and clinical midwifery care and clinical skill sharing were considered aspects of the role of program midwives. Furthermore, some of the interconnected themes from these interviews included the recognition of time and commitment as being crucial to working interculturally, the importance of two-way learning and respecting AMIC workers' cultural knowledge and community links. Additionally, issues associated with the introduction of the AMIC worker role, and the resistance of some hospital midwives was also raised as themes.

The first evaluation described the AMIC workers roles as offering holistic support to the client and their families, being the cultural broker in the partnership, coordinating the care of women and team meetings, as well as delivering culturally safe care. Since that time the role has developed such that, AMIC workers are required to have specialist skills, knowledge and attitudes in maternal and infant care. It has recently been considered desirable for AMIC workers to be able to provide antenatal healthcare, post natal and infant healthcare, information and strategies in sexual health, to support women during childbirth, as well as function effectively across mainstream and Aboriginal health services.

This chapter attempts to further explore the role of the AMIC worker from the perspective of AMIC workers, clients, midwives and medical practitioners, and draws on interview data to gain insight into the discourses used to describe it. As the role has been created to address problems associated with access to maternity and infant care, it is fitting that the role is predominantly described in terms of a caring role, rather than a role addressing only clinical aspects of a clients' care. Different perceptions of the AMIC worker are described below, with the important aspects of the role being highlighted. In particular, we gain insight into who the AMIC workers are and what they mean to different people. These constructions are crucial in understanding the relationships and nature of work the AMIC workers undertake.

### **The role of the AMIC worker**

As already stated, AMIC workers are always of Aboriginal descent. This is important to the nature of the relationships that they establish with clients of the program; along with the level of understanding they are able to develop around their clients' needs. Client1 touched on the importance of AMIC workers being Aboriginal women, and believes that she is *'closer to Aboriginal people than non-Aboriginal people, and I just feel more comfortable.'* Furthermore, AMIC1 clearly describes the significance of the AMIC workers being Aboriginal women and stated that despite coming *'from different country and different [language] groups, we're all still Aboriginal women, we're all still looking after [a] disadvantaged group.'* This is of significance because *'usually someone is connected in some way or would know a good way to approach [different cultural needs].'* In this way the AMIC workers are able to *'treat everyone with respect and equal[ly].'* Furthermore, connections to clients and community is enhanced because, as put by AMIC1, *'we're all married to different language groups [...] and have lots of family connections [...] the majority of us [AMIC workers] that are in the program, our family connections [...] have been here in Port Augusta for a long time.'* Program Midwife2 also understands the importance of AMIC workers being Aboriginal women who are linked with community, and that clients *'that are in the program know these AMIC workers [...] know these women outside of the hospital.'*

Prior to their involvement with the program, many of the clients already had links to, or well-established relationships with, their AMIC workers. For two clients, their AMIC worker was identified as an Aunty, which no doubt contributed to the uniqueness of their experience with the program. For other clients who were not related to their AMIC workers, two went to school with one or more of the AMIC workers, another's father had a long standing relationship with her AMIC worker and another knew her AMIC worker well through her cousins' involvement with the program.

Before I explore the nature of these relationships, it is important to describe Aboriginal kinship systems and how they define and determine relationships. Each Aboriginal group has its own kinship system, which influence the types of relationships and subsequent interactions Aboriginal people have with each other

(including physical, mental and spiritual interactions). There are many kinship protocols that influence who can be spoken to, who must be avoided, who has certain responsibilities, who has a teaching role, who can marry whom and who can attend different aspects of sorry business (Franks, 1996). Evidence of kinship systems influencing the relationships AMIC workers have with their clients, was given by AMIC7 who described some of the complexities:

*Even though we are both first cousins on both sides. I prefer to work with my sisters, rather than my first cousins, rather than my cousins ... So if one of my sisters come in, my mum's sisters' kids, I call them brothers and sisters. But my mother's brother's kids are my cousins ... They are from the male. Yeah, so I won't. It's disrespectful to call him my brother or her my sister, because that's my uncle's children. So yeah. But if my aunty's daughter came in I would look after them. But people will say, but they're your first cousins too ... it's like nah, yeah they are but you know... sit down [laugh], have you got two hours [laugh]. It's really complicat[ed]. But um ... Yeah it will feel a little bit uncomfortable, but I can talk to them to a certain extent, about certain things... but they'd probably want um ... someone else looking after them.*

This gives insight into the complexities of relationships and interactions that are determined by kinship systems and how these relationships affect the interaction AMIC workers have with their family and clients. Despite the significant impact kinship has on the AMIC workers, kinship networks and subsequent relationships are generally unknown and invisible to non-Aboriginal people.

Furthermore, there are suggestions that because AMIC workers are Aboriginal women, they have an in-depth understanding of client's lives. This was viewed positively. As such, when asked what her experiences were like with working with her AMIC worker, Client4 responded:

*I think that, [AMIC] being an Aboriginal and mother, well and Aboriginal person as well as an AMIC worker, um ... it was just her level of experience I guess and um ... and she probably had an understanding of what I was going through as well, like she had that idea.*

This extract demonstrates a client's perspective of the many important roles that the AMIC workers have. Being an Aboriginal person, a mother and an AMIC worker are all influential to how this client perceives AMIC workers' understandings of her needs and experiences. Client7 also commented on the importance of the AMIC workers being Aboriginal women. In response to the question asking her perceptions of how her AMIC worker fits in the community she stated:

*... oh really good I think. Because you've got actual Aboriginal women there who are again providing that link and that in between thing, between accessing just services and you've got an Aboriginal person.*

This extract speaks to the roles of the AMIC workers, describing them as a link between community and healthcare services. Furthermore, it is important to this client that Aboriginal people are working towards improving access to maternity care. They help clients to feel more comfortable and increase their willingness to access the program.

Not only are established relationships with AMIC workers important to clients, but so is the influence of the established relationships that family members had with them. For example, one client talks about the impact of her dad being comfortable with her AMIC worker, and how these feelings of acceptance were important to her. She went on to comment on not knowing her AMIC worker prior to becoming involved with the birthing program, but how they seemed to *'talk about anything and everything.'*

It seems that these relationships not only have an effect on the subsequent relationship that develops between the client and the AMIC worker, but also the way in which family accept or encourage the client's involvement with the program. For example, Client11 spoke about the impact of the positive experiences a number of her cousins had had with one particular AMIC worker. This was important to her and her family, and influenced both her desire to be involved in the program and to have that particular AMIC worker:

*[my cousin] was pregnant at the time so I got her to chase [AMIC] for me ... 'cause she did good with all of my other, all my cousins.*

Two of the older clients interviewed spoke about their relationships with their AMIC workers having long-standing roots. Of one of these relationships, ties had been maintained from years before and they still caught up frequently for meals. The interview with this client was constrained as she was facing other challenges. Later, in discussion with her AMIC worker, I got the strong impression that this relationship extended beyond the boundaries of the AMIC-client association, and this AMIC worker looked out for the client in her own private time. In this example the AMIC worker's role was primarily to be a source of care to the client.

Client10 spoke about her experiences of going to school with her AMIC worker along with both of them having their first child on the same day in the same hospital ward. This particular example illustrates a number of unique aspects of this relationship. While this client lost her first baby, her AMIC worker did not, and as such her AMIC worker was very sensitive in her dealings with this latest pregnancy. The client valued being asked permission by the AMIC worker to be involved with this pregnancy, along with her AMIC worker's concern of raising any bad memories. As such, AMIC workers' long standing relationships with clients are evident and impact positively on the overall experience clients have with the program.

Interestingly, there were examples of clients describing their relationships with AMIC workers in terms of being family. Client2, whose AMIC worker is her aunty, stated that *'she is like a mum to me.'* Further, Client4 who was not related to any of the AMIC workers said that they *'become a part of your family as well.'* These two examples illustrate the uniqueness of these relationships and how significant they are to many clients of the program.

In contrast, Client7 found her relationships with her midwives to be more significant throughout her maternity care, than that with her AMIC worker. She felt this may have been the case for a number of reasons including that she was an older non-Aboriginal mum and perhaps not as *'needy'* as a young *'Aboriginal girl maybe having her first baby.'* However she believes that despite her positive experiences with her midwives, in some cases she felt that *'the AMIC worker would be there even more you know for an Aboriginal person.'* Again this highlights a unique aspect about the



nature of the care and support Aboriginal people are able to provide each other with. It also raises the point that AMIC workers may be best utilised with clients who have more complex needs.

Another aspect around the importance of the AMIC workers being Aboriginal women emerged from the client interview data. The country and family group the AMIC workers come from influences their cultural knowledge, values and kinship structures. After the birth of her child, Client4 wanted to travel to the north of the state to visit family members and introduce them to her newborn. The client's AMIC worker also had connections to that region and understood the importance of travelling long distances to visit family. This client described how grateful she was to have the support of her AMIC worker in this instance, and how through previous experiences other people had not been supportive of her desire to go back to country with a newborn. This highlights a mutual understanding between client and AMIC worker that the client clearly benefited from.

As touched on earlier, many of the clients felt they were able to talk to their AMIC workers about '*anything*' (this word used by three clients), which I would argue signifies how comfortable they felt in these relationships. Enablers to this level of comfort that were mentioned include the '*circle of trust*', lack of judgment and respect that existed between many clients and their AMIC workers. Client2 explained that she gained respect from her AMIC worker that she did not receive from anyone else.

Interestingly, a prominent topic of conversation between them as clients and their AMIC workers was around personal issues and family members: this supports an understanding that AMIC worker's relationships with their clients extend beyond a professional capacity. Being able to talk about their own children and family with their AMIC workers was important to the clients. For example, Client11 mentioned how it was good to be able to talk to her AMIC worker about anything '*like my sisters and that, and how their kids are going.*' Client10, whose relationship with her AMIC worker stems back to their childhood, said that it was good to be able to talk about family with her AMIC worker and valued the opportunity to reconnect. Not only were the things that the clients spoke about with their AMIC workers unique, but also as mentioned by Client4 '*the way you speak about them*' was both important and

different to the way she would speak to other people, including her midwives. When asked what the relationship with their AMIC workers meant to clients, a number of responses were given indicating how unique this was to them. Some responses touched on the importance of the relationship and spoke about it in terms of how strong it is. For example *'it meant a lot'* and is *'very strong.'* Client2 believes that her AMIC worker is *'closer to me than anybody else'*, and Client4 said her AMIC worker would *'forget that she also has other clients'* and she *'sort of took real ownership of her.'*

Furthermore, the relationships that clients establish with their AMIC workers extend beyond their time in the program. Two clients described the relationship they have maintained with their AMIC worker, and how they appreciate the genuine interest they still have in the health and wellbeing of both them and their babies:

*Client5: Even now when you see her, she's you know ... always got a smile on her face and pleased to see [son] ... always asking how we are going and we always, you know, stop at the shopping centre and have a yarn.*

The significance of these relationships and the attachment to their AMIC workers was vividly described by Client4 who said that when her time in the program came to an end she felt *'like the cord has been cut ... we'll find a way. Any excuse to go back.'* Not only does this reveal how this particular client was affected, it also shows how determined she is to maintain the relationships that were established during her time in the program. The symbolic metaphor which illustrates the repeated themes in birthing and relationships.

Clearly there are a number of factors influencing the depth and uniqueness of the relationships between clients and AMIC workers, which enable clients to feel comfortable accessing maternity care. Being Aboriginal women, with in-depth understandings of culture, country and family networks are amongst the most important factors in establishing and maintaining these meaningful (rather than merely instrumental) relationships.

### **What clients like about having AMIC workers**

The interview data indicates that there are a number of aspects of having an AMIC worker that clients of the program value. Analysis highlights four main themes including the support clients receive from their AMIC worker, the significance of this relationship, the personal characteristics of the AMIC worker, and the clients' positive understanding of the role. This section will endeavour to explore these themes and discuss them in relation to the benefits of having AMIC workers engaging with the clients of the program.

Clients spoke about many different aspects of support they received from their AMIC workers, indicating that it took different forms and meant different things for each of them. There were some commonalities amongst the things clients appreciated about this support.

All clients interviewed valued the support they received from the AMIC workers in attending appointments. Each client commented on how this attendance was of benefit to them, with some responses focusing on the significance of having their AMIC worker attend appointments with them. To some clients this was important because their AMIC worker was able to break down the medical terminologies or 'jargon' frequently used by their doctors, practitioners and in some cases midwives, and allowed them to feel more comfortable and confident in understanding the information being shared with them. Their AMIC workers also explained things in a manner that clients could relate to and allowed clients to feel, as put by one client of the program, that *'no question was a stupid question.'*

The support offered to clients by their AMIC workers around their appointments not only related to information transfer. Also of importance was assistance in making appointment times and the transport to and from these appointments. While perhaps not traditionally recognised by a mainstream health organisation as being a barrier, for some of the clients of the program getting to appointments is often very difficult and without the support of the program often impossible. *'I don't miss any of my appointments because [AMIC] picks me up and drops me off.'* As such, transport to appointments was highly valued by many of the clients interviewed. The assistance they were given in bringing their other children with them to appointments was also

highly valued. The facilitators identified included having access to car seats in the program vehicles when travelling to and from appointments, and support of the AMIC workers and program midwives in ‘minding’ their children while they attended their appointments. Client5 talks about this as being one of the most important things her AMIC worker was able to do for her:

*I think maybe just her support with [daughter] was probably the biggest thing for me. When I'd come to appointments and stuff she was always more than happy to take her and play with her and she got along with [daughter] really well. [Daughter] just loved her. So ... it was really good.*

Many of the clients discussed valuing their AMIC worker's support during the labour and birth of their child. While not all clients went through this process without the support of their partners or family, many did, and for them the assistance and support of their AMIC workers was especially important. Some clients spoke of their AMIC worker contacting family members on their behalf to inform them of the labour or birth. One client mentioned how her AMIC worker went to her home to collect various items she needed during her time in hospital. For this group of clients it was common that their AMIC worker would come to work when they went into labour, even if they were not rostered on. This often meant the AMIC workers would be called in after hours, including during the early hours of the morning or on weekends. Again, this is evidence of the AMIC workers' commitment to their clients, as it is not part of their job requirement.

In addition to these forms of physical and emotional support, some clients spoke about their AMIC workers taking photos of the birth and giving them photo books as keepsakes. Client4 described how ‘*they took some photos of her [...] so that was really nice.*’ Other gifts given to clients by their AMIC workers which were mentioned as being of special importance included ‘*a box of body wash for myself, a sponge and clothes for [baby son]*’, as described by Client2. There is a small budget within the program to provide these items.

When asked whether or not their AMIC workers gave them special things or did special things for them, which they didn't get from anyone else, most clients said that

they did. Things that they mentioned, which I have not already touched on, included ‘the circle of trust’ afforded to one client by both her AMIC worker and midwife, ‘respect’ and assistance with everyday living such as helping with the grocery shopping.

Some of the responses to this question also alluded to other special forms of support offered to clients by the AMIC workers. For example, Client11 said one of the important things that her AMIC worker was able to do for her that no-one else did was talking to her and calming her down during stressful times:

*... like when I'm feeling down or stressed out or whatever I don't like talking to my family, I'd rather talk to her. 'Cause it stresses them out and makes me worse.*

Several clients mentioned the importance of emotional support. Three examples from the data particularly stand out. For Client2, this support also took the form of being calmed down when she was flown to Adelaide with medical complications. This client described the situation as being frightening as she was ‘*freaking out*’ about the seriousness of going into very premature labour and being sent to Adelaide for specialist care. The same client spoke about receiving help with her depression from both the AMIC worker and midwife, after the loss of a close family member. She described this period as being ‘*a really tough time*’ and believed that ‘*if it wasn't for them I would have, I probably wouldn't have had him, probably wouldn't have been able to cope with it.*’ She felt that this support changed outcomes for her and she ‘*thought [she] was going to be alone, but [...] had more people than [she] thought.*’

Client11, who was pregnant at the time of our interview, said that one of the best things about having her AMIC worker is that:

*She is there all of the time. Even if you just ring her out of the blue, she always takes time to listen to you.*

It would seem that these different forms of support facilitate the relationship developed between the AMIC workers and their clients. The way in which clients described these forms of appreciation would suggest that in some cases a form of emotional attachment or deep appreciation of this relationship develops.

The AMIC workers are also able to provide their clients with information that clients did not access elsewhere. Two clients stated that some of this information was around *'healthy eating and just the common sense stuff'* [Client1], whilst another Client2 commented on how her AMIC worker *'tells you everything, not just a little bit of the side line.'* This suggests that this particular client has had experiences or expectations of not being fully informed around health issues and highlights the importance of trust and a degree of transparency afforded to her through her relationship with her AMIC worker. This client went further to say that in comparison to her midwife, her AMIC worker would *'explain it to me'* rather than simply describing it in a way that only makes sense to the midwife. The effect this had on her was that she would *'understand it more and be more comfortable in doing stuff.'* Other information she felt she benefited from was *'probably just help to raise [newborn son] and let me know what was going to go wrong and if it did when to stress out and when not to.'*

Not only did clients value the support provided by the AMIC workers, but they also spoke of how it was important to their partners. One client mentioned how her partner was grateful for the support both the AMIC worker and midwife gave to her, and how it helped him to feel more comfortable knowing she was in good hands when he had to go away for work. Aside from this type of support, AMIC workers were also known to support clients' partners during the labour and birth. Client5 described how her AMIC worker was called into work when she went into labour, not only to support her but also her husband.

*I think they ended up calling [AMIC] in because I just had my husband and I think he was getting a bit tired of all of the back rubbing and stuff and needed a helping hand ... [AMIC] came in and she did a really great job. ... and I think it was a good support for [husband] as well, to have her there.*

The importance of the support afforded to the clients by their AMIC workers and also midwives has been highlighted in this section. This discussion heightens an understanding that these relationships are unique and valued greatly by most clients of the program. The impact of this support and the extent to which it is valued, is spoken about as having a positive impact on health outcomes for clients and their families.

Two clients explicitly mentioned how without the support of their workers they would not have gone through with their pregnancy. The support mentioned does not only relates directly to the clients' needs that are associated with pregnancy and birth, but also to many other aspects of their lives.

Clients' understanding of the AMIC role varied according to their own experiences and relationships with the workers. Most clients had only positive feedback to report about the role of their AMIC worker in assisting them with their pregnancy, labour and postnatal care. Some clients believed it was the role of the AMIC worker to provide them with '*one on one*' care, with one client stating her AMIC worker was '*a support person I could talk to, [who] would be at every check-up.*'

Interestingly the role of the AMIC worker was often spoken about in comparison to the role of the program midwife. In the following example, Client5 was asked specifically about the comparison between the two roles and believed that her AMIC worker did more for her than her program midwife, particularly at the birth. She valued her AMIC worker's ability to '*do the little things that matter*' including supporting her husband and rubbing her back. In this example the program midwife was described as having to '*run around thinking about all of the other things like how the baby is coping and all of that.*' She described her belief that the AMIC workers are responsible for the personal rather than clinical aspects of the labour and birth, but also recognises the AMIC workers ability to attend to the clinical aspects of the birth:

*I think that if it was a perfect pregnancy and labour and whatever, the AMIC workers would probably, not that they do the deliveries, but you know they're probably nearly at a point where they can do it themselves anyway.*

Client1 also described the roles of her AMIC worker and midwife at the time of birth. The relationship she developed with her AMIC worker, which was likely strengthened by the frequency of support at antenatal appointments, may have influenced her perception of the two roles. In this instance, this client perceived her midwife's role as mainly being there for her during the labour, as opposed to her AMIC worker who was there throughout the entire pregnancy.

Aside from the support the AMIC worker was able to offer to her client through her role, also of importance to Client4 was her understanding that the AMIC workers give cultural advice to non-Aboriginal staff members of the hospital. To this client, her AMIC workers ability (enabled through the role, but I am sure also dependent on personality) to advocate for her desire to take her placenta back to country was incredibly significant. Through this example it can be understood that for some of the AMIC workers their role is also used to educate the wider work environment about the needs of their clients.

**Program midwives and medical practitioners understanding of the role**

The program midwives demonstrated a complex understanding of the AMIC worker role. The importance of the relationship AMIC workers establish and maintain with their clients was frequently referred to, and understood to influence who the most appropriate support person was for each client. The significant role the AMIC workers play in providing care for clients was described by Program Midwife2 who also touched on the importance of AMIC workers being Aboriginal women:

*... they've got the ability to increase the antenatal visits throughout a pregnancy, um ... the girls want to be looked after by, you know an Aboriginal person, so they can come in, they're involved in their care, um ... they often can communicate better with them. And as we build up a relationship with them over a period of time you find that towards the end of their pregnancy you know, I like to think that we generally have a good relationship with them. But not the same as what the AMIC worker does.*

Furthermore, Program Midwife6 spoke about the ways the AMIC workers work, and how they negotiate the complex needs of their clients and the needs of the health service:

*[AMIC] workers work around the girls to make sure they know what's going on, and around their life, you know some of the girls probably don't even own a clock, let alone have a structured life so an appointment at ten o'clock means nothing to them. The AMIC workers can help be, a sort of that bit of flexibility between the structure that we expect and the life that they have, sort of a bit of a balance.*

In describing the roles of the AMIC workers during the labour and birth, Program Midwife2 stated that it is 'more important that the AMIC worker be there' than the



program midwives, because they are the ones who have *'built that relationship with the girl.'* This was described in terms of being a *'doula support role'*, that is someone who is able to assist a woman before, during and after birth by providing physical assistance and emotional support. In contrast, while acknowledging the importance of the AMIC worker role, Program Midwife1 describes how the AMIC worker role entails much more than that of a doula:

*... sometimes there [are] girls who haven't got anybody so they want their AMIC worker in there, thank you very much. But they're not doulas. I mean, they could be and sometimes they are, but that's not their total role. And the midwife, it's very hard for a midwife to be the doula, to be this to be that, to be worrying about whether we need to call the doctor yet, or anything, or not. Or ... nah nah nah this is normal, let's just go with the flow, let's just keep the mother relaxed. You know what I mean. You need to have a team of people getting a woman to birth safely [laugh].*

Program Midwife6 also acknowledged the important role the AMIC workers have during the labour and birth, making specific reference to how they remain respectful of clients cultural needs:

*I think they try and respect the women as much as they can especially in labour and birth, like keeping them covered and you know, you know some girls are still quite traditional and only have women in the room, where other girls prefer their partners to be in the room. So they cater for that. They are quite good at finding out who they want and don't want in the room. Um ... and they're quite quiet and keep things quite calm so I suppose that's a culturally appropriate way to keep them covered, or if we've got them uncovered remind us to keep them covered you know, and if men walk in the room, like a male doctor, keep you know, cover them up.*

Not only does this acknowledge the complex role of the AMIC workers, but also highlights the role the AMIC workers play in teaching others about being respectful of culture and clients diverse needs.

Perhaps the best way to summarise the role of the AMIC workers is through the words of Medical Practitioner1 who stated they *'are the connecting link.'* It was also reiterated by others, including Program Midwife6 who described them as the bridge *'between the structure[s]'*, and Client7 who said they provided *'that link [...] that in between thing.'* Importantly, AMIC1 described how she believes teaching other staff

how to act appropriately and advocating for the needs of clients is paramount to the work that they do. Firstly, in relation to teaching other staff how to be culturally appropriate AMIC1 expressed that:

*... our women are very shy, very [...] reserved [...] I had to talk to [program midwife] about, you know, maybe talking a little bit more quietly and things like that. Um ... and that I think the biggest thing is that, how they app, how they approach and how they come into the first you know meeting with that client is so important because [...] our women just read them straight away. And they'll say whether they want them to continue to look after them or not. So, you know they have to be careful about how they approach and how they go about doing that. [...] I mean Port Augusta, I mean our program's really designed that we look after the individual woman's needs.*

This extract touches on respecting client needs and teaching other staff to interact appropriately with the clients, as well as explaining the impact this has on client's willingness to engage with them. Advocating for the clients is another important aspect of the AMIC role that AMIC1 described. Considering the differences in cultural beliefs and subsequent needs of women, she believes that it is 'so great that we have a choice now' and can organise for clients to have access to a female obstetrician and female staff, when the client 'wants a woman.' AMIC1 feels that this is one strategy for 'combating' issues clients may otherwise have with the service being inappropriate to their needs.

#### **Understanding and respecting the needs of clients**

It was recognised by all staff interviewed that clients of the program have complex needs. As acknowledged by AMIC3, 'there's so much going on in that girls life' that it is important to be aware of other aspects of their life that may be affecting their health and wellbeing. A more in-depth discussion around this occurs in Chapter 4. AMIC5 acknowledges that the understanding AMIC workers have of the lives and cultural needs of clients' assists the AMIC workers in working appropriately with them. Again being an Aboriginal woman is described as being significant in these relationships:

*... there are so many things that happen, you know in our everyday lives, like with the girls um ... you know they can have deaths in the family or the loss of a baby and*

*things like that. So you have to be committed and understand their ways as well. Yeah, their cultural ways. And there's different groups of Aboriginal families, different um ... clans. So they've all got different ways.*

AMIC3 went into some detail about the complexities of client's lives and how she often hears people saying that the clients are '*children having children*' which she understands is true but does not believe it is appropriate to '*discriminate*' against clients in this way because there is '*so much going on in that girl's life that you're not only looking at the pregnancy.*' As an AMIC worker, she feels her responsibility to the client is assisting her with '*other things, like housing*' and writing '*support letters for the girls to get housing because a lot of them are homeless*' and '*couch surfing and things like that.*' This was also mentioned by Program Midwife3 who acknowledged that clients lives are often '*such a mess*' and '*they sleep wherever they can find a bed.*' Program Midwife6 also spoke about how '*a lot of girls ... don't have houses or want to move out of crowded houses.*' AMIC3 understands that as AMIC workers, they '*need to look at trying to get [the clients] a house before the baby comes.*' Furthermore, she describes some of the other difficulties clients encounter when trying to access other services, including Centrelink, which can be an issue for some clients because '*a lot of them don't even have birth certificates.*' Additionally, Program Midwife6 acknowledged that some clients '*don't have transport*' so accessing their care can be difficult for some who '*miss appointments and scans.*' In this way, the role of the AMIC worker is extensive and includes addressing aspects of a client's social life that will assist in improving the health and wellbeing of them and their babies.

Furthermore, it was acknowledged by many staff interviewed that clients are often involved in abusive relationships or have had extensive experiences of different forms of abuse or hardships throughout their lives. Program Midwife3 described how for clients accessing the program '*there is a lot of domestic violence and these girls are just in terrible relationships that they can't seem to get themselves out of.*' She believes that seeing that these '*girls can't help themselves [...] they go back to these men that beat the crap out of them*', '*over and over again [...] really gets to you.*' Program Midwife4 also described how she has '*been blown away by the problems that these girls have*' including '*sexual abuse*' and '*physical abuse.*' She believes that

one of her greatest learnings from being involved in the birthing program is that the clients have *'got so many issues'* that *'sometimes they just need somebody to care.'*

Program Midwife2 also spoke about how she understands that *'some of them have such sad lives'* and are:

*... living in such cramped conditions with so many different people in the house. With so many problems you know, from the drug use to alcohol use to ... you know domestic violence to you know ... it's just mind blowing really. And to me it was such an eye opener that we would have such poverty and um ... you know just terrible living conditions in not even an hour from where I live.*

The social determinants of health in clients' lives are paramount in this context. Program Midwife3 described how *'nobody sees the picture around some girls smoking fifteen cigarettes a day who might be having her sixth child and doesn't really want to do it but has left it too late to have a termination.'*

Medical Practitioner2 summed up the importance of the social aspects of clients' lives and how the program offers a unique support for clients during their pregnancy.

*If antenatal care improves pregnancy outcome, it should be improving pregnancy outcomes for these women. At another level, however, these women have a huge history of isolation, domestic violence, poor education, sometimes sexual abuse or sexually been taken advantage of and they have very few people who they can share their story with. Their own community is quite closed, there is limited range of people you can talk with, there are often breaches of confidentiality. So there is no place where they can place their stories.*

In contrast, AMIC4 believes that while *'you get a lot of girls with a lot of social problems'* it is difficult to *'deal with that'* and as AMIC workers *'you have to deal with the pregnancy.'* She also acknowledges that *'some girls need a lot more care than others.'* This highlights both a dominance of the medical aspects of care, and also the difficulties in addressing the complex social needs that many of the clients have. AMIC5 also acknowledges the importance of being *'able to get [clients] to come along and to help them with their health needs'*, because *'a lot of them don't do*

*it' rather they 'find out that they're pregnant and that's it [...] they don't do anything else after that.'* Furthermore, AMIC5 believes that clients *'don't really have an understanding'* of *'how important it is for them to have all of those health checks'*, which is one of the things AMIC workers try to address, and *'explain to them why'* it is important *'in a way that they can understand.'* Program Midwife6 also acknowledged that *'some of the [clients] don't understand why they have to see the doctor so often'* and often *'have [other] stuff going on'* that they *'want to go and see family in another city or just pack up the car and go.'* Client priorities are obviously not always in line with medical aspects of their care.

Many participants of this study raised the issue of clients avoiding the hospital system, with the predominant issues being around fear or shame. Fear stemmed from a fear of accessing a service they do not feel comfortable in (i.e. uncomfortable with the staff and process of the hospital or negative past experiences with the system), a fear of going through their pregnancy and birth without their partner, as well as a fear of having their baby removed (which was described by program midwives and AMIC workers as a situation they had witnessed). Medical Practitioner1 described how some girls *'have big issues, concealed pregnancies'*, access the program late and then *'need even more support because there is something that has kept them hidden from the system.'* They described how *'clients are scared [that] their partners might not be there'* which was the cause of *'every week for the last four or five weeks we have had one concealed pregnancy, at 24, 25 and 26 weeks.'* Furthermore, Program Midwife6 described how one client did not have any antenatal care during her pregnancy, because *'all of her previous children had been taken by Families SA. And her husband was in jail when she fell pregnant so there was that, more social stuff than anything else.'*

Furthermore, Program Midwife2 described a situation prior to her involvement with the program, where she believes she may have been culturally inappropriate when assisting an Aboriginal client through the birth of her child. She described how her time in the program has been critical to improving her cultural awareness, which has largely been learnt from the AMIC workers. The following extract describes the situation, which may also illuminate the extent of client disempowerment and a possible lack of understanding around what happens during birth.

*“... if you don't let me get down there to try and deliver the baby it's going to deliver and you'll tear.” And she said “no”, and she was hanging on to her knickers by the sides and I had to get the scissors and cut them off. And then the baby birthed. And she was so mad with me that I had ruined her knickers ... And that was all that she was concerned about, that I had cut her knickers off.*

Program Midwife2 did acknowledge the discomfort experienced by this client in this situation, and brought her a pack of new underwear to replace the pair she had destroyed. She believes this mended the distrust the client felt towards her, and ten years afterwards, the client still approaches her in public to discuss how her child is going.

Medical Practitioner1 also touched on their belief that many of the clients accessing the program are very young and have limited understandings of pregnancy:

*... [clients often have] their babies when they are 14, and 16 and 17 and 18. So normally they have no concept of what it is. They are not using contraception and they get pregnant. So, that's why we are also concentrating on these girls to put Implanons and Mirenas, so at least they have a spaced pregnancy. 'Cause a lot of them it just happens. And go out and get pregnant and come back, within two or three months. Like one girl came back and I put an Implanon in six weeks after her delivery, and six weeks later she came back and she was ten weeks pregnant. She had been pregnant for a week when I did the Implanon. So it's amazing but this happens. And I had to take the Implanon out [...]. So now we have decided before they leave hospital to put one in. [...] Some of the girls are very fertile, young and fertile, and if they are not breastfeeding they can get pregnant straight away.*

This highlights a number of issues, including young clients' ambivalent understanding of contraception and pregnancy, along with their tendency to become pregnant soon after the birth of a child. All of these issues contribute to the complexity of the clients' lives and the plethora of issues AMIC workers are required to work with.

### **Culture is changing**

Differences among Aboriginal culture was a common discourse that emerged throughout the data, which impacted upon the best ways to approach and work with

clients of the program. There were many reasons attributed to these differences, including the effect urbanisation has had on cultural practices. It is important to consider how differences in culture and the cultural needs of clients affect the role of the AMIC workers and require them to be flexible and maintain a high level of respect.

AMIC1 described how urbanisation has affected clients' *'connection to culture.'* She spoke about how *'a lot of the younger girls now are more urbanised'*, have *'got their young partners'* and *'may not have that connection to culture anymore'* despite their *'nannas and auntys [...] telling them things.'* AMIC1 believes that *'times have changed.'*

Discussion around *'the more traditional girls that come from the land'* was prominent throughout the interviews, and as put by ProgramMidwife6, they *'are quite different to look after than the girls that are based in the city.'* This is touching more on the differences between cultural groups according to them being more remote or urbanised. Program Midwife6 recognises that *'the girls from bush tend to keep to themselves and if they don't come with anybody at all they want nanna there'*, whereas *'the girls from town generally will have their partners there which is quite a change.'* AMIC1 further describes the importance of respecting women's business for women who maintain strong cultural beliefs:

*So, I mean we do have more traditional remote women that we have looked after in the program. And, um ... there's certain beliefs and er ... you know that they believe that it's very much woman's business, men aren't to be involved. Even to the point of not even having a male doctor.*

Client11 gives some insight into why links to culture may be changing for more urbanised Aboriginal women. She explained how with *'my way, with my nanna and that, we weren't allowed to grow up around culture.'* It was important that the elders *'knew it'* but *'we'd get in trouble if [...] you hear something wrong or whatever. We wasn't allowed to learn how to speak the language.'* Client11 understood this to be *'for our own safety'* because there would be strong consequences for getting it wrong.

Medical Practitioner<sup>2</sup> gives a description of Aboriginal cultural change and how it affects the way he/she believes Aboriginal people define themselves. This is important to this discussion because it clearly demonstrates the diversity of culture that AMIC workers are expected to deal with:

*The issue is, of course, is that Aboriginal people live in a dominant non-Aboriginal Australia. And so they are on a journey of transition to living alongside or within that dominant culture. So people will define themselves as being extremely traditional with extremely traditional beliefs, through to modern sophisticated people who have a better understanding of these things than many of the health professionals who are dealing with them. And people need to be allowed to define themselves, and many people will have a mixture of old beliefs and new beliefs and some of those will be helpful to them and some of them won't and some of them will appear and would be seen as scientifically truthful and others wouldn't be.*

During the interview, AMIC<sup>1</sup> considered how these changes and differences affect the role of the AMIC workers. For her the difficulties can arise in negotiating and moving between clients with more traditional beliefs and needs and those who have adopted more western approaches to maternity care:

*I think that that change or that shift between err traditional, I guess Grandmother's Law woman's business and how it is today um is really difficult sometimes ... and umm, especially as us as AMIC workers, cause you know, err, you have to know where you come from, you have to know and have respect for the way it used to be. Um ... but also, we're living here now, twenty-first century and we have to still look after these young girls as well. So it's important for us to be flexible in that way I think.*

Remaining respectful to the diversity of the clients' needs requires having knowledge about a range of different cultural beliefs women may have. It is important that AMIC workers remain flexible to these needs, and maintain a good understanding of the way Aboriginal cultural beliefs may affect the needs of clients. I argue that these differences are not widely understood by non-Aboriginal people or the health services and consequently the AMIC workers are often engaging with highly sensitive situations and remaining respectful to relationships which may be difficult to maintain, without the appropriate recognition or support.



## **Conclusion**

The complex and important role of the AMIC workers was adequately summarised in the words of Medical Practitioner1:

*I think AMIC workers are a great asset to the program because they are the connecting link between the patient and the services and I've seen some of them working great work and they know them culturally and they can relate more to them and they can explain what we want to in their own terms or in their own environment.*

As such, AMIC workers are cultural brokers, advocates for both clients and other staff, and play a central role in providing clients with important aspects of their clinical and social care. The analysis in this chapter has clearly described how AMIC workers are vital in establishing and maintaining meaningful relationships with clients. The knowledge AMIC workers have about the lives of their clients and their families is an important factor in establishing these relationships, and is particularly helpful in developing and building upon understandings of client needs and appropriate forms of engagement and interaction. These factors are crucial building blocks for the AMIC-client relationships and enable a two-way respect that encourages clients to feel comfortable accessing AMIC workers and receiving the subsequent care.

This chapter also identified that it is largely the caring aspects of the AMIC role that are highly valued by clients. For many clients interviewed, the care and support they received from their AMIC worker was unique and not gained from other sources. Clients valued having many of their non-medical needs met by AMIC workers, which were often spoken about as being as important (if not more important) than their medical pregnancy care. For some clients, the AMIC workers were a major source of support that ranged from someone they felt comfortable talking to about personal issues, to receiving assistance with transport and living arrangements.

Furthermore, the AMIC workers in-depth understanding of the complexity of clients' lives, along with the diversity of cultural needs clients have, allows them to sensitively address issues that are relevant to each client. The discourse around these factors touched on the uniqueness of the local knowledges (including family

structures and culture) of the AMIC workers and the importance of these knowledges for clients. In many instances, the relationships between AMIC workers and clients were based on their cultural or family links which adds another layer to the depth of understanding and also sense of responsibility AMIC workers have towards the clients' lives. An appreciation of this by those in the workplace who have a sense of this depth of understanding also highlights how valuable their role is in the care of program clients.

Through these analyses, it has been made clear that no other role within this context is able to address these concerns. It has been well-established that without the AMIC workers, clients would not feel comfortable accessing the program and the delivery of appropriate maternity care to these women would cease.

## CHAPTER 3: MEDICALISATION

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Rose (2007) has argued that medicalisation ‘has made us what we are’ and through its many practices has significantly transformed the way we live, what we recognise as being harmful or helpful to our health, the meaning we assign to our experiences of our world, and the extent to which we are artificial beings.

Medicalisation is a complex concept which describes the process through which a non-medical human condition or problem is defined and treated as being medical (Conrad, 1992). The term emerged in the social scientific literature in the 1970s, and receives most attention when a non-medical problem is believed to have been made inappropriately medical. Medicalisation has affected Western understandings of and approaches to pregnancy and childbirth events with a shift from the ‘natural’ to the medical. While many factors contributed to this shift, early critiques of these processes within the sociology literature focused on the excessive power biomedicine has been afforded through medicalisation, and a strong anti-medical discourse emerged. Subsequently critiques have increasingly recognised both the role of physicians and women in what can be considered the socio-political processes of the medicalisation of pregnancy and childbirth. Both women and doctors are seen as active agents in these processes, rather than passive recipients. While many of the criticisms are useful in understanding the ways in which medicalisation has come to affect how we perceive and approach different issues relating to normal bodily processes, recent critiques also argue for the many benefits of biomedicine for improving pregnancy outcomes. These benefits are perhaps most obvious to women who do not have access to biomedical assistance during pregnancy and childbirth.

### **The history of medicalisation of pregnancy and childbirth**

Medical monitoring of pregnancy was non-existent up until the early 1900s (Speert, 1980 as cited in Barker 1998). Prior to this, pregnancy and childbirth were viewed as natural human experiences (Riessman, 1992). A shift in thinking, influenced by the Cartesian philosophy which conceptually separated the mind and body (Saggers & Gray, 2007), led to different understandings of health. Through this lens the body was understood to be made up of smaller biological parts, whereby illness was reduced to biological processes which were targeted by various interventions (Germov, 2005).

One criticism of the biomedical model of health has therefore been its reductionism, and the ways it has objectified the body and denied human experiences of illness (Saggers & Gray, 2007). Through this biomedical shift in understanding, childbirth and pregnancy were consequently perceived as a pathology or illness, and therefore as medical events (Riessman, 1992). The psychological and social factors involved in health and illness were viewed as secondary to the biomedical model (Saggers & Gray, 2007), which contrasts strongly with holistic understandings of health (Germov, 2005).

Up until the late 1940s pregnant women in Western society received no routine medical prenatal care (Barker 1998) and typically delivered their babies at home with a local midwife. Only women who experienced severe complications during pregnancy were seen by a physician before giving birth (Speer, 1980 as cited in Barker 1998). Patterns of care utilisation have changed dramatically during the twentieth century, as the dominance of the biomedical model increased, with the majority of women in Western society today receiving some form of medicalised care throughout their pregnancy (Barker, 1998). This care currently includes assessment and monitoring of maternal and fetal health, including screening and diagnostic procedures, health education and health promotion (Riessman, 1992). Through this process of adopting a biomedical understanding of pregnancy and childbirth, a social model of birth which adopts a more holistic view of health (Donnellan-Fernandez, 2011) has been overshadowed.

One of the reasons maternal and infant healthcare became so medicalised is because it involved women. It has been suggested within the feminist literature that medicalisation has affected women more than men (Riessman, 1992; Rose, 2007). These differences may be the result of the way women have traditionally been positioned in society, and the influence of numerous power relations. Riessman (1992) argues that women's 'problems' are more likely to be defined and treated medically, when compared to those of men's. Examples of common instances of medicalisation for women include childbirth, premenstrual syndrome and abortion. However, as described by Riessman, women have not been passive in the increase of the medicalisation of their 'life problems'. They have had an active role, and to deny this is to accentuate 'the very kinds of assumptions about women that feminists have

been trying to challenge' (Riessman, 1992, p. 123). Women engage in the process because of their own needs, whereas physicians get involved due to their own economic interests and their training (Riessman, 1992).

#### ***Anti-biomedical feminist critiques***

Initial criticisms of the medicalisation of pregnancy and childbirth came from feminist literature, which viewed biomedicine in general as having too much power. Conrad (1992) argued that the adoption of the medical model resulted in social issues being de-contextualised. As such social issues were considered to be irrelevant, individualising something that might otherwise have been considered to be a collective social problem.

Feminist critiques argue that the rise of medicalisation has affected the way health is perceived, and created standards and norms around who should be involved in associated processes. As contemporary medical knowledge was constructed from a discourse focusing on the biological, it inevitably gave physicians an authoritative power and hid the social constructions influencing the formation of knowledge. The dominant expertise of these physicians allowed them to enforce medical knowledge claims and practices, effectively privileging their own position in both organisations and society. From this perspective, physicians are viewed as dominating client-physician interactions and relationships. It has been noted in Marxist literature that medical training and registration is a means for controlling who is involved in the health workforce, along with its size, which is enabled by a number of economic variants (Jordanova, 1995). As such, French historians have used the proportion of medical practitioners in a population as a measure of the extent of medicalisation, as the very presence of a physician brings medicalisation.

The consequence of professionalisation for maternal and infant healthcare, as argued within the feminist literature, has been the introduction of clinical experts in many countries who now dominate a field that until quite recently involved only birth attendants. Over a period of more than a century (Riessman, 1992), Western society saw the emergence of an Obstetrics and Gynaecology discipline, dominated by males; whereas pregnancy and birthing was traditionally an area that had concerned only female midwives and traditional birth attendants. The development of this discipline

in contemporary medicine involved a struggle for physicians to gain recognition and superiority for their knowledge and skills, as they actively worked towards changing public perceptions and understanding of health and health services. It has been suggested that they created a 'cultural authority' (Starr, 1982 as cited in Riessman, 1992) to distinguish themselves from 'regular' doctors, in order to increase both their status and employment opportunities (as did other medical specialties).

Not only did this physician professionalisation change the personnel involved in the delivery of care during pregnancy and birth, but it also changed the site of care. There was a shift from home care and births to a hospital setting, along with a shift from non-interventionist to interventionist approaches to care (Riessman, 1992).

Interventionist approaches involved the use of technology and drugs, and were documented as being the cause of harm in instances when the intervention was unnecessary (Martin, 2001; Wertz, 1989). Some evidence suggests an increase in mortality for both mother and child occurred during this period as a result of physician's interference and involvement with birthing (Wertz & Wertz 1979, as cited in Loudon, 2000; Riessman, 1992), and more recently the increase of privatisation and surgical birth interventions (Amnesty International, 2010). Through these processes and shifts, the meaning of childbirth was transformed from being a natural event to a medical problem (Riessman, 1992).

While these critiques are very strong within this literature, it should be acknowledged that with these changes in who delivered maternal and infant care, along with the site of care, improvements in biomedical health outcomes have also been documented (Dye, 1980). Looking specifically at maternal mortality, it has been found that during the late nineteenth century the provision of professional midwifery care at birth has been largely attributed to halving the maternal mortality ratio in some industrialised countries (Van Lerberghe & De Brouwere, 2000). Progress in lowering maternal mortality rates, ascribed to improved management of infection, better surgical techniques and universal access to care (Van Lerberghe & De Brouwere, 2000) was also achieved following World War II when access to hospital care improved (Ronsmans & Graham, 2006). This was demonstrated through the dramatic drop in maternal mortality ratios in Sweden and the USA from 1935 (300 and 600 deaths per

100,000 live-births respectively) to 1960, when rates reached 20 to 30 deaths per 100,000 live-births in all industrialised countries (Loudon, 1992).

Over the past 40 years in other countries, improvements in maternal mortality have also been demonstrated. Specifically, in Thailand rates have dropped significantly from 1960 to 1984 (400 to 50 deaths per 100,000 live-births respectively) and in Malaysia and Sri Lanka maternal mortality ratios have halved. Many of the improvements have been attributed to medicalised approaches to maternity care, including the recognised importance and investment into midwifery training and referral hospitals; and a supportive healthcare system that is regulated, controlled and medically supervised (Liljestrand & Pathmanathan, 2004; Seneviratne & Rajapaksa, 2000). Similarly, in one rural region of Bangladesh, despite the majority of women still delivering at home, a drop was seen in the maternal mortality ratio (600 to 200 deaths per 100,000 live-births between 1976 and 2001). It is thought that an increase in access to surgical obstetric care (including emergency care), along with improvements in general health, a fall in abortion related deaths and lower fertility have contributed to this reduction (Chowdhury et al., 2007; Dieltiens et al., 2005). It has been suggested that the main factors associated with these declines in maternal mortality ratios can be attributed to improvements in maternal care rather than higher standards of living. As such, malnutrition which would seem a logical contributor to poor levels of maternal mortality has been found to be only a minor determinant (Loudon, 2000).

***Women recognised as being active agents in the process of medicalisation***

While the processes of medicalisation were initially viewed very critically within the feminist literature, a shift in thinking became evident in Riessman's work in the 1990s. Research drawing on Foucauldian perspectives recognised that medicalisation is not only imposed, it is embraced and reproduced by its subjects. As such, Riessman described medicalisation as a 'critical' concept because it highlights medicine as both a scientific and social business (1992). Riessman draws out the ways in which pregnancy and childbirth became medical issues, and highlights that Western women in the nineteenth century encouraged medical changes for various reasons. Life for working class Western women during this period was often difficult and encumbered with hard living and working conditions. The reality for many women included a high

number of pregnancies with a high risk of maternal and infant death. Childbirth was experienced by many as a ‘terrifying ordeal’ (Dye, 1980). The relief from pain that could be offered by physicians along with the period of rest they could have following the birth, were two reasons why some women encouraged the medicalisation of childbirth. Furthermore towards the end of the twentieth century, with a decrease in the number of children born by women in the upper classes, the fear of death heightened along with the value placed upon each birth (Riessman, 1992). Women who could afford the assistance of physicians during birth chose to have them present, because of the perceived benefits of having access to physicians’ surgical equipment and skill along with medications to assist in cases of difficult labour and births (Dye, 1980; Wertz, 1989).

Riessman recognised that the development of medicalisation relied upon both physicians and women. As such medicalisation can be understood as the intersection between the interests and beliefs of physicians and the needs of women (which Riessman distinguishes as being class-specific). It is at this meeting point that a justification for the transformation of pregnancy and birthing from the natural to medical is reached (Riessman, 1992). Riessman argues that the process of medicalisation can be viewed as being a function of both ‘the interests and beliefs of physicians’, ‘the class-specific needs of women’ and ‘the ‘fit’ between these’ (Riessman, 1992, p. 126).

While Riessman’s account offers a new perspective on women’s agency within medicalisation it still highlights problems associated with the dominance of the medical model over the social. Consistent with previous feminist critiques, Riessman argues that women’s social problems and needs are frequently ignored because of the biomedical lens through which many issues are viewed (1992). Furthermore, she argues that by disregarding the social, influential political factors become invisible. This can be better understood when recognising that medicalisation cannot be separated from politics, and that it affects populations in different ways. For example, minority groups experience limited power, and they are more likely to be medically labelled and put under medical control by medical authorities (Riessman, 1992). Furthermore, Riessman argues that, ‘to ‘de-medicalise’ is not to deny the biological



components of experience but rather to alter the ownership, production and use of scientific knowledge' (1992, p. 143).

### **Professionalisation**

While the professionalisation of medicine saw a shift in who was considered appropriate to provide maternity care for women, the authority of medical knowledge also spread amongst other health professionals. This occurred at different rates in different fields (Rich, 1974) and included three related processes; the development and justification of a specialist body of knowledge, the control over a specific client group (and exclusion of competing groups), and the control over professional aspects of work (including practices, responsibility and obligations) (Turner, 1987). However, professional status can only be established when the skills are in adequate demand (Johnston & Rabbins, 1977).

Professionalisation within maternal and infant healthcare has seen the introduction of a number of different skilled health professionals. These include, and are not limited to obstetricians, midwives, general practitioners, anaesthetists, paediatricians, neonatal nurses, pathologists, ultrasonographers, social workers, psychologists, physiotherapists and health workers (NSW Department of Health, 2008). Each of these professions claim their own expertise of their specific areas, and in doing so exercise their authority over other professions (Bilton, 2002).

### **Medicalised concepts of time**

*'Ideas about time [...] expectations generated by these, influence the way people live and relate to others.'* (Stevens, 2009, p. 123)

Medicalised concepts of time continue to shape the provision of healthcare in Australia. Within hospital maternity services it has been suggested that three differing concepts of time are at play (Stevens, 2009). Stevens (2009) discussed the uneasy alliance between three concepts of time in this setting: physiological time, institutional time and personal time. Physiological time was described as that which is guided by 'gestation, labour, and the demands of the neonate' (Stevens, 2009, p. 110). It requires a service that can be accessed at any time of the day, on every day of the year. Institutional time refers to time rationalised by the premise that the service needs

to serve many, rather than the individual, and creates forces to encourage an adherence to this ethic. Institutional time is dominated by the relationships between the control of time, status and power, which are closely aligned with medicalisation. Personal time encompasses and acknowledges the reality and complexities of people's lives, both those who provide and those who access the service. It recognises that working for and being a visitor to the service, is only one aspect of a person's life.

Whilst in an 'ideal' world these concepts of time would merge successfully without any tensions, this is far from the reality of the daily workings of a maternity ward. Stevens' ethnography revealed the tensions that exist between physiological and institutional time in the delivery unit, whilst institutional time and personal time were found to clash throughout the hospital (2009). Physiological time, although natural, was frequently influenced by some form of control (for example the monitoring and assessment of the progression of labour including interventions to hasten labour). Despite physiological time's ability to dictate the organisation and happenings of a ward, with events such as spontaneous labour, it can be overrun by institutional time, with scheduled procedures (including elective caesarean sections and scheduled inductions). In this way many tensions between the two concepts of time arise.

Stevens describes the representations of these different concepts of time and the dominance of one over another. She argues that representations of physiological time are often made by using 'the board' found in the Delivery Office of the maternity ward. By using a shared space in which to document information about clients, including their progress during labour, different staff members of the ward are able to monitor when they may or may not be required to assist with different procedures or processes regarding the client. As found by Stevens, 'the board' influences the organisational structure of the ward, along with behaviours and subsequent workloads (2009). In many instances, this meant that the sharing of information acted as a form of control, further illuminating existing power differences. For example, if the midwives did not keep information up to date or behaviours deviated in some way from what was expected, the potential for tension between midwives and obstetricians arose. Although physiological time is that which the workings of the ward should be centered around, institutional time was in fact dominant.

This demonstrates existing hierarchical structures that are often found on maternity wards. It has been noted by Zerubavel (1979, as cited in Stevens, 2009, p. 111) and supported by Stevens, that ‘the association of flexibility and control over one’s time’ is ‘inversely related to status and power within a hospital.’ This is made obvious when examining the patterns of shift work, with night shifts typically covered by junior staff, and senior staff and specialists attending these shifts only in the case of an emergency. Furthermore, hospital schedules are often based around appointment times and clinic lists, frequently controlling physiological time and giving specialists the power to dictate a number of aspects concerning the workings of the ward and client experiences.

An interesting finding of Stevens’ study was the domination of institutional time over midwives’ personal time. She discussed this in relation to midwives use of the term ‘days on’ as opposed to ‘days off’ and argued that midwives personal time was arranged around the needs of the institution. It was made clear that this was often to the detriment of the midwife and her family, particularly when it came to special events and times of the year (for example Christmas).

### **Hospital Midwives vs. Caseload Midwives**

Hospital midwives are those who work within a hospital system and are employed to undertake a number of midwifery care hours, in contrast to caseload midwives whose work is more closely aligned with a continuity of care model and employed to undertake responsibilities (or activities associate with their client’s maternity care needs) (Stevens, 2009). A direct comparison between hospital and caseload midwives reveals different understandings of time within differing approaches to midwifery care. Stevens found that hospital midwives’ time is routinised, controlled, scheduled and de-personalised; whereas caseload midwives’ time is purposeful, flexible, uncertain and personalised (2009).

Stevens noted that within the maternity setting a scheduled time exists, which takes a form that appears to be set up and unalterable. Not only has this concept of time become embedded within this context, but also in many cases it has become the ‘norm’ and influences the delivery of this form of healthcare. This has been challenged by caseload midwifery, which adopts a flexible approach to time. This

illuminates one of the potential causes for conflict between ward midwives, and the birthing program staff in this study, as program staff (including AMIC workers) have broken through this structured use of time and have, to an extent, been given back control of time. Stevens describes this notion of ‘giving back’ recognition of the control and power the institution has over its staff. Although organisations are not explicit with this acknowledgement, it is a demonstration of a form of freedom experienced by caseload midwives. As found by Stevens, caseload midwives were no longer employed according to the number of hours they worked, rather they were contracted according to the tasks they were required to complete.

### **Rapprochement**

More recent critiques focus on medicalisation as a productive concept, highlighting the benefits rather than its negative effects or outcomes. Unequal power relations between practitioner and client are viewed as being somewhat inevitable and beneficial for the practitioner, arguing that naïve approaches to this topic fail to recognise that power relationships exist in health contexts that remain unmedicalised (for example a traditional healer in a non-Western society). As such, scholars including Nikolas Rose have encouraged alternative ways of thinking about the processes of medicalisation and the ways in which they affect the individual and institutions in developed countries. Rose has demonstrated, despite the many criticisms of medicalisation, we must recognise that through its many advancements and benefits such as introducing the practice of vaccinations and the subsequent widespread control of some diseases, the adoption of medical approaches to different aspects of life has been widely encouraged. Through our engagement with these processes of medicalisation, we have allowed our own existence to be shaped through a biomedical lens.

Whilst these new, more balanced understandings of medicalisation, have emerged, contemporary critiques such as those by Davis (2009) suggest that we still need to remain critical of the concept. Davis highlighted the role of medicalisation in individualising health issues, as it obscures the role social structures and institutions have in their construction. He argued that in this way social injustices persist and remain invisible. Problems are attributed to the individual rather than highlighting the structural factors that contribute to the construction of these ‘issues’. One of the

associated dangers of medicalisation is that ‘medical answers can close off public deliberation of complex societal problems, deny value legitimacy to alternative social or political interpretations and eliminate other strategies of intervention’ (Lock, 1991, as cited by Davis, 2009, p. 224). A holistic approach to health, that is one that considers the whole person (including social and mental factors) ("Shorter Oxford English dictionary," 2002) may be one way to overcome some of these issues (Davis, 2009). A provocative statement highlighting one of the dangers of medicalisation is that “always it is easier to put up a clinic than to pull down a slum” (Wootton, 1959, p. 329). While it is important to remain cautious of the potential shortcomings of medicalisation, it is also critical to remain aware of people’s active participation in its processes and growing reliance on its benefits. The trajectory of the processes of medicalisation encourages critical thinking about the ways it influences perceptions of health and healthcare along with how this may affect other cultures.

### **The misfit of a dominant medical approach to healthcare for non-Western communities**

While it has been widely recognised that cultural appropriateness is important in the delivery of healthcare, less attention has been given to ensuring the models of care are more suitable to the populations they are intended to serve. In the context of maternity care, assumptions have been made and systems imposed by dominant institutions, which often fail to incorporate different cultural understandings of health and wellbeing. The focus has been largely on the appropriateness of the environment and the conduct of the individuals that give the care, rather than the underlying philosophy of the care itself. Whilst recognising the importance of ‘cultural appropriateness’ it is also essential that epistemologies of the models of healthcare are understood and also made appropriate to the populations they are working with. The contemporary Western model of health that has been widely adopted, and in many cases forced upon minority groups, needs to be tailored to suit the different contexts that it works within, rather than the contexts of people’s lives and communities being made to change to fit it. As previously mentioned, holistic approaches to health that consider a broader social framework are more relevant to Aboriginal cultures. As such, it has been found that a combination of a medical approach and Aboriginal ways of knowing to pregnancy and childbirth has been found to improve health outcomes (Kildea et al., 2010; Stamp et al., 2008).

This approach has traditionally come from a non-medical conceptual framework and is based mostly on alternative therapies. Davis (2009) made mention of the debates around holistic health being viewed as a process relating to both medicalisation and de-medicalisation. In terms of Aboriginal understandings of holistic health, holism pertains to a connection between the physical, emotional, spiritual and mental aspects of life. This has been noted as different from Western spirituality and health which is typically disconnected from these other factors (Franks, 1996).

### ***Culture of risk***

One aspect of medicalisation that has been criticised is the construction and wide adoption of risk discourses in relation to health. It has been argued that these discourses are pervasive in Western society and contribute to a 'risk society' (Beck, 1992; Zola, 1972). While it can be argued that this 'risk society' now transcends cultures and classes, the discourses change with differing contexts. Typically, women in developed nations are concerned with risk despite low rates of mortality and morbidity (Eckermann, 2006), whereas women in developing countries who have less access to the benefits of biomedicine and healthcare may be concerned with risks involved with labour that are no longer life threatening for Western women. Scholars have also demonstrated that 'risk' in relation to pregnancy and birth can look very different, in terms of conceptualisation and place of birth, for women and their families belonging to cultures other than the dominant. Eckermann (2006) found that women in rural Lao Peoples Democratic Republic perceive a high degree of risk associated with birthing in a hospital that denies or under-appreciates traditional birthing practices. Similarly, Kildea (2006) found comparable realities for Aboriginal women in Australia, and the concept of hierarchies of risk, which will be described in more detail towards the end of this chapter. Furthermore, difficulties of translating medical risk with Aboriginal women throughout the Northern Territory have also been found. Wild et al. (2012) demonstrated that while the Aboriginal women interviewed in their study valued medical knowledge around fetal anomaly screening, translating this information in a meaningful way requires appropriate communication which often differs to common Western approaches.

Communication difficulties have been widely recognised as a barrier to accessing appropriate cross-cultural biomedical care. Cross-cultural studies concerned with

communication have found that not only is it common that biomedical staff do not speak an Indigenous language, but they also have the tendency to be condescending and discriminatory towards Indigenous people (Forsyth, 2007; Paradies, 2007; Trudgen, 2000).

It has been argued that Beck's work around 'risk society' is particularly relevant to modern understandings of pregnancy and childbirth (Mitchell, 2010). Within the industrialised context, which Beck suggests is influenced by environmental, economic and health dilemmas, these understandings are characterised by individualisation, choice and flexibility, presenting new dilemmas for women and their families. Decisions around scientific testing in relation to pregnancy, along with expectations around self-management, influence the extent to which women now perceive their own accountability regarding decision-making. They also influence the degree of anxiety which women experience.

With the strong biomedical risk discourse in Australia, systemic frameworks that support biomedical dominance are typical for mainstream health organisations (Donnellan-Fernandez, 2011). As such, in Australia, current rates of medical intervention in childbirth are excessively high, with approximately one in three women having a caesarean section (Laws, Li, & Sullivan, 2010). The privatisation of healthcare for birth in Australia has steadily increased since 2000, with women in the private sector being twice as likely to deliver via caesarean section (Donnellan-Fernandez, 2011; Laws et al., 2010), which is not associated with an increase in biomedical risk or birth complications (Shorten & Shorten, 2004).

It is now recognised that views on the associated risks of pregnancy and childbirth differ according to the particular 'risk society'; where 'modern' cultures are concerned about the dangers of life, and traditional cultures continue to fear the risk of death (Reiger, 2006). Eckermann (2006) has argued that some cultures (namely more traditional cultures), that have not yet experienced the intensity of a risk society, may be able to avoid it.

Eckermann (2006) suggests that while there are important aspects of both traditional and scientific approaches to pregnancy and birth, the approach that would reach the

best health and wellbeing outcomes would be one that encompasses aspects of both. While Eckermann argues that the 'risk society' that has developed in the West can be avoided by communities still experiencing high infant and maternal mortality, she also suggests that these women can benefit from technological advances within modern medicine. By acknowledging the spectrum, or 'risk continuum' (as it is referred to by Eckermann) on which these approaches are based, a safe space that recognises different risks can be realised.

### ***The Inuit***

In Canada, it was through this deconstruction of risk that an appropriate model of pregnancy and birthing was realised (Daviss, 1996). It has been argued that this model should be adapted to suit other Indigenous groups around the world, particularly Aboriginal communities throughout Australia, who share many of the challenges facing Inuit communities (Kildea & Van Wagner, 2012).

Inuit and Australia's Aboriginal communities have been described as being very similar (Kildea & Van Wagner, 2012). Taking into account the geographical similarities of Australia and Northern Canada, distances for remote communities can create difficulty particularly in instances where communities are unable to access other communities and services. Additionally, literacy and numeracy levels have been found to be similar between remote Indigenous communities in both countries. These factors have influenced the development of competency-based training whereby maternity workers are able to start working in the model without any previous experience. The success and sustainability of this model is thought to be dependent upon this onsite approach to the midwifery model, which has shown to be effective (in terms of health outcomes and satisfaction with services) in these communities (Kildea & Van Wagner, 2012).

Medicalisation of pregnancy and childbirth brought external control and monitoring of Inuit women. Uniform evacuations during the 1970s and 1980s for all births in the Canadian Arctic to obstetric wards in southern hospitals was one consequence and a cause of tensions between Inuit culture and biomedicine (O'Neil et al. (1991) as cited in Douglas, 2006; Kaufert & O'Neil, 1990).



*'This intimate, integral part of our life was taken from us and replaced by a medical model that separated our families, stole the power of the birthing experience from our women, and weakened the health, strength, and spirit of our communities.'* (Van Wagner, Epoo, Nastapoka, & Harney, 2007, p. 384)

In the 1970s the tradition of birthing on country in many northern Canadian communities ended, specifically in Nunavik in Quebec, with the implementation of policy to evacuate all pregnant women by plane, typically at 36 weeks gestation more than 1000 kilometres to southern Canada to birth (Crosbie & Stonier, 2003). This change came as a result of a shift in midwifery 'standards' and the influence of a medicalised understanding of pregnancy and childbirth. Women were leaving their families behind whilst they left the communities for weeks, sometimes months prior to childbirth (Chamberlain & Barclay, 2000). This had obvious negative psychosocial costs for both the women and their families, including loss of autonomy, separation from other children and family, lack of support networks, loss of community knowledge about birth, loss of connection to land and consequently community acceptance, and problems associated with adapting in a new environment (Daviss, 1996; Douglas, 2006). As a result of community advocacy (Daviss, 1996; Van Wagner et al., 2007), in 1986 a birth centre was opened in Puvirnituk, following a movement instigated by Inuit women and supported by the governing community board. Consequently, Inuulitsivik Maternities were formed, a model of maternity care which translates as "place of healing" (Kildea & Van Wagner, 2012), through which midwives are the leaders in care. Through this new Inuulitsivik model, based on a combination of community development, traditional birthing knowledge, midwifery skills and some aspects of modern approaches to pregnancy and childbirth, Inuit health workers were given greater recognition. While this model initially included the involvement of non-Inuit midwives who were employed to train Inuit women within the midwifery service setting, it changed over time to include predominantly Inuit midwives who took over the role of leading the care of clients during pregnancy, birth and postnatally, regardless of the risk status. The midwives were required to work as part of a broader team including nurses, social workers and physicians in the health centres. An important recognition of the role of the non-Inuit midwives from the outset was that their role was to teach and not to lead.

Over time, the success of this Inuulitsivik model has seen its adoption by two other large Inuit communities in the Nunavik region. Evaluation of outcomes of these birthing programs has found that between 1986 and March 2005, 80% of women from the Hudson Coast gave birth in Nunavik, avoiding transfers south. Of the 3000 births that occurred in these three birthing centres since opening, the perinatal mortality rate has declined and is better (8/1000) than in comparable Indigenous populations of Northwest Territories (19/1000) and Nunavut Territory (11/1000) (Van Wagner et al., 2007). Furthermore, comparative data for this region between 1983 and 1996 found reductions in rates of induction (10% to 5%), episiotomies (25% to 4%) and transfers south (91% to 9%) (Van Wagner et al., 2007). Follow up data has since been collected for the period between 2000 to 2007 which found that of 1,377 labours and 1,382 babies (eight sets of twins and one set of triplets) 86.3% of births occurred in Nunavik, with less than 14 percent of women being transferred out (Van Wagner, Osepchook, Harney, Crosbie, & Tulugak, 2012).

Additionally, perinatal outcomes for these centres have been found to be equivalent to obstetric wards in hospitals and intervention rates were lower (Chatwood, 1996, as cited in Douglas, 2006). These results quite clearly demonstrate the capability of these birth centres in dealing with pregnancy and birth effectively, highlighting the sustainability of the model. As such, it has been internationally recognised as the most impressive 'Birthing on Country' model (Kildea & Van Wagner, 2012).

Whilst the model has been unable to offer birthing services and support for Inuit women living in smaller communities (25% of total Inuit women), these women have access to antenatal care in their villages. Although they are still required to evacuate to one of the larger Nunavik communities at 37 to 38 weeks' gestation for birth, the care they receive is more appropriate than if they were evacuated outside of Inuit Territory. Whilst this is not ideal, it is an improvement from being evacuated to parts of southern Canada to give birth.

This model has proven successful for a number of reasons, and as highlighted in reports from communities, has been essential in the working towards the restoration of community health, healing and culture (Kildea & Van Wagner, 2012). As documented in the film *Birth Rites*, community members of Puvirnituk, one of the

communities of Nunavik, believe that the return of birthing to community saw men establish a new found respect for their partners once gaining an appreciation of what childbirth meant for women (Gherardi, Rawlings, & James, 2002). This appreciation has anecdotally been reported to translate to reduced rates of domestic violence and sexual assault, and an increase in men's involvement with the care of their partners during pregnancy and childbirth. It was also claimed that some aspects of culture that had been lost over the period of evacuations were regained, and returning birth to communities has assisted with the healing processes associated with social dysfunction and loss of culture.

#### **Australia's Aboriginal populations**

When considering what an appropriate maternal and infant healthcare service may look like for Aboriginal women across Australia, Kildea suggests it is important to acknowledge the different risk discourses that exist for different cultural groups (Kildea, 2006). She argues that recognition of these may create a more appropriate and accessible service for Aboriginal women. Perceived risks around pregnancy and birth within a mainstream medical service exclude acknowledgment of the social, cultural and emotional risks that are associated with a highly medicalised system. One of these cultural risks is not birthing on land, and Kildea et al. (2010) argue that Aboriginal and Torres Strait Islander leaders believe it should be acknowledged and included in risk assessment processes. As Kildea (Kildea et al., 2010) argues, failure to account for these risk factors has many negative implications for Australians who live in remote locations, particularly many Aboriginal people who maintain traditional knowledges around birthing. Kildea describes the ways Australia's maternity services fail these women, particularly the assumption that birthing in larger centres with access to greater medical resources is safer. This assumption fails to recognise the other needs of women, particularly Aboriginal women, along with the detrimental affect relocation can have on the wellbeing of both the individual and community. Through her exploration of relevant risk discourses, Kildea reveals a hierarchy of risk as experienced by many Aboriginal women. This hierarchy includes risks that are invisible within the biomedical model, along with the institutions and systems based on its approach. As a consequence, Kildea argues for an open dialogue and exploration around the construction of risk to encourage rethinking about current birthing services offered to Aboriginal women and their families.

Kildea unpacks the influence authoritarian knowledges have on the manner in which risk and safety in birth are perceived in mainstream Australian society. She argues that the current authoritarian knowledge informing the provision of maternity care services in Australia is not grounded in evidence, rather driven by popular views around what constitutes risk and safety, as informed by dominant Western medical discourses. Jordan (1993) describes this type of knowledge as the most convincing and influential, particularly in the context of pregnancy and birth. Specifically, these views affect the lack of availability of pregnancy and birthing care to women in remote Australia, to the extent that services in these regions have mostly been removed. As a result, women are required to travel great distances to receive care influenced by biomedical knowledge, that which is prescribed by the mainstream as being the safest. Kildea argues that there is no evidence to suggest that Aboriginal women are 'safer' when they receive care from the services that are now the only option. There is a difficult balance between the benefits of the medical approach and the negative implications it has on women's health and wellbeing as a result of relocation, and the Western health system's neglect of their social and emotional needs.

The policy of transferring women from remote communities to larger centres for childbirth remains the reality for many Aboriginal women in Australia who live in remote areas (Department of Health and Families, November 2009). Relocation for birth in remote areas of Australia has increasingly been supported by the Australian Government since the 1970s and is now recommended practice (Ireland et al., 2011; Kildea & Wardaguga, 2009). The number of Aboriginal women birthing out of hospital in the Northern Territory is decreasing (11% in 1987 compared to 4.5% in 1995) despite lack of evidence of associated poor health outcomes (Kildea, 1999). Women are encouraged to leave their communities at 38 weeks of gestation, or earlier if they are advised of risk by a medical professional. In cases when women are considered to be at risk of complications and go against advice to evacuate to a regional birthing centre, they are recommended to have a skilled birth attendant present at the birth. Unfortunately there are skill shortages in the area of maternal and infant healthcare throughout rural and remote Australia, and adherence to such recommendations is often unrealistic (Kildea, 1999). Reports since 1996 document

the closure of 158 birthing services that performed less than 500 births per year across the country, with 130 of these closures being rural units (Data from Australian Mothers and Babies Reports, 1996, 1999, 2006 as cited in Ireland et al., 2011). There is recent evidence to suggest that some women avoid the Western health system and care altogether because of its misfit with women's preferred cultural practices and birthing context (Ireland et al., 2011). This may have been amplified by the lack of support given to providing the choice remote Aboriginal women around the type of care they are able to access.

Ireland et al. (2011) found that having to relocate from their remote community to Darwin to give birth, contributed to a change in and also a loss of some cultural practices. Other reasons that remote women avoid the health system during pregnancy and childbirth include negative previous experiences of evacuation, not wanting to leave other children while awaiting childbirth in another centre, feelings of isolation, and issues around shame (Ireland et al., 2011; Kildea & Wardaguga, 2009). Shame has been described as a complex concept, emotion and feeling (Wilson, 2009), affecting women's behaviour and willingness to partake in maternity care (Ireland et al., 2011). It can be experienced in a range of situations and varies between individuals and in this context can include feeling shame (i.e. humiliation or shyness) when men are involved in women's business, being singled out in front of a group, or for some young women when their pregnancy begins to show (Ireland et al., 2011). As such it has been suggested that primary maternity services in remote communities would be of benefit to women who chose to avoid standard care. It may also prevent issues that arise with avoidance and improve women's health outcomes (Ireland et al., 2011; Kildea & Van Wagner, 2012). Some Aboriginal women still have a preference for birthing on country, and with the disparities between their needs and those offered by birthing services, are known to avoid the system (Kildea & Wardaguga, 2009). Kildea & Wardagagu (2009) found this was the case with between 5-22% of women in three of Australia's largest remote communities. It must also be recognised that avoidance of Western maternity care services also occurs for Aboriginal women who do not live in remote communities (Buckskin, 2004; Campbell, 2000). Furthermore, despite financial assistance in the Northern Territory for women evacuating to regional centres for childbirth whereby travel, accommodation (typically in a hostel) and an escort (for a woman under the age of 15 or when

required under special circumstances) is provided, 10% of women evacuated to Darwin in 1997 returned home to their community prior to birth (Statistics from the PATS clerks and Darwin Air Medical Service as cited by Kildea, 1999). Historically some of the reasons given for women returning home to community included problems at home, a death in community or lack of money (Dye, 1980).

In Kildea's (1999) report on Birthing Services for Aboriginal women from remote areas in the Northern Territory she provided insights into some of the barriers Aboriginal women face in accessing appropriate maternal and infant care. Some of the findings included; women's lack of choice around services, the lack of security and food when staying in hostels, inappropriateness of antenatal care models and available materials in rural and remote areas, inappropriate and inefficient communication between staff and patients in regional hospitals, lack of skilled maternal and infant health professionals in regional and remote locations (including midwives and Aboriginal health workers), and minimal opportunity for these staff to continue their education. Kildea suggests that the costs involved with existing antenatal and birthing services offered to rural and remote women could be reduced if services were improved. She proposes that savings could occur along with an increased appropriateness and access to these services as women would be less likely to: return home to their community prior to birth (often requiring air evacuation during labour or following birth), require medical intervention during labour, or have a baby of low birth weight (Kildea, 1999). Kildea argues that providing a remote area birthing service would be advantageous to the health and safety of Aboriginal mothers and their babies (and have possible positive effects on community), and would provide a safe environment for women who avoid Western services, care and education prior to and following birth. Furthermore she suggests that it would assist with the development of an appropriate service delivery model (Kildea, 1999). According to Kildea women believe more choice, increased access to appropriate services within a safe environment would improve health outcomes.

Birthing practices vary amongst cultural groups across Australia; however common practices include burying the placenta on country, holding smoking ceremonies and having only women present. These practices are collectively known as Grandmothers Law (Congress Alukura and Nganampa Health Council Inc, 1999). These traditional

practices are not unique to remote women only, but remain commonly practiced in remote communities and are not typically offered in tertiary birthing centres. Smoking ceremonies share similarities for Aboriginal groups across Australia, and are often considered integral to strengthening the mother and baby after birth. In some instances smoking ceremonies are also used to stimulate the production of breast milk, assist with healing and decrease bleeding. Despite smoking ceremonies not being possible in the hospital setting for childbirth, they often still occur when the child returns home (Kildea & Wardaguga, 2009). Kildea and Wardaguga (2009) found that many older women would like to see this practice re-established at the time of birth. This is one example of the misfit between some Aboriginal women's needs and what services are valued and offered within a health institution.

Recent studies have revealed what Aboriginal women value in maternal care services. While understanding that needs vary across groups, as Aboriginal women are not a homogenous group, there are a variety of preferences women consistently have in relation to antenatal and birthing care (Wilson, 2009). Wilson (2009) found that Aboriginal women in Central Australia wanted to have choices around aspects of their care during pregnancy. These choices included; different aspects of family involvement in their care, the types of antenatal service they could attend, the location of the service, who cared for them (midwives and Aboriginal health workers) (Buckskin, 2004), and the role their partner or the father of the baby had (Wilson, 2009). These choices reflected on a number of factors including; the degree of confidentiality of the service, the sex of the healthcare provider, the skills of the healthcare provider (along with their profession), continuity of care by the midwife and the Aboriginality of the healthcare providers (Wilson, 2009). These findings have been mirrored in other reports, identifying that having a culturally safe birth along with having their other children nearby are also important factors that are missing from many maternity services (Kildea, 1999; Kildea & Wardaguga, 2009).

Despite the many similarities Australian Aboriginal women have in terms of birthing practices, there are also marked differences which highlight the unique experience every woman should be entitled to during childbirth which is tailored specifically to her needs. While considering the different traditional birthing practices some Aboriginal groups still engage with, and the types of care many Aboriginal women

have been found to value, it is important to understand that every woman has her own preferences, and therefore generalisations of what is most appropriate for her should not be made (Kildea & Wardaguga, 2009). Instead, maternity services should be flexible with what and how they are offered to women and their families.

A number of maternal and infant healthcare programs and services have been introduced across the country to address some of the barriers Aboriginal women face in accessing antenatal care. A review of the literature, published in 2005, revealed a number of key factors in antenatal care or baby programs that have been identified as improving maternal and infant health outcomes for Aboriginal women and their children (up to the age of 5 years) (Herceg, 2006). Most of the studies reported on in the review were Level III-3 according to NHMRC hierarchy of evidence (comparative studies with historical control groups). The common factors for successful programs (Herceg, 2006) included:

- community-based and/or community controlled services
- a specific service location intended for women and children
- providing continuity of care and a broad spectrum of services
- integration with other services (e.g. hospital liaison, shared care)
- outreach activities
- home visiting
- a welcoming and safe service environment
- flexibility in service delivery and appointment times
- a focus on communication, relationship building and development of trust
- respect for Aboriginal and Torres Strait Islander people and their culture
- respect for family involvement in health issues and child care
- having an appropriately trained workforce
- valuing Aboriginal and Torres Strait Islander staff and female staff
- provision of transport
- provision of childcare playgroups.

A follow up review in 2008 investigated the changes reported in 10 quantitative evaluations of antenatal care programs for Aboriginal women in Australia, ‘the impact on care utilisation and quality, birth outcomes and women’s views about care’ (Rumbold & Cunningham, 2008, p. 83). This paper highlighted that despite claims of



improved outcome measures, a lack of statistical power and inconsistency in the evaluation data made claims about the effectiveness of the programs inconclusive. As identified by the authors of this review, there is a need for high quality longitudinal data collection to better understand how positive health outcomes for Aboriginal women and their babies can be obtained through antenatal care services in Australia (Rumbold & Cunningham, 2008).

**Aboriginal knowledge and cultural logic**

Aboriginal authoritative knowledge is very different to that which informs healthcare in Australia. This knowledge involves the connections to land, country and kinship (Kildea & Wardaguga, 2009), and is rarely, if ever considered or understood by non-Aboriginal people. Social unity, cultural identity and spirituality are gained from connections to land (Durie, 2003); country is not simply a place, it is family, culture and identity (Kwaymullina, 2005); and kinship is the system through which all relationships are determined and defined (Franks, 1996). As already briefly described, traditional birthing practices and beliefs are central to the wellbeing of women, babies and the community. Traditional beliefs around a baby's place of birth and its affect on the baby's acceptance into the community are held by some Aboriginal people, and breaking these traditions can disconnect people from their acceptance in community (Ireland et al., 2011; Kildea, 2006; Kildea & Wardaguga, 2009). In such cases, people's social and emotional wellbeing suffers. Jilpia Jones (2011) also discusses this and its relationship with the breakdown of traditional values, the importance of birth place in the establishment of a connection to land, and the implications of this for Native Title.

Kildea cited Daviss (1997), who worked closely with Inuit communities in Northern Canada to bring birthing back to their communities, and related thinking around perceptions of risk to Aboriginal communities in Australia. Daviss established a framework through which to analyse and understand the types of logic different people (from the caregiver to the birthing woman and the administrator) have in the context of pregnancy and childbirth, and how these affect perceptions of normality and what constitutes risk. Included in this framework are eight types of logic, one of which she named cultural logic. Daviss describes cultural logic as being 'concerned with the development or demise of fundamental beliefs about how a given society

should manage birth. This category can include traditional community logic and spiritual logic' (Daviss, 1996, p. 443). Kildea suggested that this type of framework has relevance to Aboriginal women in Australia and could be used to explain why they conduct their own risk assessments, weighing up what presents the greater risk to them: the cultural risks associated with leaving the community to birth or the obstetric risks of birthing in the community without the assistance of Western medicine's technology.

The suppression of Aboriginal authoritative knowledge in this context is considered to be potentially harmful to Aboriginal people. This consequence was discussed by Kildea as being a cultural danger, and she found that inappropriate birthing experiences were considered responsible for the breakdown of culture as well as for social dysfunction.

As demonstrated by other models of care, including those of the Inuit, tailoring services to meet the needs of these women and their communities improves health outcomes (including social and emotional wellbeing) (2002; Kildea, 2006; Van Wagner et al., 2007). Australia's health systems failure to adopt a similar model highlights the dominance of authoritative health system discourses of medical risk. Kildea suggests that, as seen in Northern Canada within the Inuit communities, an exploration around the constructions of risk has the potential to make the provision of services to Aboriginal women living in remote areas more appropriate.

Kildea argues that women need to be listened to and their voices included in the construction of the discourses that influence the creation and implementation of maternal and infant healthcare services. She believes current failures of the healthcare system are indicative of the need for reflexivity and a willingness to change. As suggested by other scholars, and reinforced by Kildea's work with Aboriginal women in remote Australia, there is value in acknowledging both Western and Aboriginal knowledges and allowing aspects of both to inform the development of appropriate healthcare services for Aboriginal women.

There are examples where biomedically informed information and practices can be delivered appropriately to Aboriginal women when there is community input into

suitable methods of delivery. Wild et al. (2012) investigated the appropriate ways of delivering information and informed choice about fetal anomaly screening to Aboriginal women in five sites in the Northern Territory, and found that effective and appropriate knowledge transition of biomedical concepts requires meaningful community engagement. Through these processes understandings are culturally defined and shared amongst relevant community members (i.e. women). It was found that community meetings, forums and informal dialogue amongst community members allowed for understandings and knowledges to be developed. These locally constructed discourses assisted in overcoming some of the issues associated with discussing and understanding risk and probability in relation to fetal anomaly screening. It is a good example of how appropriate consultation allows for better cross-cultural health communication.

**Medicalisation and Aboriginal Health Workers: negotiating two authoritarian knowledges**

One way to better understand the manner in which different authoritative knowledges exist and affect Aboriginal women in maternal and infant healthcare is through the involvement of Aboriginal health workers who are able to translate knowledges between Aboriginal women and the Western biomedical model (Genat, 2006). Rose Ellis, the then editor of the *Aboriginal and Islander Health Worker Journal*, clearly described the important role of Aboriginal health workers, including their role in advocating for their community and people they serve. While there is a long history around the development and inclusion of the Aboriginal health worker role in different health services across Australia, which Genat describes in-depth, it is important to acknowledge that the maternal and infant healthcare programs that have been discussed in recent reviews as being successful, acknowledge Aboriginal health workers as being key to their success (Kildea & Van Wagner, 2012). In particular, service models which acknowledge the importance of partnerships between Aboriginal health workers and other staff (for example midwives or nurses), have been found valuable (Kildea & Van Wagner, 2012). As will be discussed in the chapter on partnerships, respectful relationships (between the staff of a health service) that acknowledge the authoritative knowledges affecting Aboriginal women and their families is one way the associated barriers can be overcome.

I argue that the *Anangu Bibi Regional Family Birthing Program* is one example through which the differing authoritative knowledges informing the most appropriate maternal and infant care for Aboriginal women, are primarily managed through the partnership between the AMIC workers and program midwives. Not only does this model offer a way for appropriate and relevant knowledges to be shared and negotiated, but it also enables the variety of risk factors (whether they be medical or social) facing clients of the program, to be acknowledged and processes put in place to best address them. In this way, the needs of the clients are at the forefront of the program, and the knowledges that can assist in achieving best outcomes for the individual and their families, can be selected and used as necessary.

### **Analyses**

An exploration around the ways medicalisation affects the AMIC worker role gives important insight into the complexities they face working within this environment. The construction of risk in pregnancy and childbirth is perceived differently by doctors, midwives, AMIC workers and clients. As such, there is a disjunction between perspectives, which can reinforce unequal power relationships. Actions and qualifications of the AMIC workers, in relation to their adherence to the medicalised understanding of pregnancy and childbirth, can perpetuate stereotypes of the role. In instances where the biomedical paradigm is not in line with the beliefs of AMIC workers or their clients, responses that are not accommodated for by the mainstream hospital service may result. Consequently the AMIC workers need to negotiate the needs of their clients (which may be different from the needs of the institution), whilst conforming to the medicalised requirements of their role. To maintain their position, the AMIC workers cannot be seen to be in opposition with medical approaches to pregnancy and childbirth, and must negotiate the hierarchies and institutional time expectations of the hospital along with the wishes of their clients.

### **Differences in the construction of risk**

*Client7: I think every pregnancy is special and different and there are so many things that can go wrong that you need that expert medical advice you know, you need someone.*

Risk is constructed and perceived differently by all who are involved in the birthing program, subsequently influencing people's understandings of what is important. While everyone within this environment is working towards achieving healthy outcomes for their clients, perceptions of risk influence the delivery of information and practices, which has been shown to cause tension. The risk discourses that emerge from medicalisation also impact upon what program data is collected, with an emphasis on quantitative clinical outcomes. This appears to be a common weakness of data collection systems for Aboriginal antenatal clients. For example, Steenkamp and colleagues (Steenkamp et al., 2012) highlighted the failure of existing data collection systems to incorporate client views in the routine monitoring of antenatal programs in the Northern Territory. Interestingly, this approach to medicalisation has impacted strongly upon emerging discourses within the 'Close the Gap' campaign; in both the way it is perceived and enacted. As such, traditional practices such as birthing in the bush have been rejected by AMIC workers and midwives because of concerns about infant mortality, which is a key target of the 'Close the Gap' campaign. Therefore the risk component makes this a topic that is difficult for people to talk about. However, as some clients still have a desire for aspects of this tradition, it is the manner in which the AMIC workers negotiate what they believe are the necessary aspects of medicalisation, through current management systems, along with how they communicate this to their clients which is of interest.

While the staff involved with the *Anangu Bibi Birthing Program* work towards achieving healthy outcomes for their clients, their individual perceptions of risk may differ. Diversity in perceptions range from understandings that having a baby is normal to a belief that interventions are always necessary when women do not fit medical criteria (i.e. are not considered healthy), highlighting the presence of the debate between the 'mechanics' and the 'organics'. The organics can be defined as those who believe that pregnancy and childbirth is a normal bodily process not normally requiring intervention. In contrast, the biomedical model has informed the mechanics perspectives which are highly medicalised (MacColl, 2009).

Medical Practitioner1 described an extreme case of how the organic and mechanic debate affected Aboriginal women in Port Augusta prior to the introduction of the

program. The following extract demonstrates the belief that birth is a natural phenomenon, and demonstrates how medical interventions can change the culture of what constitutes a ‘normal’ birth if they are not challenged.

*... women have been giving birth for millions of years, you know listen to your body, do what your body tells you to do. And we aim for a normal birth. When I came here, in one month, out of 19 births, 17 were caesarean section. Some of the GP Obstetricians thought that women could not give birth, especially Aboriginal women, and have to be sectioned. So we worked very hard to break that myth and say that ‘these are the people that need to be given a chance’ you know. And now most of our patients deliver normally.*

The debates explored in the recent book ‘birth wars’ (MacColl, 2009) around the clash of these perspectives suggest that it is difficult to find a space that satisfies both parties. Power dynamics between personnel are evident in both sides of the debate, with an unequal power distribution favouring the mechanics. The above extract offers support for this notion, with GP Obstetricians being the individuals making decisions for Aboriginal women, based on their own beliefs.

With strong risk discourses evident amongst the mechanics, many of the ways the organics approach pregnancy and childbirth are disputed. As such, the organics are strong in standing up for non-interventionist approaches that encourage the natural process of labour and birth (that don’t include medical interventions such as inductions, epidurals or caesarean sections) which are often unsupported in a medicalised environment (MacColl, 2009). This issue was raised by Medical Practitioner1 who described women who chose to have their babies at home as ‘*perfectionist girls [...] those hippy type of girls who challenge the system.*’ ‘*I know midwives who have done it at home, and had a hospital at home*’ suggesting that these midwives still hold the belief that medical interventions may be necessary and are important to have on standby. It is well documented that midwives can experience the effects of these debates within their daily work, between other midwives and health professionals, which can be problematic (MacColl, 2009).

In the context of the birthing program, where many of the clients are considered to be high risk from a medical perspective, it was considered essential (by all AMIC workers, program midwives, ward midwives and medical practitioners) that clinical monitoring and interventions are important aspects of client care. Program Midwife1 gave a clear description of why it is important for doctors to fit the mechanical stereotype:

*And of course need to be mechanical, in one sense they do, because they're there to deal with the mechanics of "well actually, nah that baby won't be alive if we don't get it out now, so we're going to have a section". That's the mechanics.*

Despite this midwife stating that she is '*an organic*', with the belief that you '*need to start from what is normal [...] it's normal to have a baby. You're not a caesarean section waiting to happen.*' She believes that in the case explained above '*you need to do that, well, intervention actually*'. This suggests that despite very strong perspectives involved in the mechanic versus organic debate, there is space along the continuum where the mechanical approaches to maternity care should co-exist with the organics. It also suggests that views are often flexible, which is further supported by midwife views that are evolving with the program in relation to their understanding of the importance of social risk factors. Furthermore, it may also suggest that midwives also feel personally conflicted, like AMIC workers do, except AMIC workers have the added complexity of different cultural views about health.

A difference in underpinning philosophies around this debate was suggested by Program Midwife5 as a reason why AMIC workers and midwives take different approaches to maternity care '*in terms of you know outcomes of pregnancy.*' Despite understanding the differences, this program midwife also noted that she '*could see that there was [also] a lot of common ground between [program midwives and AMIC workers].*'

Clients of the program are typically understood as being of high risk in terms of medical risk. As such, I argue that clients understanding of what constitutes appropriate care during pregnancy and childbirth reflects a strong medical risk discourse, through which none of them express a reality of a healthy pregnancy and

childbirth without, at least, the opportunity for some form of medical assistance. Clients typically drew on the discourse that *'there are so many things that can go wrong'* justifying the need for medically trained personnel to assist them, particularly during childbirth:

*Program Midwife3: 'Cause even if they [client] think they know everything and they've had millions of kids, the cord could be wrapped around their neck and it's not like the mother is going to know. "Oh wait there the cord's wrapped ..." [laugh] Or you know the heart beat's slowing down and they might be really stressed out in the tummy. The mother's not going to know. So, I just ... hate that when women say that. "I don't need, I don't need nurses!" You do.*

In this instance a demonstration for the need of AMIC workers and nurses is emphasised. A difference in perceptions of who is appropriate in assisting with medical care during childbirth was also evident. Client7 described how she believes that *'if everything is fine you don't need a doctor. You need someone who knows what they're doing. So just having a midwife, I think, is fine.'* She raises the point that the AMIC workers are *'probably nearly at a point where they can [deliver] themselves'* providing *'it was a perfect pregnancy and labour.'* Despite the acknowledgement that AMIC workers are being trained in the clinical aspects of pregnancy and childbirth, the conjunction *'if'* suggests they are currently unable to deal with medical complications. For this client, the reality of this hierarchy is that provided a labour and childbirth are progressing without complications, midwives are appropriate people to deliver the baby. She believes *'you definitely need the midwife, but you don't need a doctor'* suggesting it is always the midwife's role to be involved in the childbirth, but doctors are only required in instances when things go wrong.

Differences in risk perception between personnel involved in the program are clearly evident in their views about whether the social, emotional and cultural risks potentially outweigh medical risks for some individuals. Program Midwife5 described that while the clinical aspects of care typically dominates their interactions with clients, there are other aspects of care that need to be respected and addressed:

*... the clinical stuff will always get the, you know, you'll always get knocked on the head and think oh I don't really understand what that important medical stuff is*



*about. So it was really about putting women's medical needs up with other, well their other needs up with what the medical needs were. Which in terms of an Aboriginal person's view of health, that is, your medical need is just one part of that not the highest priority. It has taken me a long time to get my head around that stuff really.*

Program Midwife5's comments highlight the tensions between addressing a woman's social, cultural and clinical needs. She describes in more detail her learning that there are other priorities in clients' lives that may be considered by clients and AMIC workers as more significant risk factors. Program Midwife5 explained that '*in the earlier days [...] there was some stuff I didn't understand*' which related to the narrow focus she had as a midwife, only considering the medical aspects of care, and the medical criteria of accepting high risk clients into the program. The following extract also demonstrates her shift from a mechanical approach to maternity care to a more organic, holistic approach, which considers a wider array of risk factors. Such an approach is important to effectively engage clients of the program, along with supporting AMIC workers in their role. She recollects a case conference where the decision to exclude a client from the program was discussed:

*... we got a referral for a girl who was a sixteen weeker and pregnant with twins and smoking dope every day and a whole lot of... you know, what I as a midwife would see as really high risk. And we used to um... we had a waiting list in those days, so we'd get a whole load of referrals and go "oh we'll take her and we'll take her and her". And the AMIC workers said... we were having this big argument [laugh] and almost it was like, it was really... we really strongly disagreed, I thought how could you not, who could be a higher priority, because I could see what was going on obstetrically. And [AMIC1] and [AMIC2] and I can't remember who else was the other AMIC worker, but whoever it was, really thinking that we shouldn't do that because, their idea was that if something happened it was around blame and our program was new and they didn't want to be associated with a baby dying. And I was more like well what would be in a program... of course the baby's going to die one day [laugh]. So I was a bit younger in my approach to it all. I remember really not getting it, and even there being... and that wasn't the only one, but there were a few of those. That was part of my growing up really.*

It is clear that Program Midwife5 recognised the shift in her own understanding of the importance of client's obstetric risks to the risks facing the program and AMIC

workers around blame and community backlash from Aboriginal family members and community members if something goes wrong. This deepens the understandings that not only are there medical and social risks facing the client, but also there are personal risks of backlash facing the AMIC workers. Therefore, although a woman's medical risk is a major influence on whether they will be assisted by the program, it is not the only consideration.

These different perceptions and understandings of what constitutes risk influence people's approaches to client care. In some instances these approaches fail to consider what is important for the client, with the dominant medical risk discourse prevailing.

AMIC1 described a situation whereby midwives sometimes *'don't understand that maybe the client has other issues that they're maybe not aware of.'* In such instances, AMIC1 believes that the priority program midwives put on clinical aspects of care becomes evident. As such, she believes it is necessary for her to say to the program midwives:

*"Look, I know you want these things done, and I know you want this antenatal check done" or whatever it might be, "but it can't happen now because, you know, there's other things that are happening within [the client's] life" or whatever it may be.*

While it is evident that the program midwives have the tendency to put the clinical before other needs of the client, discourses emerged from the program midwives suggesting they understand this occurs and is an issue they feel exists with staff external to the program. Two program midwives who have been involved in the program for many years, identified situations when the inappropriate interactions of other staff, have posed the risk of being harmful to clients. As such, Program Midwife1 gave the example of when a focused on the clinical aspects of a client without acknowledging the client at all. She opened up this discussion with the statement:

*And, you know how they say specialists don't have any bedside manner well I think that's true in some respect. They are so busy on about wanting to specialise and want to talk about this interesting case over here, and that's the person sitting there.*

This example highlights the danger of focusing solely on the medical aspects of a client and as a result depersonalising situations, which she states as being *'just shocking.'* This midwife has *'had some big clingers'* with doctors over such issues where she said she has been accused of shutting a doctor out of the labour ward. Perhaps this example can be considered a demonstration of a program midwife advocating for her client by standing up against inappropriate behaviours that are fuelled by medicalisation and social distance. It is interesting that the AMIC workers did not speak about these types of situations in-depth, suggesting that some of the advocating program midwives do for clients and the program go unnoticed.

Furthermore, senior Program Midwife<sup>5</sup> spoke about how she often feels scrutinised by other midwives on the ward who have been known to check up on her clinical work. This again highlights the interplay of the mechanics and organics, and demonstrates that the program midwives are more organic in their approach than other staff. As such, in a discussion where this midwife acknowledges the birth as a small part of the process of having a child (that is the pregnancy and growing up of the child are far more significant), she describes how her important work is mostly done outside of the hospital setting and in the clients' own environment. When in these settings she feels confident with her skills, however when she is required to work within the hospital, in times such as the birth, she becomes uncomfortable. This midwife uses the metaphor of being followed by the police as a way of describing how she feels about ward midwives judging her work:

*I felt like if you're driving a car and got the police behind you the whole time, you know that kind of feeling, like I never relaxed or enjoyed that part of it. And because then I didn't do it very often, we were only doing twenty a year, it wasn't like I was doing it every day. I think that was the hardest part, um... and I think in terms of, you know I'd know other midwives that would go through those charts checking what had happened and looking for mistakes.*

This further highlights the focus of other staff on the clinical aspects of care rather than on the client (and the client's needs). Such instances of dehumanising a client or scrutinising the clinical work of a midwife illustrate the emphasis and interest the medical model has on biology and doing things in a prescribed way. In many ways

both of these approaches are inappropriate and potentially harmful. These points are important to make when considering some of the difficulties facing the program midwives, which are evidently invisible to many of their colleagues.

Also demonstrating a level of contradiction in individual views of the program and what constitutes health and health risk, is the perception of Medical Practitioner1 who articulated a belief in the program's outcomes and thereby demonstrated an appreciation for a holistic approach to health.

*... we have seen how the women have responded, it's not only good outcomes we have seen but girls developing you know socially, their skills, their confidence, they can make eye contact, they are so much more confident in the second pregnancy. You know it's a huge human development, not just a good pregnancy outcome. When I came here there was no antenatal care, we would get girls who had ruptured membranes for days, they didn't know their dates, we had such bad outcomes, there was no antenatal program at all. Nothing was done and it was presumed they would have bad results because of their ill health and anaemia and all of that.*

This clearly describes the success of the program in terms of the social and biomedical models of health, and also highlights the negative consequences of making assumptions about health outcomes of Aboriginal women during pregnancy. Furthermore, this medical practitioner spoke of the impact on workload of working with clients of the program. Whilst discussing this, a discourse around problems relating to clinical aspects of care emerged, further suggesting there are a number of contradictions that exist in the way people talk about healthcare for clients of the program:

*Not to be involved with [the program] was less work, [clients] came as an emergency and you dealt with it. Now we are more involved with it because we know there are problems, and sorting [clients'] problems and getting them to hospital and making sure they are taking their iron tablets and when they get antibiotics they take them. It's extra work for us, but we are happy to do that because the results are good.*

These differences in risk perception also influence the level of engagement the program has with clients. Both AMIC workers and program midwives are engaged

with the program in hope of better outcomes. As AMIC6 stated, everyone working within this environment is *'striving for the same thing'* that is *'healthy outcomes for the girls'* and *'healthy babies at the end of it, and healthy mums.'* Similarly, Program Midwife4 stated that *'we all want the same outcome, healthy babies and good birth weights.'* It is the different ways in which people view and approach clients with the aim of improving health outcomes that can raise issues. Program Midwife4 talks about some clients as being *'a bit naughty'* because they do not adhere to medical advice or are hard to find in the community when there are aspects of their clinical care that need addressing. I would suggest that this perspective is perpetuating negative stereotypes of Aboriginal women and is both unhelpful and makes inappropriate assumptions about a client's personal life. Tensions arise between staff when clinical risks are addressed in inappropriate ways without concern for other difficulties the client may be faced with. One situation was spoken about by a number of AMIC workers and midwives as causing conflict between a midwife, client and AMIC worker. The following is a brief account of the situation as described by the midwife (Program Midwife4) involved:

*... when I first got here [to the program], there was one client that I just thought, she's got no hope of keeping her baby. She just has no idea. And they [AMIC worker], one of them got really worked up about it and, I was right, but I 'spose I could have [...] gave her a chance, this client of mine.*

This extract is pertaining to the midwife inappropriately addressing the living conditions of a client. Although understanding there are factors other than those directly related to clinical care, it demonstrates that insensitively approaching a client may be damaging. Furthermore it alludes to judgments about a client that may be made out of context, or without an understanding of other factors impacting the client's life. It is not surprising that this patronising approach to a client was the cause of tension between those involved. The AMIC3 worker implicated in this situation also gave her perspective of the incident and stated that:

*...she's just lucky she said it to the girl she did. Because if she had of said to anyone else, by gosh me and her could have been in a lot of trouble [...] a lot of crap there from the community.*

Again this demonstrates the layers of risk involved with working with clients of the program, which are often invisible to those with a relatively narrow approach to and understanding of the complexities of factors influencing clients' health and wellbeing. The dominance of clinical risk was also highlighted by AMIC4 who described an instance of focusing on the clinical aspects of a client's care whilst lacking any sensitivity to the client.

*... Yeah [doctor] just come in and sat down "well if you don't deliver this baby today or tomorrow you know you're going to die and so will your baby, so we're going to take you to Adelaide". And this poor girl is like "What? I just finished having dinner and now you're dropping this on me!"*

While the program midwives' discussions touch more frequently on this notion of focusing on the clinical rather than the client, this was the only distinct reference to it made by an AMIC workers. Instances of this nature were not mentioned by clients as being caused by midwives or other healthcare professionals, examples given were restricted to doctors leading this type of care. Without knowing the medical context of this example it is difficult to comment on the state of urgency this particular doctor had regarding the health of this client and her baby. However, whatever the circumstances, approaching anybody in this way is unnecessarily abrupt and would be likely to cause anxiety and panic for any client. This may be an illustration of where the medical model has the potential to depersonalise women's health, along with disempowering women from making their own decisions regarding their pregnancy and childbirth.

A suggested strategy for addressing the confusion or invisibility of risks for other staff involved in the program (excluding AMIC workers) was to simply listen to the advice of the AMIC workers. This was in relation to what clients would be accepted into the program and the ways to best engage and work with them. When it came to recommended clinical interventions and aspects of care, the program midwives took the lead. Program Midwife5 described this as an effective way of preventing tensions and conflicts between staff in the program. She explained that:

*I think in the end we came to understand that the bottom line was if the AMIC workers said no, it was no. And that they didn't really have to justify that to us. And once we were kind of settled about that that was part of my learning I guess. I don't know how I came to it, maybe I took a year to get to that point, where we didn't have those disagreements about who, what was important and what wasn't important.*

This is a very clear example of the importance of 'letting go' of the dominant medical risk discourse, and trusting the AMIC worker's judgement on how to best negotiate the various risks facing either the client or the program. Although this may be a moral dilemma for the midwives when the decision relates to including clients in the program who are considered to be of high medical risk, they need to respect the AMIC worker's decision which will likely protect the AMIC workers (and prevent them from extensive emotional labour caused from community backlash) along with the local Aboriginal communities perceived credibility of the program. I would recommend that there are appropriate processes in place for such women to access required support and assistance, other than the program. This will be discussed further in the Emotional Labour Chapter.

**Constructions of risk have affected the acceptance of Aboriginal birthing practices**

The construction of risk within the medicalised context has affected the way that many people perceive traditional Aboriginal birthing practices. Despite AMIC workers and clients speaking about their mothers, aunties or grandmothers having engaged with practices associated with birthing in the bush, and some even wanting to re-engage with the practice today, the clinical risks involved with childbirth have influenced the likelihood that this will never be a reality for them. There are potentially two main issues that influence this, the perception of clinical risk as a result of a medicalised model of care and generalisations about the poor state of health many women are in when they become pregnant, which is in part a legacy of colonisation. The following quote suggests that medicalised risks are still viewed as more important than cultural risks.

*AMIC1: I reckon it would be fantastic to go back to [name of place] where, that's where my dad was born, and you know to think about, oh I could have had my babies there. You know, like if you had normal births and you knew everything was going to be ok.*

All of the AMIC workers were in support of the Aboriginal tradition of birthing in the bush. While some were more enthusiastic than others when discussing the importance of birthing in the bush, they spoke about the health risks it involves and described a situation of a 'normal' birth as being optimal for birthing in these circumstances. As described below, a 'normal' birth is one without anticipated complications, and as touched on by AMIC4, who expressed her desire to attend births outside of a hospital setting, she flagged the reality of risks:

*Yeah I'd like to do a traditional birth, but then um ... there are two things that I'd like to do in my role and that is a homebirth and a traditional birth. But with, but anything can go wrong you know.*

Furthermore, AMIC6 spoke about her acceptance of birthing in the bush, and how it is the choice of the individual. However, she followed this statement by noting the requirement of having medical interventions on standby.

*I think that's [birthing in the bush] ok. It's up to the woman I suppose. And making sure that they've got all of the resources they need, emergency backup and all of that.*

While discussions included clients of the program not typically having the required healthy profile to birth in the bush, others touched on the risk of things going wrong. Despite AMIC workers' desire to support women's opportunity to birth in the bush, their opinions were influenced by the medical model of pregnancy and childbirth (this may be due to their training and employment within the Westernised health system, but also because of the way medicalised ideas have widely influenced modern society and their personal experiences of attending births).

*AMIC1: I think that again it's a choice of the woman and if she wants to do that I think she should have that choice. I totally am for it. I just sort of think um, traditionally that's how we used to birth. I can understand the reasons behind not wanting to if, if ... women need hospitals, if there's emergency situations of course not, but if the woman, you know that she's healthy and has had really good antenatal care and she chooses to do it, and you know that hopefully the birth will be normal, they should be allowed to do it.*



For this senior AMIC1 worker birthing in the bush should be an option for women having ‘*normal births*’ who do not have the need for medical intervention. While her discussion touches on birthing in the bush as not being an option in emergency situations, she, believes that if a woman is ‘*healthy*’ and has had ‘*really good antenatal care*’ she should have the choice to birth on country. When these two factors are at play she considers the birth will likely be ‘*normal.*’

*... if you had normal births and you knew everything was going to be ok, you know why couldn't there be women that, Adnyamathanha women that were from the Flinders Ranges, and if there was a spot up there that was really significant to them, if they wanted to birth there. You know, without any medical interventions. But because of insurance and everything else you know, that can't be offered to them.*

Another AMIC worker shares the same belief, and goes further to state that medical assistance would also be a requirement for women who want to birth in the bush.

*AMIC5: I don't think many would do it [birth in the bush] nowadays. Because they do need to have that, you know unfortunately we live in these times now, and you know ... the intake of food and you know the other health problems that they've got now, so it is important that they do have their ... you know, I ... that they do give birth in hospitals. I mean, there's a way around it, they still have their antenatal checks and you know, there's um health workers and a or a nurse on board or whatever out bush, however if they want to do it you know, it could be done.*

This demonstrates that the discourse around a ‘normal’ birth is commonly accompanied by discussions around medicalised risk. While all AMIC workers regard birthing in the bush as being ideal, there is an understanding that when women have complications [AMIC4] they need to go to the hospital to have their babies. Similarly, if a woman chooses to birth in the bush it is thought that she requires [AMIC6] ‘*emergency backup*’ in the event that something goes wrong.

The poor health status of many Aboriginal women today was used as a reason by many participants of this study for why birthing in the bush should no longer be practiced amongst these women. Senior AMIC4 worker gave reasons why she thought birthing in the bush would compromise the likelihood of a ‘*successful*’ and ‘*safe*’

birth for Aboriginal women today, highlighting one way in which medicalisation has affected the contemporary birthing practice. This was further supported by AMIC4 who believes the poor health status of Aboriginal women *'these days'* means they cannot birth in the bush, even if it was something that was offered to them. She believes that these women need to birth in hospitals.

*... our girls are young, first time mums, alcohol, drugs, gestational diabetes, they don't really have a good health upbringing, healthy upbringing to have a good healthy adult life. So, you know they're already, they were born you know on the back, you know, they were born with everything against them anyway. So, yeah. I'd be too worried about if something went wrong.*

Furthermore, AMIC3 despite her desire to birth in the bush and to assist women in this practice, spoke about how she *'understand[s] why they need to come to the hospital with the complications and things like that.'*

Although this AMIC worker stated that she would like to see birthing return to country, and for home birthing to be an option for women, she understands that broaching this topic in relation to clients of the program, is *'very dangerous ground'* because of their health co-morbidities and likelihood of experiencing associated complications. The strong risk discourse this AMIC worker engaged with was reinforced to her following an experience she had had with a healthy client, who she thought could successfully birth at home, but ended up with serious complications. This AMIC worker had actively encouraged this client to have a home birth, and following the seriousness of her complications has learnt that despite how healthy a mother and baby may be *'anything and everything can go wrong in pregnancy.'* She describes the situation:

*AMIC4: But I was saying oh but you're fit, you're healthy, you're young ... the day she had her baby she ended up with pre-eclampsia, and they resuscitated the baby for twenty minutes. You know, but the baby is alive, she was in ICU, they flew the baby to Adelaide, so I've learnt to pull back a bit because it just goes to show that no matter how healthy you are that anything and everything can go wrong in a pregnancy. Yeah. Labour or birth.*

This example was used as a justification by this AMIC worker that birthing in the bush (home-birth on country) can no longer be a reality for even healthy women. It also suggests that AMIC workers also give precedence to medical risk, which may be a result of their training, and therefore contribute to imposing a medicalised model. Also contributing to the debate against birthing in the bush or home birthing is medical indemnity and its associated costs. Within this framework, even broaching the topic of birthing away from an accredited birthing centre is largely unaccepted. There are various issues that contribute to this situation, one being the rising cost of medical indemnity in general for obstetricians and midwives, the other being recent legislative reforms that have made it very difficult (if not impossible) for any practitioners to attend births outside of a hospital or birthing centre. AMIC1 worker attributed issues associated with medical insurance as impacting against women's opportunity to birth on country, *'because of insurance and everything else you know, [birthing on country] can't be offered.'*

The sadness some AMIC workers felt when reflecting on their own experience and understanding of this loss of traditional cultural practices, also emerged strongly from the interview data. While in many ways this loss can be understood in light of the processes of medicalisation, there are many other factors (including colonisation which was discussed in the opening chapters) that have influenced the reasons why birthing in the bush is no longer common practice for Aboriginal women.

While the dominant discourse rejects the idea of birthing in the bush and denies many Aboriginal women the opportunity, there is evidence that some women still have the desire to engage with this practice. The client interview data indicates a potential pattern between older Aboriginal women valuing the tradition more so than the younger women. From Client1, who was 19 at the time of interviews, stating there is *'no way'* she would birth in the bush, to Client5 who does not *'really see a problem with it.'* There are many reasons why this may be the case, however it is likely associated with a woman's connection to traditional culture and the relationships she has with other women who are able to share their knowledge of birthing traditions. This is another example highlighting the dynamic nature of all cultures. However, three older clients [5,7,10] (aged 29, 41, 39 respectively at the time of interviews)

spoke about birthing in the bush as something that women should have the choice of doing, provided they are not considered to be at *'high risk'* of complications at birth.

The following extract demonstrates one client's position on birthing in the bush, with reference made to traditional birthing knowledge and practice. This client's views are shaped by her belief that health complications are more likely for women living in a contemporary Western society, in comparison to the past. This understanding is likely rooted in the medicalised model of birthing and creates a justification for the risk discourse:

*Client5: I don't really see a problem with it [birthing in the bush]. They've been doing it for many, many, many years... [laugh] and they probably know what they are doing. In saying that though, there seem to be more things that can go wrong these days than there used to. So having someone with some sort of knowledge is probably better than nothing. Whether that be you know, a worker out there that knows something, yeah...*

In contrast, when asked her opinion of birthing in the bush, a younger Client1 stated that there is *'no way in hell I would do it! [laugh] NO WAY!'* Additionally, client2 described how she *'would not be able to do it [birth] in bush land'* and *'wouldn't be able to do it without them needles in my back. Fuck. I thought it was good, three hours later "put those needles in, put those needles in! I can't stand this!" [laugh].'* Such an account again highlights the impact the medical model has on women's desire for clinical interventions during childbirth, and the impact a heightened level of medical technology has had on the choices women make in regards to childbirth. It also speaks to Riessman and indicates that medicalisation is not just imposed (Riessman, 1992). This is true for both Aboriginal and non-Aboriginal women who have an understanding around what technologies are available to them.

Also of interest is the way in which clients refer to the past and in some cases their own families' engagement with traditional practices of birthing in the bush. Client7 spoke of her grandmother having her children in this way, and Client10 described how her mother was born out bush in the back of a paddy wagon. For some

Aboriginal women thinking about a loss of culture may have induced feelings of sadness, as demonstrated by AMIC1:

*And that's the society and that's the change, and that's what we are living in now.  
And that's you know ... you lose that. I think that's the sad part about it.*

This description suggests that birthing in the bush is no longer a reality for Aboriginal women because of the changes in society regarding what accepted methods of birthing practices are. Again, these changes pertain to the medicalisation of maternity care. Client11, who described that her grandmother had decided not to teach her family aspects of her culture in fear that it would be taught and practiced wrongly, responded to the question seeking opinions of birthing in the bush that *'I'll skip that one!'* suggesting this is not something she was willing to discuss. This offers another perspective around why contemporary methods of childbirth are adhered to by some Aboriginal women.

Another client spoke about how birthing in the bush is not something that she would consider for herself and explored ideas around when it is appropriate for a woman to do it. Within this discussion she made mention of the factors she considers important to safely birth in the bush. While her response to the birthing in the bush question was similar to other clients, she also found similarities between some Westernised styles of birthing and birthing in the bush. Once again the risk discourse dominated her perception of when alternative methods of birthing were appropriate:

*Client7: Not for me individually no, it wouldn't be something that I would support.  
But like with every pregnancy being different um... you know and everything is good with that pregnancy and everything is fine, you know, and you've got emergency procedures on standby if something goes wrong, you know, maybe it is alright, maybe it would be alright. But yeah, I don't know like... it's just like people giving birth in water and giving birth in their own homes, it's the same sort of thing isn't it. I think as long as you've got, you know, as long as your pregnancy has been fine and everything is ok, and as long as you've got a backup plan for something that goes wrong, then yeah...*

Client10 also spoke about birthing in the bush in relation to home birthing whilst again emphasising the inappropriateness of birthing in such environments for women who are considered to be high risk. While discussing alternative methods of birthing, a younger Client1 discussed water births as a possible option that some women may like to have. Of particular interest was her reference to home birthing, which she considers appropriate for others, particularly *'those people who are really posh and stuff'* providing they have a good environment. This may relate to a perception that such women are able to access back up emergency care easily.

In contrast to client perspectives on birthing in the bush the AMIC workers would like to see this tradition still practiced, however do not perceive it as being a reality because of the health risks. I argue that the following extract again demonstrates that medicalisation has impeded the opportunities of birthing in the bush for Aboriginal women. Although not explicitly stated, the repetition of the word *'if'* (coupled with other emergence of the risk discourse from AMIC workers) suggests that traditional birthing methods were not an option for this AMIC3 worker because of the impact medicalisation has had:

*AMIC3: If I could, you know if I had the chance I would definitely do it [birth in the bush,] now you know! I'd love to do it! I wish we could bring it back!*

Differences among Aboriginal women's views on birthing are not only related to age, there are also variations in urban and remote beliefs. AMIC1 described how the services offered through the birthing program do not accommodate for this diversity of needs.

*When we're talking about traditional or remote women, um ... you know, they have really strong cultural beliefs and ceremonies around the birth of the baby. And, it's not all of that we can offer within a hospital setting, at all. You know. Um ... and that's part of like, there's lots of um like in the Northern Territory even up in Arnhem Land, Manangrida, there's been lots of work done over the years where you know, trad ... our women in those countries they want to birth back on land. You know. Um. It's the way it used to be done in the past, and with no medical interventions at all. So there's still lots of people out in the community that want that way of life. And if they come to Port Augusta and they birth in the hospital we can't offer any of that. So*

*that's a huge disadvantage to those women. You know they should have freedom of choice if they want to birth on their own country.*

This demonstrates the belief that the system should not dictate to Aboriginal women about where and in what way they should give birth to their babies. Furthermore, variations in perspectives also existed among staff. While there was more contrast in the views of the program midwives on birthing in the bush, the midwives who had been involved with the program for longer periods of time saw the importance of it. Although a risk discourse emerged from their discussions, which prevented the reality of this practice in today's society, they were more open to the idea than ward midwives. This demonstrates a level of *cultural* sensitivity and respect.

Program Midwife3 discussed how she *'would love to birth in the bush'* and how she is in support of the recommendation made at a recent conference in Alice Springs to *'work towards birthing in the bush for women.'* She is particularly supportive of it *'if as Aboriginal women you have a really strong connection with the land.'* She believes that in such cases *'it's probably something that we should be looking at, maybe being able to do safely for them.'* Program Midwife1 described how she would be supportive of clients birthing in the bush, again the risk discourse prevailing, *'if everything was normal and healthy.'* However she describes that the problem arises because:

*... when girls smoke, drink, are obese, have got diabetes, got renal disease etc., and then they want to have their babies, then they'll die. Or the baby will. Or those kind of disastrous outcomes, and you can't have a caesarean there in the bush. No.*

Despite having an appreciation of the ideal of birthing in the bush, the risk discourse again pervades how program midwives both perceive and approach the topic.

Program Midwife6 drew on the poor health of the current generation of Aboriginal people and how she feels the subsequent health risks would impact negatively on the prospect of women birthing in the bush. She considers herself to be a junior midwife and as such feels uncomfortable with this way of birthing because *'so much can go wrong.'*

Similarly, other midwives were strongly influenced by the ideas of medicalisation, as opposed to the importance of traditional practices for some women. It may be that these midwives do not understand the deep importance for some Aboriginal women of engaging with traditional practices, or alternative methods of birthing may not be something they have ever considered as being an option for anybody. When asked her thoughts about birthing in the bush, Ward Midwife4 stated *'birthing in the bush? Oh my god! Terrible! Never! It's too dangerous'* clearly demonstrating her opposition to the practice. She went on to say that she does not *'agree with birthing at home either'* and that she has *'changed [her] philosophy'* about home births. *'I'm not a young midwife anymore, I've had lots of years experience to know what is safe, what you can get away with and what you can't get away with. And there are no second chances in this.'* Interestingly, she does believe that for Aboriginal women there is a shift away from birthing on country to birthing in hospitals. She attributes *'this shift of culture towards safety'* and claims that it is *'not cultural safety, it's just safety for them and their infant really'* which is what she believes has changed.

Although senior Program Midwife3 considers birthing in the bush to be a *'fantastic'* idea, for her the reality of birthing involves medical intervention, or at least assistance. She believes having medical back up and trained staff available at the birth of a child is vital, as is *'having that ability to be able to come and utilise the health system if you need to.'* This midwife is not alone in her belief that medical assistance is required at the birth. Junior Program Midwife4 considers birthing in the bush to be scary and *'very stressful for anyone involved.'* Her emphasis was on having the appropriate staff available to assist with the birth, and left little consideration that for Aboriginal women birthing in the bush may mean without the assistance of a Western qualified nurse or health worker. Instead, she understands that with a shortage of midwives *'and people that are willing to study'* alternative ways of birthing, it *'would be hard.'*

Junior Program Midwife6 spoke about how unlikely it is that women will be able to birth on country *'in this day and age'* despite it being something that some Aboriginal women want to do. She feels that while there are things that the program can be doing to make the birthing process more appropriate for women, the program *'addresses it as much as it can whilst keeping everyone sort of happy.'* This acknowledges that while the clients may not be satisfied with the options available to them, the



compromises that are made to them by the hospital mean that a reasonable agreement is reached. Program Midwife<sup>6</sup> also made reference to the point that despite some clients wanting to birth on country, she believes there are limited numbers of doctors, midwives or nurses *'that would be likely to birth away from the hospital.'* She feels that by not allowing women to birth on country health staff are kept happy. Furthermore, while birthing on the bush is something that Program Midwife<sup>3</sup> believes is achievable, she understands that the *'obstacles would be phenomenal.'* This midwife's perspective contributes to the above discourses, underlining the obstacles she identifies to be associated with the legalities of something going wrong during birth rather than emphasising the need for medical assistance or intervention. With her understanding of death holding alternate meanings in different cultures, she believes if it is accepted and considered to be a part of life, then the fear of being sued for something going wrong is minimised. The reality of this being the case in a mainstream hospital in today's society is questionable, considering the great impact medicalisation has had on people's perceptions of understanding of medical intervention and assistance.

This demonstrates some of the complexities and range of views that exist around people's ideas and understandings of birthing in the bush. It is obvious that the medicalised discourse around risk have permeated the way everyone in this setting thinks about childbirth, and dominated views of those who are less familiar or accepting of birthing in 'alternative' ways. For these women, birthing in the bush is not something that is even considered and relates to the invisible hierarchy of risk proposed by Kildea (2006).

The affect that medicalised views have on participants thoughts around birthing in the bush raised the issue of compromises, and it is likely that clients of the program are influenced to some degree to where and how they will give birth. While the roots of this compromise can clearly be understood as coming from the influence of the Western medical model, it has more recently been compounded by the poor health of Aboriginal people at a population level which stems from the complex issues associated with colonisation. Having poor health gives a greater justification for a medicalised approach to pregnancy.

While Program Midwife<sup>2</sup>, who raised the topic of compromise in this context, recognises that her understanding and appreciation of birthing in the bush is limited because she is *'a hospital based, hospital trained midwife'*, she believes that controlled home birthing within the local community is something that should be considered for low risk women. While considering alternative ways for women to have their babies she never wants to see *'that there's a compromise to mothers and women and babies.'* In her experience of what Aboriginal women want, she has found that when you sit down and explain to them what birthing in the bush means (realising that this midwife's explanations and considerations would predominantly be from a medical perspective) many of them no longer seem interested in it. This was reinforced to her by women in Alice Springs who, despite having access to a traditional birthing centre for Aboriginal women, choose to give birth in the hospital rather than at Congress Alukura.

Program Midwife<sup>5</sup> displayed a rights-based approach believing that place of birth should be a choice for all women. She believes that Aboriginal women are *'bullied into not'* having their babies on country by people influenced by the medical system and has the understanding that:

*If they were an empowered group of women then they would just say well "no we're not going, what can you do, it's not against the law to do this". It's not against the law to have a baby wherever you like, it's your baby, you can actually have it wherever you like.*

While medicalisation has affected the way in which society currently perceives childbirth and the risks associated with it, it seems from this midwife's account that it has further disempowered Aboriginal women in making their own decision around birthing on country. With risk discourses emerging from this section around poor health and the dangers of having co-morbidities, a realisation of the cultural, social and emotional risks facing some Aboriginal women was also reached. A potential resolve to improving the general health of communities was offered by this midwife. Her suggestion was that health would improve if whole communities were empowered by something as simple as having the *'really important things'* happen within the community. This particular example specifically alluded to women having

the opportunity to have their baby in community, a way that is alternative to what is prescribed to them by the mainstream health system. These findings relate to Kildea's work around the hierarchies of risk (2006).

The unacceptable risk of death associated with birthing on country was pervasive across the interviews. However, several participants commented on the construction and perception of this risk and contrasted it with socio-cultural risks. The focus on the risk of death has been perpetuated by the language and outcomes of the 'Close the Gap' campaign, which will be discussed later in the chapter. I argue that the concept of death has also been affected by the processes of medicalisation in this context, and perhaps its decreased frequency puts more weight on death when it does occur. It may also be that people's acceptance of death has decreased, and may have changed the way people perceive death. This issue is about Aboriginal women and their families weighing up the importance of birthing on country with the acceptance of complications, including death. As touched on by Medical Practitioner1, an acceptance of death should be reached (or potentially re-established) before birthing in the bush is practiced:

*...[people] want to go back to the African, or Asian, or Indian way of doing things, but those people realise that they will not get a 100% result if a baby dies. In those cultures they accept it. Whereas here, people want a 100% result and want to do it their way, or naturally, and nature is not always very kind. So there should be a sentiment to bad results as well.*

Program Midwife5 noted death as not always being the worst outcome. This was the biggest learning she believes she has ever had from working within the program. This issue was also explored by senior Program Midwife3 who discussed death as being perceived in other cultures as '*a part of life and a cultural thing as part of your life.*' Her discussion was around how the Inuit people understand and deal with death, which may be similar to Aboriginal cultures in Australia. She explained how a woman who worked with the Inuit communities had described to her how although there are some instances of death, '*it's how you look at death*' that is important and to understand that '*you're not going to be sued for it and all the rest of it.*' Throughout this discussion she mentioned how they have '*amazing statistics*' with '*some*

*incredible, like 97% normal vaginal births.* Midwife3 also described how Amish communities understand death as:

*... a part of life ... our grieving is part of this and you're stopping us from grieving by taking our baby away, and all of this you know. So it is how you see it you know. And Western society is very litigious and you know, if, and I think that's a lot of how we practice is around this fear of somebody suing you, whereas that isn't the case, and yeah ... it's part of that whole cycle of life and death.*

For women who do not want to go to hospital to birth, several participants considered the potential risks to other aspects of women's health and wellbeing. Program Midwife1 considers the situation facing those women who do not want to go to the hospital to birth. This is a serious issue for remote community women who are encouraged to leave their community, family and often other children, weeks prior to their due date to birth in a hospital setting (Ireland et al., 2011; Kildea, 2006; Kildea & Van Wagner, 2012; Kildea & Wardaguga, 2009). In this midwife's discussion, she demonstrates an understanding of both the emotional and health implications for the woman and her family, along with the difficult situation that often presents to some of the health workers who, following the birth, work with the client.

*Program Midwife1: You know I can understand girls out at Yalata for instance, who don't want to be taken away from their family for six weeks to have a healthy, normal baby. Or sometimes they're not so healthy and normal, but you know what I mean. The baby might survive but the mother's not healthy and normal... she might have diabetes and things like that. So, it's a headache for care workers if they're not around, or they haven't been around. But its blumin' awful for the family to drag them out, away for that long. And what would make it culturally appropriate would be to have them where they could bring one of their siblings, which we do actually.*

Again the thread around normality and health risk arises but is considered in light of the other risks to the woman. Senior Program Midwives5 contributes to this discussion by talking about the social, emotional and cultural risks that situations like this often present to the woman and her family. She makes the point that the health risk discourse is *'pretty skewed'* because it fails to recognise the other aspects of risk the woman deals with as a consequence of birthing within a mainstream health

setting. The woman's *'ability to mother a new baby'* is considered by this midwife as being a risk of not birthing on country. Senior Program Midwife<sup>3</sup> talks about the importance of respecting Aboriginal people's connection to the land and that the health system should be working towards making birthing in the bush *'safe'* for these women. She reflects on the changes in the health system that have allowed the Inuit people to birth on country under certain circumstances, and provokes thought around how this may be a reality for Aboriginal women within Australia's health system.

The interview data suggested that the birthing in the bush debate sidetracks discussion around incorporating other cultural aspects of the pregnancy and birth.

#### **Other cultural practices**

Five AMIC workers spoke about the practice of offering the placenta to clients for burial on country.

*AMIC1: ... if she's more of a traditional woman. Um ... within the hospital now there, we have got a policy that um ... you know if they believe in taking their placenta home to their own country and having their ceremonies and that, that we can, we can um keep that for them.*

Despite the frequency of this topic being discussed, it seems it is not a common request that women have, and AMIC<sup>3</sup> stated that she has had only one client *'that wanted to keep the placenta and take the placenta home.'* Medical Practitioner<sup>1</sup> also touched on this, and made mention of how it is also something offered to non-Aboriginal people. Through their own experiences of this, *'very few will take it.'*

When asked whether there were many cultural practices AMIC workers are able to support clients with at time of birth, AMIC<sup>2</sup> believes there is a lot of work to be done to improve this type of support and stated that the program is unable to do very much:

*AMIC2: There's one [practice] where we can give the ladies back their placenta. So they can take it back to where they come from.*

Another cultural consideration all AMIC workers spoke about was respecting women's beliefs about women's business and where possible having only women

present. AMIC1 stated that ‘*respecting women’s business*’ is about ‘*making sure that if she doesn’t want a male, that she doesn’t get a male.*’ AMIC3 describes some of the diversity and complexity around this topic:

*I think the culture is kind of changing a bit there where they are becoming a bit more Westernised and letting the males in and that stuff. I think that, I don’t mind it really. If they’re happy with that that’s fine.*

Furthermore, one of the medical practitioners spoke about respecting women’s business and how in their experience Aboriginal women are shy than other clients they work with:

*... they are a bit shy to be exposed. And we don’t let medical students be there, or male family members. So we try not to expose them too much. Obviously we do that for everybody, but they’re a bit more culturally shy.*

It has been demonstrated that there are ways to be flexible to allow the incorporation of some cultural practices. There are small improvements occurring, even among ward midwives (albeit informally), which support my argument that their needs to be a more systematic approach to change practices (i.e. through hospital guidelines) to ensure the need for more flexibility is recognised.

As such, the difference between more ‘traditional’ and non-traditional women was also noted by Ward Midwife1 who spoke about her experiences of working with ‘*girls that come down from the lands*’ who she understands have strong cultural beliefs and practices. She described one situation where an elderly woman accompanied a young client to the hospital for the birth, and did ‘*strange things in the birthing suite*’:

*She was doing weird things to her, and I just said “what are you doing?” and she said to me “bush medicine” and I said “ok”, and I thought you know there were some things that I was thinking “don’t do that!” you know, but I could monitor the situation and I could see that the woman was responding, I mean she was only eighteen, but she was responding really well to what the elderly lady was doing and*

*things. You know, so you just have to pick up on, I think it all boils down to the experience and how safe you feel in the birthing suite.*

This statement touches on this ward midwife's understanding of some women practicing certain aspects of culture during time of birth. Through her description of these things the dominance of her clinical understandings of childbirth was obvious, yet her acceptance of the birth going well and willingness to accept alternative practices was also evident:

*... she was doing weird things! Yeah just pushing so hard on this girls belly and I was thinking, oh the placenta is going to abrupt or something. But you know this girl had a beautiful delivery you know, it was really nice.*

The issue of pregnancy and birthing being women's business was an issue that all AMIC workers respected, but that they also demonstrated flexibility around individual women's needs. For example, some women want to have their partners present at the birth, and AMIC6 believes it is important for the father of the baby to be present so that *'he can see ... what the woman has to go through.'* She went on to state that the men need to understand that *'it's not just you know getting them pregnant and not being there [at the birth]'*, she believes that they *'have the responsibility to be there for the birth.'* This was not a view that was made explicit by other AMIC workers, although all stated that they respect the women's wishes in regards to this issue. AMIC3 spoke of some of the flexible protocols the program is able to follow to allow for cultural sensitivity and to respect individual needs:

*... taking the placenta, giving it back to them if they need to. Um. I guess removing the males if they wish to, you know. Um. yeah we haven't really got that many, but I'm sure that we could do whatever you know. Well ... yeah. We could do it I'm sure. So even like even if a baby had passed away in the hospital, they've got the ability here to do the smoking ceremony.*

#### **The emphasis on clinical outcomes and data collection**

Medicalisation also influences what data is collected within this program, with an emphasis being put on clinical measures and outcomes, as opposed to social and emotional wellbeing. The extent to which medicalisation has permeated what information is documented and the ways the AMIC workers reproduce this, can be

obtained through the strong discourse that emerges around the importance of statistics. Four of the six AMIC workers made mention of statistics and their relevance to the program, with AMIC5 using statistics to make reference to the identified health gap between the Aboriginal and non-Aboriginal populations. She stated that this is a demonstration that *'our women aren't getting the treatment that they need'* and makes the interpretation that this measured gap is indicative of *'something going wrong.'* AMIC5 describes this as her motivator to becoming an AMIC worker. Additionally, this AMIC worker's frequent use of the phrase *'our stats are going down'* as evidence that the program is improving the health outcomes of its clients, supports the powerful way in which medical measures have influenced perceptions of what is important in relation to the program.

Furthermore, by adopting a medicalised approach to pregnancy care and birthing, the importance of collecting appropriate statistics and evaluating the program *'properly'* can be justified. Junior AMIC3 believes that the statistics *'definitely prove'* that the program is doing a good job. This idea of proving the program's success was further described by senior AMIC1 who stated that:

*... we are documenting everything properly, because I mean everything comes back to funding and proving that it does.*

This perspective was further supported by Program Midwife3 who explained, *'these sorts of programs are very popular with management levels, you know to improve statistics.'* The underlying understandings of what constitutes meaningful statistics, and how relevant the prescribed data collections are to the health and wellbeing of the clients in the program, may be problematic.

Furthermore the discourses used to talk about the success of the program were predominantly clinical and often made mention of funding. As such, Medical Practitioner1 said that this is the *'first time tax payers' money has been put to a right'* and believes that:

*... if you achieve a healthy pregnancy and a good baby then you are cutting out so much, like a long stay in the neonatal unit or intensive care and a sick baby for the*



*rest of their life. And if this program is working, and there is a good spacing of babies and people are not going for too many babies and they are not delivering sick babies or premature babies then you are saving so much money at the other end.*

This extract is in relation to the recently announced funding cuts that will affect the program from July 2013, which program staff are ‘*so surprised*’ by, as put by Medical Practitioner1 who believes ‘*[the Government] should not cut funding on this at all.*’ Aside from current funding issues, this passage highlights how achieving good clinical outcomes in a clients’ care is related to financial savings in the long run. Interestingly, there were no comments made by any participants around social aspects of care and financial outcomes.

The success of the program was frequently spoken about in terms of the number of antenatal appointments women attended, along with birth weights. Program Midwife4 also spoke about improved birth weights, with only ‘*a few that have been below 2.5kg*’, along with increased rates of antenatal checks as evidence that the program is ‘*getting on top of things.*’ Furthermore, Program Midwife2 described how great it is to ‘*see that the birth weights are improving, [...] less prem labours, [...] girls that have come in that have had eight, ten, twelve antenatal visits with the midwives*’, further supporting the impact prescribed medical key performance indicators have on the perceived success of the program. However, using only the documented statistics of the program to measure success may not adequately capture improvements beyond the medical gaze. It is also unrealistic to expect to see differences in outcomes such as birth weight in programs that have a relatively small number of clients. Medical Practitioner2 made comment on how birth weights have likely not improved as a result of the program, and while still largely referring to measurable outcomes, touched on discourses around the importance of contexts and creating a welcoming hospital environment:

*At the level of improving birth weights it may not have made a huge difference. Its difference will have been qualitative in reducing the amount of substance abuse and smoking but also creating a culture of openness and discussion about those things with the patients, where they are less judged and where they can know about it and help them and their babies. It probably has reduced, I would believe, the number of*

*premature babies or small for gestational age babies. And that's a very good outcome.*

The recognition that increased engagement with the program and maternity care may not result in improved clinical health outcomes was demonstrated. Program Midwife5 medically described improvements to health and wellbeing that the medical model may not recognise:

*If the success would be measured as, as Aboriginal women and their families getting maternity care then I would think that the program is successful, and the data even supports that in terms of number of antenatal visits and gestation at first visit and stuff. Maybe it doesn't turn into birth weights... but that's a harder thing to achieve.*

As such, Program Midwife5 stated that, *'I think it's made a huge difference to young Aboriginal girls in terms of their experience of pregnancy and births'*, which may not *'be churned out as outcomes in terms of birth weights.'* Similarly, Medical Practitioner2 believes that *'if antenatal care improves pregnancy outcomes, it should be improving pregnancy outcomes for these women.'* This participant also suggested that, *'I think if you look at the annual figures, you will find that there is marked uptake in using antenatal services by Aboriginal women and in some cases Aboriginal women are now approaching non-Aboriginal women.'* This is also touching on a change observed in Aboriginal women feeling more comfortable accessing support delivered by non-Aboriginal women. Medical Practitioner2 *'thinks that's really good.'*

Program Midwife5 recognised that it is *'too big of an ask'* to expect a single program to address all of the social factors that impact on a client's life. Yet, the data the program is encouraged to collect largely fails to acknowledge these other factors. While the midwives spoke about the importance of looking at the impact of broader measures of health and wellbeing, the dominance of the medical model continues to be perpetuated in the way the program is evaluated and presented to health management and the wider community. This also threatens the allocation of funding to the program.

A theme emerged from two program midwife interviews, revealing that some of the statistics recorded in the program are decontextualised and therefore considered to be meaningless. Although smoking was recognised as being an unhealthy behaviour having a negative *'impact on health and certainly on developing babies'*, as Program Midwife1 stated, it was acknowledged that *'there's so many other issues going on in girls' lives.'* She went on to explain that, *'in actual fact the bigger picture is... that this girl gets beaten up every week'* and it is these *'issues that need to be looked at as well.'* She described how these issues *'fade into insignificance 'cause they, all they want are the stats on smoking.'* Yet Program Midwife1 describes how *'it is very hard to have an impact on smoking. Because hugely there's so many other issues [...], that you think, no that's the last thing I'll ask her to get rid of.'* These are amongst the reasons why, as Program Midwife3 discusses, the program *'fails miserably at'* decreasing rates of smoking amongst clients, despite it being one of the programs key performance indicators. Whilst it is acknowledged that it is a difficult behaviour to change, Program Midwife3 describes an example of why a client continued to smoke during her pregnancy:

*But nobody sees the picture around some girls smoking fifteen cigarettes a day who might be having her sixth child and doesn't really want to do it but has left it too late to have a termination, and you know... So one of the things that they want to do is smoke. You know it's a stress reliever, and for a lot of these women, pregnancy is a really stressful time and it's the one time when you cannot make them give up their cigarettes.*

These discourses provide further support to the debate that the statistics privileged through medicalisation fail to recognise the holistic benefits of the program, and push workers to pursue the biomedical aspects of care. They also suggest that despite the understood risks smoking poses to the health of a woman and her baby, the lack of focus given to the reasons behind the engagement in this behaviour means expectations to decrease rates of smoking will not be met. This highlights the medical model's narrow lens, which fails to recognise other influencing factors, and how problematic a focus on documenting only the frequencies of smoking without considering what the social, emotional or cultural factors may be.

While it seems a focus on the collection of data is a reflection of one way in which medicalisation influences this program, through the interviews with program midwives it has been demonstrated that these statistics are often irrelevant to the broader context of women's lives.

Through all of the program midwife interviews, a discourse emerged around the positive outcomes of the program that related to the statistics that are recorded. These included increased birth weights and increased rates of attendance at antenatal appointments. Although it is understood that these are important health outcomes, which have positive implications for the women and their children in later life, it is interesting that midwives did not speak about the positive social and emotional outcomes for women in the same way. My interpretation of the prevalence of this medically focused discourse is that it is almost inculcated into the program staff by management and throughout their training, as a way of justifying the existence of the program. Furthermore, two of the programs more junior midwives (4 and 6) spoke frequently around the notion of *doing things* to clients, highlighting how the medical model has potentially encouraged their focus on the clinical rather than the emotional needs of a client. It is unfortunate that all staff involved in the program do not explicitly share the views of senior Program Midwife<sup>5</sup>.

*So it was really about putting women's medical needs up with other, well their other needs up with what the medical needs were. Which in terms of an Aboriginal person's view of health, that is, your medical need is just one part of that not the highest priority. It has taken me a long time to get my head around that stuff really.*

While demonstrating the importance of recognising that clients' medical needs are often not singularly their highest priority, this extract also illustrates that this understanding takes some time to be realised. I would argue that for midwives and others who have been trained in and worked within a system that is influenced heavily by medical ways of knowing, coming to such an understanding would be slow. It makes sense that successful midwives in this program adopt a more holistic approach rather than one focused on a more medicalised approach to pregnancy. This part of the discussion has, while focusing on the recognition of client needs, been heavily influenced by a discourse around outcomes, and what outcomes are reinforced by the

data. While I have touched on how outcomes that are measured have influenced many of the program's foci, I have not specified how other outcomes could also become a dominant discourse within the program.

The other outcomes I am alluding to relate to the emotional and social aspects of a woman's life, primarily I am highlighting the importance of recognising a woman's positive experiences of the program and understanding how these experiences may have potentially improved some of her measurable health outcomes. Senior Program Midwife<sup>5</sup> touched on the importance of a woman's experience of her pregnancy and birth but is not documented in the same way the medical outcomes are:

*I think it's made a huge difference to young Aboriginal girls in terms of their experience of pregnancy and births. So that might not be churned out as outcomes in terms of um birth weights, and then because of the social determinants I don't think a single program can ever ... yeah that's too big of an ask. But in terms of um... the experience that women have, and I think for lots of those young girls it's one of the nicest experiences they've ever had in their whole lives, and that coming into that program and feeling part of that sort of family and feeling special and nurtured, for some of those young girls that's the first time that's ever happened to them. Yeah. And then when you see them come back for their second baby or third baby, they're quite different. They're quite changed in that time and I think that's because they've been nurtured in that first time. Yeah. And you know the women just keep coming back. They come back and back and back looking for that program.*

While the program may not be showing improved measurable health outcomes that are profound by a medical standard, it is these other outcomes that are of the same (if not greater) importance. The subsequent difficulty this program faces (particularly because it is predominantly based within the hospital setting) is dealing with the dominance of the medical model in understanding the program's success. While those who are influenced by a strong medicalised perspective may adopt a negative discourse when analysing only the key performance indicators of the program, there are clear examples of positive outcomes that are not measured and recorded. The importance of these outcomes (which are often invisible through a medicalised lens) need to be realised and promoted.

Furthermore, discourses from the ‘Close the Gap’ campaign are evident amongst the AMIC workers, program midwives and clients, which may further reinforce the importance of clinical aspects of the program. While a political discourse is currently prominent for both government and the Australian public around reducing health inequalities between Australia’s Aboriginal and non-Aboriginal populations, it is used by some AMIC workers as a way of justifying the importance of the program. As AMIC3 described, her role as an AMIC worker is very important as *‘it’s a part of like closing the gap. It all starts with the mum and baby that’s growing inside.’* She believes that *‘if you can start at that stage it might close that gap in the future’* and understands that *‘trying to close that gap’* is a *‘big part’* of her role. This may be a reflection of the pervasiveness of the ‘Close the Gap’ language rather than the recognition that antenatal care is a key strategy in the campaign. Either way, the point to make here is that ‘Close the Gap’ is a dominant discourse within the program. Furthermore, AMIC1 acknowledges the inconsistencies of governments, stating they *‘change all the time and their way of thinking and that, but I hope that they understand, that they do get that we are making a huge difference and we can continue to make a difference to close that gap.’*

Although an important campaign in promoting awareness regarding the differences in health status between these two Australian populations, I would argue, among others (Black & Richards, 2009), that this campaign has effectively medicalised issues that have broader social implications and potentially further marginalised a minority population. When talking about ‘closing a gap’ we are making the assumption that all aspects of health and wellbeing can be measured. As already discussed, these measures are predominantly driven by a medical understanding of health (and collected quantitatively) and fail to account for other health models. It has also led to a focus on infant mortality despite it being unrealistic to be able to show differences in mortality within small programs such as this one. The focus on this outcome is concerning, especially if it will be used to inform future decisions about funding.

#### **The importance of the social model of health**

While discourses around the importance of documenting clinical aspects of the program emerged strongly from the data, AMIC1 Worker made the point that positive

relationships also contribute to positive health outcomes. She argued that aspects of the program that are not viewed to be clinically relevant are also highly important to the health outcomes experienced by clients. As such, while discussing the value she sees in evaluating the outcomes of the program she also raises the importance of measuring something that the medical model fails to account for. That is:

*... how important the role of the AMIC worker has been in making these changes? You know you can talk about increasing birth weights and antenatal visits and all of that, but how are all of those things being done?*

I would also argue that the last question asked by AMIC1 is key to understanding the successful workings of the program. Despite the need for statistics and evaluation, which are tied to funding, shifting our focus to factors influencing the development of meaningful relationships is likely to shed light on the important aspects of the program that current data collection fails to account for. These other factors are believed by people such as this senior AMIC worker to translate into positive health outcomes. It is these factors that the medical model fails to account for. As such, Medical Practitioner2 draws upon the complexities of the client lives and how the importance of the program may actually be in creating a safe environment where clients can access support and share their stories. Their relationships with the AMIC workers in this account are considered crucial to creating a path to achieving these positive outcomes:

*... these women [clients] have a huge history of isolation, domestic violence, poor education, sometimes sexual abuse or sexually been taken advantage of and they have very few people who they can share their story with. Their own community is quite closed, there is a limited range of people you can talk with, there are often breaches of confidentiality. So there is no place where they can place their stories. And I think it actually allows these women to open up and talk about a broader aspect of their lives and even just talking about it may be in one sense helpful for some women, for some women it will have little effect and for some it will actually take the lid off something that is really hard to put back in and will need a lot of therapy and counselling. I guess we would take the approach in general that while the outcomes may not be improved by those women immediately around that stuff, the process of having a place to put it and building trust with people who can hold that trust is*

*really important. The AMIC workers themselves are an essential part of building that trust and an essential part of knowing those stories.*

Furthermore a strong discourse around clients ‘having a lot going on’ in their lives is evident in the program midwife interviews. Whilst it seems that an understanding of the complexities of clients’ lives is something that is developed over time, all program midwives made reference to it in terms of clients often having important needs that are not clinically orientated. Client lives were described in terms of being quite chaotic, with women often prioritising their other needs such as safety and family obligations, over the health of themselves and their baby. Junior Program Midwife<sup>4</sup> touched on her realisation, after coming into the program, that there are many more serious concerns that clients have (her example was around sexual and physical abuse). By understanding at least some of the complexities of the clients’ lives, the program midwives have gained some insight into why clients may not attend appointments or may engage in behaviours that may be considered ‘risky’ to their health. One example given was of when clients want to go to another town or city to visit family, they *‘just pack up the car and go.’* In such instances they may miss aspects of their healthcare, such as antenatal appointments, that some midwives would consider to be more important than visiting family. One of the more senior midwives summarises this:

*Program Midwife<sup>3</sup>: I suppose looking at the big picture, something like a midwives appointment really isn’t that important to them. You know, it’s important for us to give them their healthcare, but um... with everything else that’s going on in their lives, this is just a very small thing.*

This extract acknowledges that attending medical appointments is not a high priority for many of the program’s clients, and that although it is something that midwives consider important it is *‘just a very small thing’* for clients. Junior Program Midwife<sup>6</sup> also demonstrates her understanding of other things taking priority in the clients’ lives and summarises that in some cases even *‘being pregnant is the last thing on their agenda.’*



Expanding on the discussion around women having priorities in their lives that are not in line with what the medical model tells us about having a healthy pregnancy, one controversial issue that was raised was around smoking. While through a medicalised framework, the reduction and cessation of smoking is considered a priority (particularly during pregnancy), the program midwives understand the wider context of clients' lives and how smoking is often not the biggest risk to their health. As a result the program midwives may be deliberate in not placing a huge focus of consultation time on this. This is an extreme case of when the priorities of the health system, as influenced by medicalisation, clash with the way in which some clients of the program are approached and worked with. Whilst reducing the rates of smoking is an established key performance indicator of the program it is not realistic to expect to see a decrease in the number of women involved in this program, who smoke during pregnancy, when considering the context of their lives.

*Program Midwife3: ... you ask them 'have you been smoking? How many do you smoke a day?' and this is the data that we fill in. But nobody sees the picture around some girls smoking fifteen cigarettes a day who might be having her sixth child and doesn't really want to do it but has left it too late to have a termination, and you know.... So one of the things that they want to do is smoke. You know it's a stress reliever, and a lot of these women, pregnancy is a really stressful time and it's the one time when you cannot make them give up their cigarettes.*

This extract clearly demonstrates the medical model's failure, within the context of this program, to acknowledge other more important psychosocial factors of client lives. Without risking the medicalisation of other aspects of clients' lives, they should be acknowledged and given attention prior to behaviours such as smoking, which is often an indication of stress in people's lives. Understanding the context in which unhealthy behaviours exist is more useful than focusing on the behaviour alone.

One of the more senior midwives, Program Midwife1, commented on the different ways to approach women who do not choose to quit smoking during pregnancy. She discussed how taking a judgemental approach of telling women they should not be smoking is not useful, and a better way of encouraging the client to cease smoking is to ask her how the smoking makes her feel or how she can afford to buy the

cigarettes. This perhaps sympathetic approach to encouraging healthier behaviours seems more fitting to a group of women who are disempowered. While this ‘soft’ type of approach is not typical for a mainstream health organisation or a medically dominated approach to pregnancy, if it helps the women to cut back on their smoking it should be encouraged.

Furthermore, through recognising other important aspects of clients’ lives, the diversity of skills required by the AMIC workers is highlighted. AMIC3 described how the non-medical aspects of clients’ lives can impact upon their health and *‘there is so much going on in that girls’ life you’re not only looking at the pregnancy.’* With her insight some of these broader issues can be better understood and also highlight the diversity of the AMIC role:

*... we’ve got to follow up a lot of other things. Like housing, we’ve done ... you know a lot of support letters for the girls to get housing because a lot of them are homeless. You know, couch surfing and things like that. So you need to look at trying to get a house before the baby comes you know.*

While the medical model is important in addressing clients’ health needs during pregnancy, it is obvious that a more pressing priority for some clients may include finding a home. AMIC workers continually demonstrated that they are in tune with their clients’ other needs, and frequently prioritise the needs of the clients that extend beyond the healthcare system reflecting the social determinants of health model.

Different perceptions of risk affect what aspects of client care are prioritised. This has the potential to cause conflict between different staff members when their priorities are not aligned. The AMIC workers demonstrated an understanding of aspects of the clients’ lives that are considered just as, if not more, important than their clinical care by the client, highlighting both the dominance and inadequacy of the clinical role in appropriately addressing the health and wellbeing of clients. This understanding affects what aspects of care the AMIC workers consider to be a priority and demonstrates another example of them having to negotiate client needs in a context that gives greater value to clinical care. This difference, and its potential to cause

conflict, is clearly demonstrated in the following extract where a program midwife has expectations of the AMIC worker that are difficult to achieve:

*AMIC1: ... sometimes [program midwives] don't understand that maybe the client has other issues that they're maybe not aware of. And they're expecting us to do something, and we can't, you know because ... and having to say to them, 'look, I know you want these things done, and I know you want this antenatal check done' or whatever it might be, 'but it can't happen now because, you know, there's other things that are happening within her life', or whatever it might be. Sometimes I think they don't fully get um ... they forget. It's not that they um, I don't think it's not that they don't realise or know that that happens to Aboriginal women, I think it's just they forget and they need reminding.*

Interestingly, this AMIC worker does not consider this difference in understanding to be a cause of conflict, rather she suggests that it is simply a matter of the program midwives forgetting about the other aspects of clients' lives.

*AMIC1: ... it's not so much confrontation about something that they're not doing right, that we're not doing right or ... conflict between us. It's more about I think that they forget.*

This also suggests that the impacts of medicalisation are also invisible to AMIC workers themselves. No comments were made about forgiving ward midwives for misconduct, however it would be interesting to explore whether or not it would also be the case.

I would argue that this 'forgetting' could be associated with the dominance and prioritising of the clinical aspects of the program midwife role, and how it has become embedded into their style of work within a mainstream health setting. Perhaps the emphasis of the medical model over the social during their training, along with positive reinforcement gained from this highly medicalised environment, influences the importance they give to clinical aspects of care.

In addition to differences in the prioritisation of aspects of care, there was evidence of conflict between AMIC workers and doctors regarding rooted assumptions about the

extent to which clients have an understanding and appreciation of the clinical aspects of their care.

*AMIC3: ...I think well, that poor girl is walking out that door and she doesn't know what to do. Like [the doctor] hasn't told her about the anaesthetic appointment, which I had to do. You know, if that girl had of walked out there she wouldn't have done that. So she would have rocked up Monday with no anaesthetic appointment, so she would have been cracking up. Well you've got to explain that stuff to her you know.*

This clearly highlights a discrepancy between what some clients are assumed to know in relation to clinical processes involving their care, and what they do know. As stated in this extract a consequence of the AMIC worker not rectifying this situation with the client would have been the doctor '*cracking up.*' Examples such as this demonstrate another instance when the AMIC workers are required to almost invisibly negotiate the needs and assumptions of their clients and other staff. This also suggests the failure of the doctor to achieve informed consent. It also suggests the AMIC workers have an important role in facilitating, which is probably unrecognised, even though the notion of 'informed consent' is an obligation of the doctor. AMIC3 attributes doctors' treatment of the client as often being impersonal, and that '*they don't really relate to the girl properly.*' She feels that to the doctors, the clients are considered to be '*kind of another file*' when in fact '*it's not another file, it's actually a person.*' She argues that it is the responsibility of all staff '*to make [clients] feel comfortable.*'

Another prominent discourse that emerged through many of the program midwife interviews was the importance of adopting a primary healthcare focus rather than the biomedical approach commonly accepted by the hospital. Whilst my initial analyses identified a preference for working outside of the hospital environment, I soon realised that this was actually touching on the broader issue of a preference for what was described as 'the primary healthcare model'. I argue that the primary healthcare model is positioned between a clinical biomedical model and a social model of health.

This analysis reveals that the discourse around the primary healthcare model refers to working in an appropriate space, conducive of developing relationships and adhering to clients other needs, while still implementing a medicalised model of care.

As such, the hospital and ward environments were often criticised by program midwives for being inappropriate spaces for meeting the needs of clients. The difference in approaches was defined by a more senior program midwife, Program Midwife1, who has a preference for primary healthcare, and whilst acknowledging some of the benefits of working with people who take a more traditional approach to healthcare, feels that her own approach is more suitable to working with Aboriginal people. She defines those from the more traditional approach as coming *'from the school who are into the ward and buzzing around'* and compares them to *'those of us who are more out in the community and primary healthcare focused.'*

Junior Program Midwife6, who is relatively new to working within the program, believes that going from an acute care setting to working within a primary healthcare setting is always challenging. Her understanding of how to best adapt to this approach, which is alternate to the one she was trained in as a midwife, requires formal training and she perceives it as *'going to be a big stepping stone to hurdle.'* Her summary about primary healthcare is that it is *'just a different way of thinking.'* This raises the point that while midwives are trained in an acute care model, those in the program are expected to adopt a primary healthcare approach, which they may not be well trained to do. Whilst the more senior midwife mentioned above considers a balance of the two approaches to be important to the program, she also acknowledges that:

*Program Midwife1: Aboriginal people are not interested in that kind of hussle bussle carry on down there ... because that's not where you make relationships.*

*Relationships happen out in the ordinary, kind of, easy going, sort of, you know, come and have a chat kind of place. Well you can't just come and have a chat down there.*

This example demonstrates how medicalisation impacts the hospital environment, encouraging a fast task orientated pace, and the misfit of using a traditional healthcare system approach when working with Aboriginal people. The focus within the hospital environment is on getting biomedical things done rather than understanding the

importance of building relationships with clients. Whilst it has been acknowledged that a balance of the two approaches is important to the successful workings of the program, I would argue that a greater understanding and appreciation of the primary healthcare approach, from people outside the program, would minimise the disputes and conflict that occur between program and ward staff.

Another benefit of time flexibility is the continuity of care and subsequent relationships that develop between the client and the midwife. This is not experienced as much by hospital midwives as their shift work rosters often mean that they deal with a client in a 'one off' type of situation. As discussed by Stevens (2009), this affects the dynamics of client-midwife relationships and the culture of the ward in a number of ways. These include the failure to develop an understanding of the mother's situation (beyond the hospital encounter they are involved in) and the high chance of a client receiving conflicting advice from a number of practitioners.

***Advocating for the model***

The *Anangu Bibi Birthing Program's* adoption of a social model of health in a clinically dominated environment creates difficulties for the program midwives and AMIC workers. While the program was developed from a recognised need to effectively engage Aboriginal women during pregnancy in order to improve their health outcomes, the time and relationships required on the ground are not always valued. While AMIC workers are often confronted with unsupportive views around their roles, including being questioned about their presence in theatre during a client's procedure, they demonstrate agency by not passively accepting the dominant views of the medical hierarchy around what is important. The following extract provides an example of how an AMIC worker's belief in the caring role has driven her to advocate for the role and the program:

*AMIC1: I think advocacy, and for me advocacy, advocating for the client is easy. But advocating for the client and for yourself, and the role, and the model ... to the government, to organisations, to mainstream organisations, to hospitals and agencies that don't get it.*

To this AMIC worker, advocating is the most important aspect of her job. Once again, this touches on another aspect of the AMIC role that is unrecognised. An exception to

this finding is evident through Medical Practitioner2's discussion of the challenges AMIC workers face when working with people who have differing priorities. This participant highlighted how well the AMIC workers manage these difficult situations:

*I think an initial challenge for the program was working alongside white professional women, and also, to a lesser degree, non-Aboriginal doctors and other nurses. I think coming in from a community setting and being accepted in a hospital setting was quite hard work. I think having a management system deal with, essentially a non-Aboriginal support system, has been a challenge for them as well. If you're in the middle ground you always run the risk of being crushed by the other side. So the risks that they run include being alienated by their own community, becoming alienated from the woman and the patients and baring their anger and frustration as the front person of the system. And they also run the risk of being criticised or treated badly by the midwives. Sometimes because of a particular situation or sometimes because people don't accept them into the workplace. And I think on average I think the AMIC workers have dealt with that with a lot more equanimity and a lot more professionalism and a lot more calmness than you would often see in a non-Aboriginal community.*

This extract is unique in that someone who is not directly involved in the program is demonstrating a deep understanding of the challenges facing AMIC workers. I argue that individuals with good insight into the complexities of the program and situations facing AMIC workers are part of the reason why the program is successful in Port Augusta. This particular individual has a strong voice at management levels and is a strong advocate for the program.

Furthermore, there were examples of program midwives valuing advocacy, specifically standing up against inappropriate behaviours that are fuelled by medicalised approaches. As such, Program Midwife1 gave an example around when a doctor focused on the clinical aspects of a client without acknowledging the client at all. She opens up this discussion with the statement:

*And, you know how they say specialists don't have any bedside manner, well I think that's true in some respect. They are so busy on about wanting to specialise and want to talk about this interesting case over here, and that's the person sitting there.*

This example highlights the danger of focusing solely on the medical aspects of a client and as a result depersonalising situations, which she states as being *'just shocking.'* This midwife has *'had some big clingers'* with doctors over such issues where she said she has been accused of shutting a doctor out of the labour ward.

AMIC1 believes it is the agencies and hierarchies, *'the people that make decisions up there sitting on important committees'*, who the birthing program needs to continue to advocate to. She believes that the program is *'working in a system that doesn't fully understand and appreciate what it is like to work with a disadvantaged group.'*

AMIC1 states that the program is constantly *'fighting [with these hierarchies] for this model of care'* and *'having to combat [...] with people that just don't get it or... people that just don't want to know.'* This suggests that for a birthing program, which functions in an atypical way compared to most mainstream healthcare programs, to be introduced and widely accepted into a mainstream health organisation, a shared understanding needs to exist around the most effective ways to engage and care for these clients. A true appreciation of the caring role needs to then be established so that some of the difficulties encountered by the AMIC workers in advocating for the importance of this role can be overcome. As AMIC1 describes below, it is about being recognised as equal to others in the work environment and gaining the appropriate respect:

*I always tell the new AMIC workers, just remember those midwives are not your supervisors. They are your equals, and they are your partners.*

She believes that *'we are so used to being put under the thumb and [we have been] working that way for such a long time [both within their public and private spheres]'* that it is easy for the AMIC workers to be undervalued. AMIC1 believes that *'[AMIC workers] come to a setting like this and may think oh, I'm under the thumb again by this midwife.'* She does not *'want [AMIC workers] to ever think like that'*, and strives towards advocating for an environment where the AMIC workers are equally respected by their co-workers and hierarchies. Throughout this discussion this worker challenges the dominance of nursing and medical staff within the environment.



## **Medicalisation perpetuates stereotypes of the AMIC role**

### **The importance of clinical skills**

Although AMIC workers espoused the importance of the caring role, when discussing their role, often their clinical skills were emphasised more, highlighting that their actions were inconsistent with the emerging discourses. The favouring of certain skill sets reflects the dominance of the medical model. The review of the history of the medicalisation of maternity care from earlier in this chapter, demonstrated that an emphasis on the importance of clinical interventions and procedures during this time of a woman's life is relatively new. With the medicalisation of pregnancy and birth, has also been the development of the associated professions with subsequent hierarchies of power emerging. These hierarchies have evolved around the level of clinical training and education. As such, within this field it is fairly typical that an obstetrician holds the greatest influence and power, with midwives following and Aboriginal health workers barely acknowledged, despite being trained to care for different types of women (i.e. obstetrician for high risk women and midwives for low risk women). When working in an environment that is influenced heavily by concepts of medicalisation and the differential respect and power staff members are given, it is the level of clinical knowledge and competency of a person that promotes recognition of the role. In this framework, underlying issues and prejudices that the AMIC workers experience in their role can be better understood. Senior AMIC1 worker described how people's perceptions of the AMIC worker role changed following the introduction of clinical training to the AMIC program and the visibility of this training within the hospital environment:

*... in the beginning I think we were perceived as, oh just another Aboriginal health worker that's interested in working with maternity care clients. I think, the change happened when we started taking on clinical skills and we started actually practicing clinical skills with the midwife. Because in the beginning they thought, yes midwife doing all of the clinical stuff, AMIC worker, like the Aboriginal health worker, go out to get the clients and bring them in. And talk to them and advocate for them, and communicate for them. But I think the difference is that hands on. We actually do the clinical stuff as well. I think that's the difference. And that's the change.*

This extract clearly demonstrates the value clinical skills have over caring skills, as spoken about by an AMIC worker. The description of being perceived as *just*

*another Aboriginal health worker that's interested in working with maternity care clients*' is downgrading of Aboriginal health workers and suggests a negative perception of them. By adopting clinical skills within the maternity setting, this AMIC worker describes how the AMIC workers are increasingly being valued as members of the *Anangu Bibi Birthing Program*. Their perceived role of going *'out [to] get the clients and bring them in'* changed as their role became more in line with medicalised understandings and values of what constitutes appropriate maternity care.

Undoubtedly, this AMIC worker is of the belief that clinical skills are valued more highly by other staff within the hospital setting than are other skill sets. AMIC2 describes *'a lot of bitchiness'* experienced from ward staff and AMIC workers *'having to deal with them because they don't know, like the cultural side.'* She highlights that the AMIC workers *'work culturally and you know we work both sides you know.'*

This recognition of the complexities of incorporating two approaches into their role, along with the lack of recognition by others in the environment, also highlights the areas in which other staff members are lacking expertise. Given the history of medicalisation and the way it has permeated Western society, the need for AMIC workers to be competent in a range of clinical skills is important to the way the rest of their working environment views them. This suggests that medicalisation is entrenched even in the training of AMIC workers. This is further supported by comments from AMIC4 worker around the importance of gaining the AMIC worker certificate which she considers *'makes you more credible and people will see that.'*

As such, when AMIC workers are still undertaking their clinical training there are times they are made to feel inadequate when working with staff independent of the program. AMIC2 worker, who at the time of interviews was still in training, made a comparison between the way she feels when working with program staff and ward staff. Again, AMIC2's feelings of inferiority stem from ward staff putting great value on clinical aspects of the job, and having the expectation that others within this working environment will be competent in a range of clinical skills. This, she stated *'sort of made [AMIC workers], err just not want to be working with [ward staff].'* A distinction is made by this AMIC worker, between the level of comfort AMIC workers feel with program midwives and ward midwives.

*AMIC2: ... we'll go up there with our own midwives and we'll ask heaps of questions, I know I do. Oh "what's that mean?" you know "what do those numbers mean?" or whatever, I just ask anything. I feel a bit shame to do it to the other midwives, because it ... you feel like they think that you should know that already, you know.*

A negative consequence of asking the ward midwives questions, as put by AMIC2, was that *'they sort of make you feel dumb when you ask.'* This example highlights the unrealistic expectations that ward midwives may have of AMIC workers clinical knowledge and skills, considering most AMIC workers were still undergoing training at the time of interviews. It also reinforces existing hierarchies and highlights an issue of AMIC workers feeling uncomfortable approaching ward midwives, in this instance purely based on clinical aspects of the role and lack of relationships. This demonstrates again, the emphasis that this working environment puts on clinical skills and knowledge, with minimal support given to people in training. It seems the expectation exists that to be working on the hospital ward, one must already be clinically 'competent'. Ironically, this is not the case for trainee midwives and doctors, highlighting a contradiction in expectations. While this hospital is a teaching hospital, the expectations about clinical competencies could also reflect a lack of support for educational activities in general and says a lot about a workplace culture that does not support a partnership approach.

It could also be argued that this passage highlights some of the misunderstandings that exist regarding the role of the AMIC worker. While some ward staff may be open and supportive of the inclusion of AMIC workers to the maternity ward, they may not know how the AMIC training operates nor understand the other aspects of the AMIC role that are not clinical. The use of words such as 'dumb' and 'shame' to describe their own feelings when asking ward staff clinical related questions highlights the destructive effects of solely prioritising clinical approaches to care. It is unclear if this is a result of lack of awareness of the AMIC role and training, or discrimination.

AMIC4 puts such instances into perspective:

*I'm not really worried about the nurses on the ward, as much as I'm worried about their [the girls'] families respecting my work and what the girls think of me and how the girls feel, um ... toward everything I do for them. So as long as they're happy, the*

*girls and the families and the midwives and my colleagues ... the outside world really doesn't bother me [laugh].*

Another source of tension exists around what clinical skills an AMIC worker is able to use. From AMIC4 worker's understanding of enrolled and registered nurse competencies, she feels there is scope for AMIC workers to be '*allowed*' to '*do more of the hands on stuff.*' She discusses how she would like AMIC workers to have a similar role as enrolled nurses when it comes to clinical procedures, and '*...would like to know how, to be able to take the bloods, pap smears and things like that.*' She also discussed her desire for AMIC workers to be able to take bloods (which enrolled nurses are unable to do) and considers the influence of working under midwife supervision may have on changing AMIC workers level of clinical competencies.

*AMIC4: But at the moment we are not allowed to do them things or take bloods or give injections you know. But um ... you know and by saying that I don't want to say all us AMIC workers should do that, but bugger them enrolled nurses and registered nurses on the ward you know. I think that um ... 'cause we have to be accountable, so I think that you know if we could give injections or take bloods, you know if they were going to say in the future AMIC workers can take bloods, give injections, well then they should err ... if we had to do it in a way that we were always supervised then I think it should also go for enrolled nurses.*

While this AMIC worker believes how a clinical 'up skilling' of AMIC workers may be a possibility, considering current restrictions on performing clinical tasks unsupervised, she is suggesting that enrolled nurses should also benefit from such opportunities. This balanced view may be influenced by this AMIC worker's enrolled nurse qualifications, her appreciation of the causes of professional jealousy, or a combination of the two. It is in stark contrast to the 'unhelpful' mentality she believes the health workers at Pika Wiya have: "*we're health workers at Pika Wiya we can do bloods but the enrolled nurses at the hospital can't.*" This further demonstrates some of the inconsistencies in the ways the AMIC role is defined.

#### **Clinical qualifications and associated conflicts**

Tensions arise between AMIC workers and ward staff around clinical competencies and boundaries. The negative stereotypes that exist around what the AMIC workers

can and cannot do, held by staff external to the program, have the potential to cause tension between the AMIC workers and others.

A lack of appreciation of the AMIC role is evident in AMIC2's description of her experiences of offering assistance on the ward when the program is quiet. She offers her account of ward midwives telling AMIC workers *"we've got nothing for you to do, so you can go back to the office and just wait until we can find something for you to do."* There seems to be a tension between wanting a level of clinical competence, maintaining existing power relationships and delineating existing professional roles. That is, ward midwives expect AMIC workers to have a degree of clinical competence, yet resist them fully utilising these clinical skills. AMIC2 questioned such encounters within the interview asking *'now what's that? They should be teaching us what they're doing.'* She feels that *'there's a bit of jealousy or they might be frightened that you know, we're there to take their job. But we're not, we're there to work with them.'* AMIC2 describes such instances as being barriers to AMIC learning and acceptance on the ward particularly from, *'...the older workers of the hospital, they don't like to change their ways hey! That's a tough barrier in itself.'* Furthermore, AMIC2 touches on comments that these staff make including *"oh I'm not going to listen to an AMIC worker, I've been here longer than them mob"*. She said that sometimes *'it hurts ... but we try not to worry about it.'*

AMIC4 worker speaks about the struggle AMIC workers have in gaining recognition of their role from both staff in the hospital and Aboriginal health workers at Pika Wiya. The discourses that she mentions suggest that the divide between clinical and caring roles exists across organisations and is not limited to the hospital setting. They are consistent with the discourses around adopting a primary healthcare model, however actions are consistent with putting greater value on clinical skills and as such highlight a failure to recognise that primary healthcare is still a biomedical model. For example, AMIC4 believes that the Aboriginal health workers at Pika Wiya think that *'them girls [AMIC workers] in the mainstream, at the hospital are only big noting themselves'* and that they *'have this thing about a health worker should be in this spot, you know and they should be working at Pika Wiya [...] and nurses should be working in the mainstream.'* This contributes another layer to the complexities of the challenges the AMIC workers face in being accepted by staff in a health service. This

also shows that AMIC workers struggle with being accepted, even from their peers. This can be explained through understandings of ‘lateral violence’, which describes this kind of conflict perpetuated by other Aboriginal people (Wertz, 1989). This argument must also be positioned by the fact that prior to becoming an AMIC worker, AMIC4 gained qualifications as an enrolled nurse. While she states that *‘a lot of people have said, “oh you know that’s good that you’re up there [hospital] because you’re an enrolled nurse and everything”’*, she argues that *‘the enrolled nurse is completely different to what the program does.’* This touches on a discourse arguing that enrolled nurse qualifications are more ‘valued’ than those of the AMIC workers. This dialogue further supports the notion that nurses should work in hospitals and health workers in community health services, suggesting there are entrenched ideas regarding the value of Aboriginal health workers and the medicalisation of training of a range of health professionals. As such, AMIC4 continues *‘the mentality is that the hospital is nurses, doctors, nurses you know, it doesn’t really hit a health worker sort of thing.’*

Furthermore, this AMIC worker described the types of things health workers say to her based on her qualification as an enrolled nurse: *““Oh [AMIC4] it’s so good that you’re doing the AMIC thing, what are you going to do now?” Cause they all think that I’m there because I’m an enrolled nurse.’* While she understands these workers believe that because she is trained as an enrolled nurse, she is well suited to working within the hospital environment, she disagrees that it makes her any more appropriate to work in the hospital when compared to other AMIC workers:

*...“she’s an enrolled nurse so she should be there, but these other girls what are they doing?” [laugh] And I always try and say “well you know [AMIC2] and [AMIC1] they started the program”, “yeah but they’re only health workers”, you know ‘cause there’s a thing about what health workers can do and what health workers can’t do.*

These examples reinforce the understanding that AMIC workers are not only confronted with tensions surrounding their role within the hospital setting, but tensions also exist in the broader community.

Furthermore, AMIC4 reiterates how she feels the qualifications you have should not be a cause of conflict between staff. She describes how barriers should be broken down between professionals within the setting so that the main focus is upon ones capacity to do the job:

*... it's trying to explain to them [other staff and health workers] that it doesn't matter where you sit in which building, you're there to do a specific job and if you've got the skills and knowledge and the know-how of doing that it doesn't matter if you're a health worker, a nurse, a registered nurse, a doctor, midwife ... but if you know how to do it and you applied for that job and you won that on your own merit then so be it hey.*

Again this discourse is entrenched in the professional hierarchy that the process of medicalisation has enabled within the maternity setting. It creates a space whereby AMIC workers are perceived as being of less value because of the lesser extent of their clinical qualifications. This AMIC worker is essentially arguing that staff should be valued whatever the level of their clinical qualifications. I would argue that this constant need to justify her position must be tiring.

Justifying the role goes beyond the maternity ward, where a lack of understanding of the AMIC role is also evident. AMIC4 spoke about AMIC workers being misunderstood as support people by other staff, with minimal responsibility. In her description about this topic, AMIC4 also highlighted her strategy of standing up for herself and voicing her opinion.

*... and when there is a girl in labour, and midwife and AMIC worker go in there, there's other nurses there, they actually think that the AMIC worker is just there for the father, or just being a support person, not actually doing any hands on stuff. Theatre's like that. They think that you're there as a support person and you don't do anything. Um ... but me and my big mouth I growl at them.*

Discrimination of AMIC workers was also raised by AMIC4 whereby other staff's ignorance about the AMIC role leads to stereotypes about whom the AMIC workers are and what their role is:

*... a lot of younger nurses, student nurses see you walking in and out and they're like 'oh this must be a client, this must be a patient.' And then you walk behind the desk and they 'oh, oh'... and look at you like is she supposed to be there?*

Again, this highlights the need for further education of staff around the AMIC role and the birthing program. Failure to do so is likely to have negative consequences for the AMIC workers, producing an undesirable work environment that perpetuates stereotypes and power relations, and does not foster an environment that is supportive of ongoing learning.

**Dissonance between clinical expectations and client needs**

While there are instances of AMIC workers taking a medicalised approach to pregnancy care and childbirth, discourses around clients more strongly relates to their social and emotional wellbeing, and the importance of educating women about aspects of their health during and after pregnancy. This approach is in contrast to simply engaging them with clinical checks. As such, there are often times when the medical paradigm is not in line with client needs, and subsequent responses of the AMIC workers and clients may not be accommodated for or accepted by the mainstream hospital service.

One AMIC worker acknowledges that client needs are often complex and that not all of these needs can be addressed. She discusses this in light of still being motivated to educate and care for clients:

*AMIC1: ... it's not like you can change everything, you can't, but um, I think you put so much more into it because the more women you teach, the more babies you change, the better outcomes, you know for everybody.*

Educating the women on a range of things, including health behaviours and engagement with the health system, to improve both their lives and the lives of their families was considered an important aspect of the role by a number of AMIC workers. This AMIC worker also described her aim to 'try and help the outcome of that little baby' by teaching the 'mother who is carrying that baby' that she needs to look after herself 'because it's all about the outcome of that little baby that's going to come.' For another AMIC worker helping women to live lives free of some of the



complexities they would otherwise be faced with was the most satisfying part of her role:

*AMIC3: ... you see them [the younger clients] grow, and I think that's the best part of being an AMIC worker and giving them the information you know that they need, that they don't really know. And ... just setting them on the right path.*

This AMIC worker also commented on seeing changes in women as a result of the education they receive on the program. The information some first time clients receive is new to them and she believes it changes their approaches to different aspects of their lives.

While these examples are not directly related to clinical aspects of clients' obstetric care, they are still underpinned by medically informed knowledge about what constitutes good health during pregnancy. While the healthcare system acknowledges that such information needs to be shared, it does not necessarily support the mechanisms AMIC workers use to encourage the clients to engage with the information in a meaningful way.

**Clinical focus negates access to non-medical resources**

As there is limited evidence for the medical paradigm acknowledging the other needs of clients, it is not surprising that non-medical aspects of the program are under resourced. While it is unclear if structural barriers are faced in relation to accessing medical equipment and resources directly related to the clinical aspects of client care (because it was not a focus of this research), the AMIC workers and program midwives frequently discussed challenges they faced in obtaining resources they require to assist them in addressing client's other needs. For example, a shortage of cars to transport clients to and from the hospital was a common problem mentioned by participants. Five of the six AMIC workers mentioned the need for another work car to assist with fulfilling their job requirements. Currently, the program has access to two cars, however staff of the birthing program believe that this number is inadequate for the number of clients they work with. This seems to be another issue creating tension between the program and management:

*AMIC4: ... upstairs they're arguing about the cars, you know. And it's like, well you've got six AMIC workers and um ... there's thirty girls on the books, so you know you're, you know you ... one AMIC worker even uses her own car when upstairs says you girls have already got two cars, you're not getting anymore, you know. But then you've got six AMIC workers and five midwives that want a car [laugh].*

Another important resource that is not directly in line with the medical paradigm, yet impacts the likelihood that clients will attend their medical appointments and the support the program is being able to provide child car seats when transporting clients and their children to and from the hospital. As such, AMIC3 describes a common situation that presents difficulty when they are working with clients who have more than one child:

*There are six AMIC workers, we've all got a whole list of girls that we've got to go see, and we've got one car. And we've both got girls, like three of my girls have all got other kids. One of them has got four kids, all needing car seats. You know. It's just sometimes impossible to do. So I think we need a bit more funding to get more stuff. You know cars and car seats. To get mobile and get them in here you know.*

As mentioned in this extract, there is a real need to improve resources, in order to ensure women are able to access the program. Making services easily accessible has been recognised as key to reducing the inequality in birth outcomes.

One AMIC worker discussed how she had run an antenatal session the previous day and asked clients what they would like to assist them during pregnancy. The majority mentioned that they would like more information around nutrition during pregnancy and to learn how to cook accordingly. Unfortunately this AMIC worker did not think the funding was available at that time to go forward with such classes, and believes that funding to support such activities would be incredibly beneficial. As such, one of the recommendations of this research is to improve links between the program and other community services available in Port Augusta. Furthermore, according to one of the AMIC workers, the program lacks funding to provide basic necessities to clients and their babies, particularly at the time of birth. A need for underwear and maternity pads were some of the items mentioned. One midwife also discussed this, as well as mentioning the need for other basic personal items such as hairbrushes.

The medical paradigm not only influences the acceptance of the types of things that AMIC workers need to do for their clients and the resources they receive, but it also dictates the type of space that is deemed appropriate for pregnancy care and childbirth. While the program benefits from aspects of being based within the hospital (such as support with providing clients with medical care), there is a strong discourse suggesting the space could be made more appropriate for Aboriginal people accessing the program. For example, program midwives mentioned the need to include culturally appropriate and inclusive artwork within the maternity ward, and all staff spoke about the need to have a space with windows, which gives clients a sense of connection to country. A more appropriate space for the AMIC workers was spoken about as being important to engaging women in all aspects of their health. AMIC2 spoke about this in relation to the prevention of women from being afraid of engaging with the hospital environment along with feeling comfortable within the space.

*I feel their needs to be a place that women are not afraid to come for anything, not just pregnancy and stuff like that. Um anything like sexual health, anything like that. Um ... and then when you've got a place like that you know, and if traditional women are here in Port Augusta giving birth, they can be at places like that and you know, sit down comfortably, not you know, being all um ... frightened to say anything or do anything you know [laugh].*

Additionally, all AMIC workers mentioned the traditional birthing space available to Aboriginal women at Alukura, in Alice Springs. They spoke about their desire to see this type of environment available to Aboriginal women in Port Augusta. This space was deemed appropriate not only for giving birth in, but for women to feel comfortable to access information and treatment of other women's business issues. Program Midwife1 also spoke about the inappropriateness of the space the program was working from at the time of interview. There have been recent changes to the program, as a result of strong discourses within the program around the inappropriateness of the physical environment. I believe this is still important to highlight, particularly when considering the sustainability of the program in other locations. Program Midwife1 stated her 'beef' about the program has always been that administration personnel 'should be off somewhere else' and not working in the same

area of the ward as other staff. She believes that the program *'really need[s] to look at a midwifery group practice'* such as a house in the community, *'an open house place where people could be.'* She believes that the space the program occupied on the ward until recently had *'nowhere to sit, you know it's [...] a boxed up room, I mean it's done a good job considering it was a store room.'* She believes the *'AMIC workers would like to be out of the hospital, out of the business of that ward.'* Program Midwife1 made the suggestion that the program should be based out of the hospital in *'the house at the corner'* of the hospital that is used by *'mostly white girls'* when they come in *'from the bush.'* She believes it would *'so ground breaking and fantastic to have that'* because clients *'would just wander in'* and *'feel at home.'* She believes the hospitality of being able to offer clients a cup of tea in a space they can bring their other children and feel comfortable consulting program staff about a range of issues would be ideal. In contrast, she believes:

*... you go to the hospital and it's absolutely clinical... you know. You can't get away from it. You're right next to the birthing suite. You're right next to the.... Well we try and make it as nice as possible and welcoming but I mean you can do that, you don't have to be restricted by the building too much. That makes a difference. It does make a difference. And just say to people "well here's your cup of tea" but it's terrible when people go "oh we can't have 'em, that many people down here, we'll have to close the doors and put signs up to say you have to go round here..." Oh you know, well stuff the signs, who's going to read them... excuse me... but you know what I mean.*

This is drawing on the inappropriateness of the clinical space offered by the hospital, which was also described earlier when exploring this in relation to a preference for a primary healthcare model. The inappropriateness of the clinical space was also touched on by Ward Midwife5, and made the suggestion that the program be moved to a vacant ward in the hospital. She feels an office with *'windows'* and *'a view'* is important, and understands that there is space on the vacant ward for a consulting room, *'rather than trying to find somewhere down on the ward'* to do antenatal checks. She believes that what would be more appropriate than their current rooms, is a space that women feel comfortable accessing, particularly when acute care and monitoring is required, and enables the program to admit clients for a short period of time. Furthermore, she feels that *'it would be a nice surrounding, it would be quiet,*

*it's away from the rest of the hospital, it's not in an ill environment'* and a more appropriate space for the program:

*Instead of that they're shoved there, everyone can see the girls coming and going, there's no windows, you know, and especially for the cultural side of it, land and everything is supposed to be so important, they can't even see the bloody land you know.*

These extracts also suggests the act of placing the birthing program in an inappropriate space is disrespectful, and can be interpreted as a form of institutional racism, whereby management's value of the program is minimal. In contrast, Medical Practitioner<sup>2</sup> spoke about how important they think having the program on the ward is, with the main advantage being changing the culture of the maternity ward to one that is more open towards Aboriginal beliefs and needs.

*I think the influence of Anangu Bibi and the AMIC workers and the midwives has actually been on the whole service and the whole unit because it has brought white and Aboriginal people together, working day by day builds bridges and that builds trust. Secondly, it has had a far wider influence than just the program, because the program is integrated into an active maternity unit. It's location, while being on the ward, might be seen as poor, in terms of community access and community issues, has actually been a tremendous advantage in changing the unit of a maternity ward because it is configured close by. If it had been a long, long way away its influence would have been much less. Now arguably you could do so much in the community but if you don't change the actual birthing unit, and it's not integrated with the actual birthing unit you would still have the same problems of women feeling that the service was callous or unfeeling or racist. And some of that has definitely been broken down.*

Ideally, a larger space conducive of women and their families coming in and out as they felt necessary could be advantageous. As suggested by Ward Midwife<sup>5</sup>, accessing vacant ward space may be one way to address this issue.

When focusing on the physical aspects of the hospital environment it becomes clear why many of the program midwives understand it to be a barrier to giving clients appropriate care and support. Rather than being a welcoming environment to the

clients of the program, the hospital environment has been described by Program Midwife1 as being '*absolutely clinical*' whereby it is difficult to offer clients '*hospitality*.' This midwife believes that the building is restrictive which makes a difference to the development and maintenance of relationships with clients, which is vital to the quality of care they receive. This midwife gives an example of how restrictions are made by the hospital on how many people can come on to the ward to visit a client, and in what areas of the ward they are welcome. While these restrictions are understandable in maintaining a respectful space for other clients using the ward, they are still inappropriate to the needs of the clients of the program who often have large families. This again highlights the very individualised focus that medicalisation has put on pregnancy and birthing, omitting the needs of cultures who still maintain strong ties to many members of their family.

#### **Avoidance**

All AMIC workers believe that some clients avoid the hospital system completely during pregnancy and for the birth. Most considered this to be the case for more traditional girls who live in remote communities (as discussed earlier). 'Traditional' was the word used by all participants to describe remote Aboriginal women who hold strong cultural values and beliefs. However, a number of other reasons were given for avoidance including the inappropriateness of the hospital space, a lack of support when transferred to other centres and the fear of services being notified. AMIC1 describes the situation of hospital avoidance for more remote women, making mention of the inappropriateness of even Alukura for some of these women:

*... more remote areas they definitely do [avoid the hospital system to birth]. I mean, even Alice Springs, there were young girls that stay out on the communities, and birth out there because they didn't want to go to hospital. Because it's a scary place to them.*

Interview data also illustrated that for some clients the medicalisation of pregnancy and birthing has meant they have been given no choice in method or place of birth. For one client, it was described (by AMIC3) how the doctors were '*actually going to make her go to Adelaide*' to deliver because she was a '*big size BMI girl*.' This was her fourth child and relocating to Adelaide for a period of time for the birth of this baby would mean she would need to leave her other three children in the care of

somebody else. Compounding this was the fact that her last delivery had also been in Adelaide where her experiences had been *'traumatic'* and she did not want to go through that again.

*AMIC3: ... she kept saying to me like "they're not going to let me birth here, I'm not coming in, I'm just going to do it at home."*

Whilst there are various reasons that have been given by participants for hospital avoidance in other sections of this thesis (including negative associations with death, language barriers and bad experiences with hospital staff), one exception to these quite common experiences was given. A senior AMIC worker, AMIC6, described a situation where one of her clients did not avoid the hospital during her pregnancy but when it came time to have her baby she was forced, in a domestic violence situation, to deliver at home. This points out that women avoid the system for multiple reasons, including feelings of discrimination, not just cultural issues. Hospital avoidance occurred to avoid negative judgements regarding parenting skills, as described by AMIC3:

*I think that there's a fair few out there [who avoid the hospital system]. Not only the fact of judgement, but also welfare and stuff. If they've got welfare background, you know ... and especially if they're them tribal ones, you know, it's quite hard. And with the language barriers, and not understanding each other, you know ... yeah I think it's a big factor. And I think the main thing is, that the hospital, you know where they're going to take their babies away, it happens a lot here. I've seen it myself. And it's horrible the way they do it you know.*

While I am not condoning child abuse or neglect, I am making the point that within mainstream systems, particularly within the realm of health, it is clear that women avoid the system for multiple reasons related to cultural safety, discrimination and the ongoing legacy of colonisation. The danger in having these prescriptions is that they may at times be removed from context and inappropriate or irrelevant to the reality of the situation. This section highlighted that these issues around avoidance could be dealt with to improve the system and demonstrates that avoidance is not only associated with the right to birth on country.

**AMIC workers are the brokers of medical knowledge**

AMIC workers are required to negotiate the needs of their clients (which may be disparate from the needs or beliefs of the institution), whilst conforming to the medicalised requirements of their role. The following discussion highlights the agency of AMIC workers in response to the difficulties of medicalisation. It demonstrates that AMIC workers are brokers of medical knowledge.

Firstly, sharing medical information appropriately with clients so that it is relevant to their needs and delivered in a way they can understand is important. AMIC4 describes this process and touches on the consequences facing the AMIC workers if this is not done well.

*... the information we give them, we have to give the girls the information that suits them. There is a lot of information out there, but it's got to actually meet that girl's needs. Because you can't give them information um ... that was made for somebody else, otherwise if something goes wrong we get the backlash from the community, so the information we give them has to be for that specific girl. Yeah, it has to be something that she understands.*

This also highlights the gap in knowledge clients have in regards to medical risks and procedures. I argue that AMIC workers are expected to negotiate the translation of this knowledge by both the system and clients, without an appreciation of how difficult this may be and what consequences may exist for them. AMIC5 spoke about knowledge translation and areas that clients have minimal understanding of, including clinical aspects of their care:

*... And they don't really have an understanding of it either. I think that, that's one of the main things, is having an understanding of why they should have it done. And as AMIC workers we sit down and we explain to them why, in our way. You know. Um ... in a way that they can understand.*

In this way, an important aspect of the AMIC role is that they are the brokers of medical knowledge. One important factor that is considered critical to the success of AMIC workers as knowledge brokers for their clients is the relationships they have with their clients along with their understanding of Aboriginal culture. AMIC1



believes *'it's just that cultural understanding, you know, our way of thinking, just our whole way of life is so similar'* as a reason why AMIC workers can *'relate to [clients].'*

As suggested, the medicalised approach to pregnancy and childbirth fails to accommodate the complex needs of the clients of the program, along with opinions of the AMIC workers suggesting inappropriate aspects of the system for Aboriginal women. Despite this, to maintain their position, the AMIC workers stressed that care needed to be taken in presenting alternative views to medical approaches to pregnancy and childbirth, and must negotiate the hierarchies of the hospital along with the wishes of their clients. In this way, the impact of the medicalisation of childbirth and the systems it operates within can be seen as contributing to another layer of complexity facing the AMIC workers in their role.

One issue raised by the AMIC workers was the lack of acknowledgement they receive in their roles from the hierarchies of the system. AMIC1 describes that *'there needs to be more acknowledgement'* from the *'decision makers within the hospital.'* She believes that *'the hierarchy within the hospital need to acknowledge the important work that we do.'* This suggests that there is a lack of support and understanding around what processes the AMIC workers need to engage with to encourage positive health outcomes for their clients, and is a clear recommendation for practice.

Furthermore, despite AMIC workers raising their desire to offer clients more in regards to cultural practices around the birth, they feel they are unable to do so because the hospital environment is not conducive to such things. As AMIC1 discusses, traditional or remote women *'have really strong cultural beliefs and ceremonies around the birth of the baby. And, it's not all of that we can offer within a hospital setting, at all.'* Discussion of options to incorporate more traditional birthing practices into the program with hospital management is not seen as an option by most AMIC workers. Cultural practices and needs are not confined to traditional women and there are some things that are done to make the setting more culturally appropriate for all Aboriginal women, including taking the placenta home. The main discourse engaged with by town-based women around this topic included having a space that would be welcoming to large families. The dominance of the medical

model, its associated risk discourses and ability to create a norm around birthing practices, prevents the adoption or support of a pregnancy and birthing model appropriate for traditional women. As AMIC1 said *'we can't offer any of that [traditional practices]. So that's a huge disadvantage to those women.'*

### **Conclusion**

While the medical understanding of pregnancy has been beneficial, its dominance over other approaches to health and wellbeing is problematic. Despite instances of clients viewing pregnancy and childbirth as natural events, most examples demonstrated women have highly medicalised experiences and perceptions of these phenomena. Clients spoke about these experiences involving medical monitoring and intervention in the environment they knew to be appropriate. A hierarchy of medical professionals was evident in some discussions. While these experiences and understandings are influenced by the way the mainstream health system has adopted the medicalisation of pregnancy and childbirth, they have consequences for women's perceptions of what is normal. This highly medicalised environment has given women and AMIC workers reasons to believe what is and is not safe, and in many cases I would argue has changed or maintained their own discourses around notions of risk.

The dominance of the medical model has also influenced the way these women feel about and identify with the Aboriginal tradition of birthing in the bush, and the likelihood that they would engage in these methods of birthing. This is evidence of a traditional authoritative knowledge being dominated by a more contemporary authoritative knowledge around medical risk. The wide spread acceptance of this knowledge and its associated approaches has left little space for the consideration of other pregnancy and childbirth options in safe settings, further demonstrating the ways an exercise of medical power has influenced the narrow, clinically bound, approaches of the health service.

Without underestimating the benefits of medical treatments, nor discounting many communities' desire for a medical approach to improve health outcomes within the maternal and infant healthcare setting, it must be understood that medicalisation displaces other approaches, often creating disproportionate power relationships within the associated environments. The enforcement of a medical hierarchy consequently

occurs whereby positions that are not considered to be clinical, such as AMIC workers, are undermined. Furthermore, the dominance of the Western biomedical approach to pregnancy and birth does not value social care in pregnancy and discounts the authoritative knowledges that exist in other cultures, failing to recognise the associated detrimental consequences this can have (particularly on minority groups). Exploration of the authoritative knowledges that exist for women in other cultures, especially Aboriginal women in Australia, reveals different perceptions of what constitutes risk. Deconstruction of the processes of medicalisation, the way it influences mainstream systems and institutions (including who can work within them), authoritative knowledge, along with concepts of risk, may make space for a more productive environment that meets the needs of Aboriginal workers and their clients

## CHAPTER 4: THE IDEAL WORKER

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The notion of an ideal worker has pervaded the manner in which Western societies and the organisations within them operate. When unpacking the concept of an ideal worker it is important to recognise both the historical contexts from which it evolved as well as the consequences it has for individuals (employed and unemployed). It is important to recognise that this construct is not static; it varies somewhat across societal contexts. However, it is important to examine how the construction of an ideal worker in the dominant (Western) culture is still largely based on traditional notions of masculinity and how these gender constructs and subsequent power relations still have a great impact on the way in which contemporary workplaces operate. Despite the popular rhetoric about the importance of creating work environments that promote a work-life balance, the hidden reality within workplaces, particularly those with more ‘traditional’ work ideals, is that a work culture based on the ideal worker continues to prevail. The question I have to put forward is this: how is a person with minority group membership supposed to negotiate this space, particularly when it is difficult enough for women of the dominant culture to gain work-life balance amidst the expectations created by the ideal worker construct?

Expectations of the ideal worker originated largely from governments and tribunals (Ellem, 2005). In Australia, workplace norms were created through the establishment of the Commonwealth of Australia in 1901. The ideal worker was male, would receive a wage and would be the breadwinner for his wife and family. With this came the reinforcement of ‘separate spheres’ for men and women (Ellem, 2005), in which the men worked in a public space and the women tended to the private space of the home. Feminists of the time accepted the division of roles with the argument that the private space was as important as the public (Ellem, 2005). Eventually women received the right to vote, which ensured middle-class women had a voice and that their dependence was not affected by their partners misuse of money, or as stated by Ellem (2005) ‘boozing away the wage.’ Within the Australian context then, the creation of the ideal worker was influenced by a number of different parties. Primarily it was the government, but women, employers and trade unions all had vested interests.

The making of immigration and population policies in Australia also affected who the ideal worker could be. With the White Australia Policy dating back to the 1850s (Abolition of the 'White Australian Policy', Australian Government, Department of Immigration and Citizenship; accessed 6/09/2011) employment in Australia was open only to 'white Australians', which included primarily British and Irish immigrants. Employment was therefore closed to the Australian Aboriginal population along with people of Asian heritage who were seen as a threat due to their willingness to work hard for a minimal wage (Abolition of the 'White Australian Policy', Australian Government, Department of Immigration and Citizenship; accessed 6/09/2011), amongst other things. Therefore, the construct of an ideal worker was essentially a white male.

Following World War II, the Australian Government felt under threat by narrowly missing being invaded by Japan. As a result they adopted a plan to 'populate or perish' to avoid future threat. As suggested by Ellem (2005), this movement supported the idea that the ideal worker also needed to support the 'ideal woman' who could mother many children in an effort to boost the population. This example within the Australian context gives insight into how both men and women of the dominant culture were positioned in society from the early 1900s and lays a foundation to understanding current workplace issues today.

More detailed examinations of what constitutes the ideal worker have suggested that educated, full-time and continuous availability (including working long hours and willingness to relocate and travel) and work-orientation are amongst the most salient characteristics (Acker, 1990; Bailyn, 2006; Hook, 2010; Tienari, Quack, & Theobald, 2002). These attributes suggest an unbounded commitment to work (Blair-Loy, 2003) including the expectation that this commitment will continue throughout adulthood (Moen, Kelly, & Huang, 2008). This construct thus creates tensions between the public and private spheres, which are assumed to be separate, along with the 'gendered organisation of reproduction and production' (Tienari et al., 2002).

Gender inequality is reinforced by the concept of the ideal worker as the man who is expected to dedicate his life to his work, and his partner, who is stereotypically a woman and a mother, expected to take care of everything outside of his work

commitments (Tienari et al., 2002). As such, this assumption around the roles of men and women, particularly within the private sphere, reinforces gender inequalities within the formal workplace.

The characteristics of the typical ideal worker are traditionally masculine. The assumption is that the ideal worker can remain committed solely to their work and not be influenced by life outside of their employment. Based on this construct, high level, managerial positions have traditionally been filled by men, under the assumption that women could not meet the needs of such roles. This created a clear sex segregation of roles in the economy, which has seen women's exclusion from powerful positions within the workplace. As stated by Williams (2000) 'jobs designed around an ideal-worker schedule discriminate against women on the basis of their inability to command the flow of family work that supports most male ideal workers.' This assumption has influenced the positions women have had in the workplace and has meant that men have held positions of power, which have maintained the masculine norms that exclude women (Williams, 2000). Within the Australian organisations, the ideal worker expectation has reinforced ideals of excessive work hours and work intensification (Fujimoto, Azmat, & Härtel, 2013).

Although there has been little evolution of the notion of the ideal worker from its original masculine roots, there have nonetheless been movements that have challenged its acceptance within the contemporary workplace. Since the 1970s, Australian industrial relations and reforms have enshrined women's right to equal opportunities in employment and education, however this has not necessarily translated into equal access to all types of employment. With this movement it would be comforting to assume that both women and men then had equal access to high level white-collar jobs, however this has not been the case. Despite the fact that more women are now in more high level, once male dominated positions (such as lawyers and doctors), they are still under represented in the high-status and 'financial reward' positions (Williams, 2001). It is still the case that women's representation in top-level jobs is poor when compared to their male counterparts (Australian Human Rights Commission, 2013; Williams, 2001). Furthermore, a significant gender pay-gap exists in Australia (Gordon, 2012). This is defined as the difference between the average wage of full-time male and female workers, which is not attributed to factors related

to skills, experience, family situation or industry sector (Equal Opportunity for Women in the Workforce Agency, 2012) As such, the ideal worker model continues to influence work culture in Australia (Drago, Black, & Wooden, 2004), and perpetuate gender inequality within the workplace.

The idea of women as ideal workers is interpreted by many as women as ‘bad mothers’ (Williams, 2001). This stems from the understanding that women are ‘natural’ and innate carers, as opposed to men, which has also contributed to the gendered division of labour in the private sphere (Merskin, 2008; Sutherland, 2010). After all, the ideal worker is assumed to be able to drop everything if required by their paid position, and a woman with other caring responsibilities may not be willing to do so and may be castigated by her peers and the wider society if she did. In this way, the expectations of the ideal worker is a disadvantage to the job prospects and career trajectories of those with caring responsibilities (Charlesworth & Baird, 2007). Nevertheless, in the last few decades there have been significant changes in social and industrial practices that have seen a higher percentage of females in employment, more part-time workers and increasing involvement of men in domestic and family responsibilities (Williams, 2001). These changes have brought new challenges to the ability to meet the expectations of the ideal worker for both men and women, causing conflicts between work and family commitments (Kelly, Ammons, Chermack, & Moen, 2010). Such tensions include ‘time strains, missed work or family activities, and the spill over of stress from work to home or vice versa’ (Kelly, Moen, & Tranby, 2011, p. 1). Work-family conflict has also been described by Kelly and Moen (2007, p. 492) as being affected by ‘family demands (e.g., number and ages of children, adult care giving duties), family resources (e.g., spouse’s time, total family income), work demands (e.g., number of hours worked), and work resources (e.g., a supportive work environment).’ Overcoming instances of ‘work-life conflict’ can be difficult to achieve (Williams, Pocock, & Skinner, 2008). Although work-family conflicts are experienced by both men and women, the gendered differences of work within the private sphere along with the cultural expectation that women will remain available to the needs of the family, maintain that women feel the effects of being overworked, more so than their male counterparts, because of their dedication to both spheres (Kelly et al., 2011). Specifically, mothers experience a great misfit with expectations of the ideal worker because it does not allow for competing commitments, particularly

not those as challenging as raising children (Gatrell, 2005; Gorman & Fritzsche, 2002; Ridgeway & Correll, 2004).

It has also been suggested that as men and women differ in the roles they take in their private work life (including family responsibilities) (Bianchi, Milkie, Sayer, & Robinson, 2000) as well as their different beliefs around expectations of mothers and fathers (Townsend, 2002). Mothers are less likely to attempt to fit the ideal worker norm (Kelly et al., 2010). The limitations around flexibility and meeting the needs of life outside of the workplace make being an ideal worker somewhat impractical and in many cases impossible for women. However, those who are unable to adhere to the expectations of the ideal worker (i.e. women) are less likely to benefit economically (Kelly et al., 2010), and may feel the negative effects of unequal workplace power relations.

In addition to this, women feel an intense pressure to meet ever demanding expectations of mothering, which have been identified as time consuming and intensive (Pedersen, 2012). This has been associated with depression, feelings of guilt and stress among mothers (Rizzo, Schiffrin, & Liss, 2012). One way of overcoming this issue is for mothers to undertake part-time or shift work, which allows them to engage in paid labour at the same time as fulfilling their mothering role (Walsh, 2007; Webber & Williams, 2008). However, part-time work for women in high status jobs often decreases chances of promotion or career development opportunities (Gatrell, 2005) and the associated pay is often low and insecure (Gatrell, 2005). Additionally, work schedules associated with part-time (especially casual) work can be irregular and have limited predictability (Walsh, 2007). Furthermore, in practice very few women have control of where they can work as well as their work hours. The ideal that part-time work improves workplace flexibility can also reinforce gender inequalities in the workplace and contribute to additional stress among women.

There have been recent attempts to design policies that reduce these work-life conflicts (Bailyn, 2010). Flexibility and the timing of work have been highlighted as important to this movement (Christensen & Schneider, 2010). As stated by Williams (2001, p. 113), 'flexibility creates workplaces that are often more, rather than less efficient. This accounts for the spread of family-friendly policies as employers seek to



cut down on absenteeism, to increase productivity, and avoid the huge replacement costs that result from high-rate turnover.’ The importance of schedule control has been pointed out by Kelly et al. (2011) as being essential for managing numerous responsibilities within both spheres, and refers to freedom over how and when one works (Karasek & Theorell, 1990, as cited in Kelly et al., 2011).

These shifts clearly point to the importance of understanding the social context of workers and that their paid work does not exist in isolation from the other responsibilities they have in their lives (Ellem, 2005). As such, it would surely be more helpful to think of the ideal worker as an out dated construct, as the employment market has changed markedly since the inception of this notion. Perhaps more constructive would be to consider how the ‘ideal workplace’ could be created and maintained, one which leaves behind gendered power relations and any belief that workers can remain separate from their life outside of the workplace.

### **The ideal worker in a medicalised environment**

When considering the specific work context of the AMIC workers, it is important to understand the expectations medicalised environments have of what constitutes an ideal worker. As medically informed knowledge dominates other ways of thinking about health, an ideal worker in this environment will also adhere to the medical paradigm and its associated concepts of time. Hierarchies based on an individual’s level of medical knowledge and clinical skills are also prevalent in this setting and also influence who an ideal worker is in this setting. The subsequent impact of professionalisation within this environment, particularly in relation to privatisation and the associated emerging roles has also influenced the ideal worker construct. The following discussion of the literature outlines how the dominance of medicine has influenced ideal worker expectations, consequently created expectations of high incomes, and in some instances perpetuated unequal access to care.

### **Concepts of time**

While the concepts of time within a medicalised context were discussed in the previous chapter, they are also relevant to deepening the understanding of the misfit between the ideal worker construct and the reality facing workers within the medicalised environment, particularly with regards to maternal and infant health. The notion of controlling time on a maternity ward has been described in-depth by

(Stevens, 2009) who noted that when information was not kept up to date by the midwives or behaviours deviated in some way from what was expected, the potential for tension between midwives and obstetricians arose. This demonstrates a conflict between notions of time, particularly physiological and institutional time that are relevant to a hospital environment. These concepts of time were described in detail in the previous chapter. Adherence to institutional time is part of what constitutes an ideal worker in this context.

***Aboriginal concepts of time and subsequent ideal worker challenges***

The Aboriginal concept of time differs to the Judeo-Christian perception of time. Aboriginal people do not perceive time in the linear form (that is past-present-future) as people from the Judeo-Christian culture do, rather time is understood as being circular, whereby time is thought of as being static and individuals are at the centre of 'time circles'. These 'time circles' position different life events relative to their perceived importance to both the individual and their community, that is events perceived to be more important are subsequently thought of as also being 'closer in time' (Janca & Bullen, 2003).

From this understanding, priorities are more important than time for Aboriginal people (Madafferi, 1998), and those related to family and community are highly prioritised. In this way, events associated with family or community needs take precedence over events scheduled for the individual. For example, a scheduled antenatal appointment that may be important for the individual may not be attended if other responsibilities related to family or community arise.

These differences in concepts of time may create challenges for Aboriginal health workers. Specifically, they can be seen as an additional barrier that Aboriginal health workers have to overcome in order to meet the expectations of an ideal worker. This may be in relation to the requirement of their role to encourage client attendance to antenatal appointments, which may be impossible when the appointments are in conflict with the client's priorities (understanding that an antenatal appointment may not even be a priority). Furthermore, additional time conflicts may be experienced by Aboriginal health workers that are associated with differences between their cultural and personal concepts of time and institutional concepts of time.

## **Analyses**

Discourses around negative aspects of working with the AMIC workers arose from both program midwives and ward midwives and are largely associated with misfit of AMIC workers with the construct of the ideal worker. The issues raised by the midwives were not necessarily viewed as problems by the AMIC workers themselves and in many instances were considered by the AMIC workers as the keys to the success of the program. Some midwives, both those involved in the program and those working predominantly on the ward, offered insight into some of these issues, considering the complexities AMIC workers face in their role. It is the differences in ways of working, the influence of institutional protocols, associated constructs of time and the blurring of boundaries, all of which are rooted in the expectation of the ideal worker, that contribute to discourses pertaining to difficulties in working with AMIC workers.

### **Differences in ways of working**

#### **Work ethic**

In interviews with program midwives and ward midwives, the issue of work ethic arose frequently. In many instances, participants described their perceptions of an appropriate work ethic for working within a mainstream health organisation and suggested that AMIC workers do not fit with this ideal. There were some contradictory views around work ethic that may be associated with differing understandings of AMIC workers obligations outside of the workplace. Program midwives with the least experience in the program spoke of instances where they believed AMIC workers were not working to their full capacity, this was often reinforced by the more junior midwives on the ward. However, more senior midwives (that is both program midwives and ward midwives who have been involved with the program or been qualified midwives the longest) described these situations in terms of the many competing challenges AMIC workers face in their everyday lives (in the private and public spheres). In this light it became clear that it is not that the AMIC workers have a poor work ethic, rather they have other obligations that may impede upon their ability to fulfil this expectation within this work environment. This is discussed in-depth in the following chapter exploring emotional labour. Furthermore, unrealistic expectations of the system, along with inherent structural issues, give

further reasons as to why AMIC workers may find it difficult to fulfil these expectations that are discussed below.

One complaint made by two junior program midwives was that AMIC workers do not always work as hard as they should. Program Midwife6 talked about some AMIC workers not following up their clients and '*picking up the slack*' to the extent that they should. However, this was described as being a characteristic of one AMIC worker rather than being transferrable to all. This midwife also commented that AMIC workers did not always follow up clients after they had been admitted to the ward, which she believes to be an important part of continuity of care in order to maintain relationships with clients. She suggested that AMIC workers assume their clients will be fine on the ward. Another reason given by this midwife (although not made explicit) was that there might be some confusion on the AMIC workers' behalf, regarding their role on the ward. She termed this a '*grey area*' where AMIC workers may assume that '*they do not need to worry about them as much.*' This midwife believed that there are differences between AMIC workers in how much of themselves they dedicate to their work, '*some put a lot of heart and soul into it, and others not so much. I think it depends on where they are in their life as well.*' This demonstrates that there is some appreciation of personal context that influences the energy of AMIC workers, however the depth of this midwives understanding of this may be limited.

Program Midwife4, another junior program midwife, attributed poor work ethic to lack of motivation among AMIC workers. She stated that AMIC workers '*need to be pushed to do things*' and when things do not get done the midwives need to '*get in there and do it.*' This midwife believed that the length of time a midwife has been involved in the program dictates the amount of respect she will receive from the AMIC workers. Being relatively new to the program herself, she felt that there were times when she wanted to tell the AMIC workers to do particular things, however she could not because she had not yet earned their respect. As such she had experienced conflict with AMIC workers as a result of doing aspects of the AMIC workers' job when the AMIC workers had not followed something up or had taken days off. Her perception of one particular AMIC worker who she feels does not like being told to do things was that this AMIC worker was '*just a little bit lazy.*' She stated this even

after describing the strengths of this particular AMIC worker in the labour ward. This discourse around laziness will be discussed in greater depth below, and contrasted with the views of a more senior midwife. Furthermore, this midwife believes that when an AMIC worker does not come to work it confirms her belief that some AMIC workers' *'hearts are not in the job.'* She also attributes not coming to work as a tell-tale sign of burnout, and she compares this to midwives who would *'come in, do our work, and just struggle through.'* Her expectations of what is reasonable behaviour when close to burnout, differ to others in the work environment, as will be discussed below. This may be reflective of burnout meaning different things, or presenting in different ways, for the AMIC workers and midwives. Burnout will be discussed at length in the following chapter.

Similarly, three of the five ward midwives shared similar opinions to these two program midwives, attributing negative views of AMIC workers to a poor work ethic. Discourses around laziness arose, along with not fulfilling work duties on the ward. Some insights were given by senior program midwives into reasons why AMIC workers may not feel comfortable working on the ward, which demonstrate another potential misunderstanding of ward midwives in relation to AMIC workers' work ethic. This is explored further in the next chapter. Ward Midwife1 spoke about *'some of the midwives on the ward [who] have had that negative image of the AMIC worker'* because of instances when they have been *'called and didn't come in.'* In relation to the discussion around AMIC workers not coming in to work when called in for a birth by a ward midwife (possibly because they know it is not a requirement of their role), tensions between ward midwives and AMIC workers were mentioned. This ward midwife believes that following such circumstances, the AMIC workers tend to *'avoid that situation where they might be confronted by the midwife that rung them.'* She also suggested that when called in after hours for a birth, *'probably 80% of the time they don't come in'* and that while she was *'not saying all of them do [this]'* it is *'only certain AMIC workers that are unreliable.'* She believes it is the newer AMIC workers who are more unreliable than those who have been there for some time. A further negative perception of AMIC workers' work ethic was expressed by Ward Midwife3 who believed that sometimes *'the AMIC workers could be a little bit more driven'*, and followed this observation with the justification that *'that's coming from a midwife that's quite passionate about what I do.'* This comment makes the

assumption that AMIC workers are less passionate about their job than the ward midwives, which is a generalisation that may give insight into some opinions held by other hospital staff. It also fails to account for cultural norms in expressing self as a worker, and by not recognising alternative ways of expressing passion, Ward Midwife3 is making judgements on what constitutes motivation. It also makes the assumption that the AMIC workers are able to find the same level of energy or drive as midwives without considering aspects of their lives that may impede these expectations.

Ward Midwife5 avoided making generalisations about work ethic of AMIC workers by stating that *'as with all people AMIC workers are terribly different, different personalities.'* She then went on to say that *'there are some of them that I would want there all the time. There are others that you call and they can't be bothered coming in, so at the end of the day you don't bother with them really.'* In such instances, this ward midwife described how she has *'been a bit cross'* but *'only because their patients want them and they haven't come and those girls are relying on them.'* While she spoke of one AMIC worker in terms of laziness, *'I always knew she was lazy'*, she described instances of when calling in an AMIC worker for a birth, when the AMIC worker has asked to be notified of their client's labour and pending birth, the AMIC workers answer the phone and say *"nah, I'm too tired" and hang up and won't come.'* Ward Midwife5 said that this had happened *'a couple of times.'* This discourse around laziness extended to AMIC workers not working on the ward:

*... they can see that the ward is busy, you know you would think that their own common sense would go "hey I'd better go out and look after our girls at least", but they don't.*

The use of words *'their own common sense'* suggests there are expectations on the ward to commit to certain tasks without being asked and makes the assumption that the AMIC workers feel comfortable in doing so, are not making compromises and that work on the ward is more important than other things they may be doing. In many ways this statement is prioritising the needs of the ward over the program.

The issue of training and appropriateness of skill sets was alluded to by AMIC4 who described how she believes people external to the program *'think that I'm there because I'm an enrolled nurse.'* This touches on the concern that despite attempts of accepting and including AMIC workers within the hospital environment, they do not fit the criteria of the embedded ideal worker expectations, which in this case are those with nursing qualifications. This dominance of clinical skills was described in the chapter on medicalisation, and helps to explain what an ideal worker is in this medically dominated environment. AMIC4 goes on to describe how because of her qualifications as an enrolled nurse these people believe that she *'should be there'* but they question *'what these other girls [...] are doing.'* Because of the system's embedded hierarchy, staff external to the program believe that other AMIC workers *'are only health workers.'* She goes on to describe that *'there is a thing about what health workers can do and what health workers can't do'* further illuminating what an ideal worker in this environment is considered to be by others.

As discussed in the following chapter, other obligations or circumstances are often the reason for AMIC workers not meeting these expectations, highlighting that discourses around laziness mostly stem from limited understandings. Ward Midwife4 gave a different perspective as to why AMIC workers may avoid the ward. She believes that *'staff members on the ward sometimes have a bit of attitude that they know best'* which may create quite an intimidating workplace for the AMIC workers. This understanding was further supported by Ward Midwife3 who stated that *'there are a few midwives that they might be scared to approach'* and stated that *'you probably would be scared of them'* offering an understanding that they may not be the most approachable women. However, she does believe that *'if you sat them down and just explained the situation ... they would be understanding'* and that *'they probably don't even realise that they come across like that or do that, but they do.'* This again suggests that a lack of understanding from both parties may be one reason why such issues arise.

In-depth understandings of situations can therefore assist in overcoming potential causes of misunderstandings. Program Midwife5 demonstrated one instance of this in her discussion around what constitutes poor work ethic. She appreciates the

complexities of the AMIC workers' lives and incorporates insights gained over time. This midwife described a situation that could be misunderstood as laziness by people with limited insight. She believes that her role as a midwife in the program is to complement the AMIC workers and to pick up any of the pieces that the AMIC workers are unable to. She described this as sometimes meaning she does not need to do much concerning a client's care and management, but in other situations it may mean she does most of it. She perceived her role to be standing back and supporting the AMIC worker in their role as much as possible. This midwife appreciated that the AMIC workers need to be the ones leading the care, because without them women would not access the program. She considered them to be at the core of the program, rather than just a link to community, which she stated is the view of some. Program Midwife5's appreciation of the AMIC workers and understanding of the constant variability involved in the program and AMIC workers' lives is illustrated clearly in the following extract:

*I think we'd always think your first commitment was really to the women that you're looking after. But in this model of care your first commitment really is to that AMIC worker so that they can deliver that care, and that you would pick up the pieces that the AMIC worker couldn't do. Which will never be the same and I think that's what people find hard to come to terms with, that it's not the same. But it just depends on the AMIC worker and the woman every time. So that AMIC worker might work really well for, with that woman, but the next time it might not go so well. So it's not predictable.*

This also touches on the reality that there are different rules on how to deal with each situation and client, and as such there is a large degree of variability that requires flexibility from both the AMIC worker and midwife. It also demonstrates the difficulty others have working in this way, as it varies from the structured expectations inherent in the medical model and in the ideal worker construct. As such, some midwives misunderstand situations previously described as AMIC workers not working to their full capacity.

Program Midwife5 also demonstrated, through another example, how what can be viewed by some midwives as AMIC workers being lazy or just not showing up, are



usually avoidance behaviours resulting from situations that AMIC workers do not feel comfortable working in. The situations may involve cultural protocols or relate to community issues that the midwives are not aware of. Avoidance or withdrawal behaviours are what this midwife describes as being common in such instances. These situations may be misinterpreted, with negative connotations, by other midwives or staff members who do not possess the appropriate level of cultural knowledge or insight into relevant complexities to understand the situation:

*I think sometimes we do expect them to do things that we don't realise until after might have been quite compromising. And then they'll just deal with it by not turning up, or not going, or leaving.*

This clearly describes an awareness of the complexities and potential compromises that the AMIC workers may be dealing with which are often invisible to others in the work environment. This raises the point of needing to remain flexible to the AMIC workers' needs and understanding when expectations of them may be unrealistic and compromising. It also suggests some warning signs of when AMIC workers may be dealing with difficult situations.

Furthermore, this deeper insight into the private lives of AMIC workers and the ways in which this may impact upon their ability to adhere to the ideal worker construct were demonstrated by two of the more senior ward midwives. As put by Ward Midwife4:

*... in the scheme of things [the things AMIC workers need to improve on] are things that are sometimes out of their control. And that's probably sick leave ... or just not turning up for their day and not letting anyone know. So sometimes communication is a problem and it's due to the fact, if you nut it out, it's due to the fact that they didn't, that they just couldn't ring because there wasn't enough credit on their phone to ring, or there wasn't fuel in the car to get here ... you know it's all those external things that really they or I don't have much control over.*

Additionally, Ward Midwife<sup>2</sup> described how as a non-Aboriginal person she *'doesn't know the half of what happens in Aboriginal society'* and that often misunderstandings and assumptions occur because of this lack of insight. She also made comment on how AMIC workers *'can't be all things to all people'* which means *'the chances are they are not always going to be around.'* This again touches on the extensive obligations the AMIC workers have that extend beyond the role specified by the healthcare system, and the aspects of their role that are invisible to the system.

Another potential reason for midwives misinterpreting AMIC workers as being uncommitted to their work was around low life expectancies and the effect this may have on the priority they give to work. Program Midwife<sup>5</sup> spoke about the reality of low life expectancies for Aboriginal people and how AMIC workers are not separate from this. She referred to the way in which one AMIC worker talks about life expectancy and how she relates these statistics to her own life.

*You know, they're in their forties those women, and the chances of them being alive in fifteen years time are significantly less than mine or you know ... no wonder they have that sense of ... you know maybe work isn't that important or you know that you don't, you're not really going to ... that expectation that you're going to get sick and you're probably not going to live for a long time. Well we expect; I expect I'm probably not going to get sick, and that I will live for many years yet. That's what I expect to happen. Where when you talk to those women, they ... it's ... I don't know if you've ever heard [AMIC1] do this talk about where she talks about the statistics and says ... 'you know that's a graph, and you know who is on that graph, my grandson, and my mother, and my father, you know that's who these people are. They're not just numbers really.*

Not only does this extract give a reason why AMIC workers may not always seem committed to their work, particularly in terms of an ideal worker expectation, but it also highlights the difference between the lives of the midwives and the AMIC workers. It is these differences that may well be the reason for many of the misunderstandings that result between workers within this environment. As alluded to, life expectancy is not something that Western people are generally concerned about for themselves, therefore it seems logical that it is not something the program midwives would necessarily realise the AMIC workers would think about. As I

highlighted earlier, one midwife could see how similar the AMIC workers lives are to their clients and as such, she may also share a similar understanding around AMIC workers identifying with the discourse around lower life expectancies. This illuminates the diverse realities of the AMIC workers lives and how they are bound by complex situations and issues. These aspects need to be better understood (without adopting a deficit model) for the AMIC workers to be better appreciated and supported within their role.

***Unrealistic expectations of the workplace***

The issue of the inappropriateness of inherent expectations the hospital system has on the ways in which people work, was also raised. Ward Midwife2 described how because of expectations the system has about certain health professional roles, AMIC workers are often put *'in a situation where they have to try to do three things'* which she suspects is *'hard, and there is a lot of compromise.'* She also spoke about this in the context of the system preventing individuals from having a voice in aspects of their work that are not considered relevant. As such, Ward Midwife2 discussed the way in which AMIC workers need to make compromises to meet the needs of the health system, which can be extremely difficult. She followed on to say that while this is likely a challenge for the AMIC workers she hopes *'that they're not worn down and they can rise to that challenge.'*

Medical Practitioner1 believed *'a good AMIC worker is someone who takes responsibility, number one, is present all of the time and makes that connection with the patient, the rapport with the patient.'* They also believe that they *'do that bridging between you and them, not stand aside and just watch.'* These comments are drawing on this participant's expectations of an 'ideal AMIC worker' as someone who creates the link between medical practitioner and client, and someone who is *'practically involved in [the client's] welfare.'* Practical welfare was described as *'bringing [clients] to hospital and making sure they go with them to Adelaide and you now practically be that support, not just watching them.'* The frequency of the discourse of AMIC workers *'not just standing there'* and *'watching them'* touches on the expectation that the AMIC workers should be seen to be actively involved in client care, which may be a Westernised view of how to most appropriately work with clients. Furthermore, Medical Practitioner1 spoke about how AMIC workers should

conduct themselves in theatre. They described the need for AMIC workers to *'learn when to stay away from things, because in the beginning they didn't know and they touched things and the theatre staff didn't like that.'* While this discourse describes expectations of an 'ideal AMIC worker', Medical Practitioner1 also acknowledged that *'everybody needs to be told what to do, and then [you] can expect things from them.'* This highlights the recognition that this expectation is not unique for AMIC workers.

Additionally, issues around the inappropriateness of and difficulties associated with working within such a structured environment were also touched on by two of the ward midwives. These discourses offered another perspective for understanding the dissonance between the ideal worker construct and the ability of both the AMIC workers and midwives to fulfil this role. Ward Midwife4 acknowledged that *'Aboriginal clients have different needs than non-Aboriginal clients and ... as a health service and also as a business'* that needs to be identified. As a result, she believed that for AMIC workers to do their work well, they sometimes *'actually require a different ... set of rules working with us.'* As such, she described how it has been:

*... a long road to engage Aboriginal Maternal Infant Care Workers as trainees into a predominantly white environment that is structured right to the point um ... where sick leave is controlled and things like that.*

Ward Midwife4 explained how it had been *'very trying at times'* because of the many *'workplace or external things that impede on the normal structure of the workplace that we ...'* have no control over. Furthermore, AMIC1 discussed the difficulties in working within a system *'that doesn't fully understand or appreciate what it's like to work with a disadvantaged group.'* She described how *'having to combat, um fight ... with um ... people that just don't get it or ... people that just don't want to know'* is the one reason she has experienced feelings of not wanting to be an AMIC worker. This is an example of emotional labour that will be described in-depth in the following chapter. The inflexibility of the system with all of the:

*... red tape of you know, working in, for a big, you know organisation like Country Health SA. I find sometimes um ... you know, it's fairly, some of the things that you*

*want to do are quite common sense by you know, the tape, I guess the red tape and all of the things you need to go through to get that approved sometimes is disheartening.*

Ward Midwife4 believed that there is a certain '*amount of trust*' that needs to be established and maintained with the AMIC workers in regards to use of cars as well as '*in the use of their quality time and confidentiality*' with respect to '*documents and machinery and things like that.*' This may also be suggesting that the system needs to adapt to allow AMIC workers to work in a different way, which is atypical to the everyday working of the ward. She also stated that:

*I let them manage their time management themselves and their work schedule because I trust them enough that they know what they're doing, I don't need to be involved.*

This discourse around trust suggests it is important that other staff trust AMIC workers and that their different way of working is effective in meeting the needs of their clients, but not necessarily the needs of the ward. Ward Midwife4 also acknowledged that the AMIC workers have '*taught us a lot*' particularly around the importance of relationships, highlighting the benefit in what may be considered a new way of working (or at least suggesting there is an understood benefit in focusing on and appreciating the importance of good relationships). These extracts clearly demonstrate this ward midwife's understanding of, and appreciation for, AMIC workers with suggestions of a misfit of the ideal worker expectation for these women.

A discourse around AMIC workers taking '*an incredible amount of sick leave*' emerged from midwife interviews, which was named by senior Program Midwife3 as being one of the difficulties she has with working with the AMIC workers. Despite this, she demonstrated a deeper understanding around why AMIC workers take sick leave than other midwives, stating that it is a reflection of '*the chaotic lives that they lead*' and is not necessarily something that is within their control. The reference to chaotic in this context relates to the challenges the AMIC workers face in their personal lives as a result of the many obligations they have to family, community and culture.

No person's work life can exist in complete isolation from his or her private life and in the case of the AMIC workers; I would suggest that this separation is even more difficult. Issues within the workplace for the AMIC workers when aspects of their private lives (including culture) are unknown or misunderstood by their colleagues. In such instances the dangers of negative stereotyping and discourses, and the potential for subsequent conflict are very real. With a greater understanding of the complexities of both the AMIC workers' and clients' lives, I suggest many of the things midwives discuss as being problematic to the program and working with AMIC workers can be overcome.

**Emotional attachment and labour**

In the following chapter I argue that discussions regarding the concept of blurring the boundaries, in the context of AMIC workers, refers to the overlap or merging of the private and public spheres of life. Program midwives expressed mixed views around AMIC workers blurring these boundaries with some perceiving it as a challenge AMIC worker's inevitably face, while others viewed it as being a negative aspect of working with AMIC workers. I argue that this negativity stems from the inherent expectations of the ideal worker construct.

As will be described at length, the difficulties associated with maintaining separate spheres for the AMIC workers include obligations to family, friends and culture. Three program midwives specifically spoke about the difficulties they perceive AMIC workers have in separating their private and public spheres. It was recognised by Program Midwife2 that in some cases these difficulties arise because AMIC workers have relationships with clients outside of work, and when an issue arises the AMIC workers tend to take the issues home with them. Program Midwife6 further supported this claim and said that these relationships often make the notion of separating *'family life and work life'* very *'tricky'* for the AMIC workers.

This extends to aspects of the private sphere influencing upon the ability of AMIC workers to fulfil the expectations of the ideal worker within the public sphere. As put by Program Midwife4, aspects of the AMIC workers' private spheres are *'interrupting their work life.'* To understand some of the complexities that the AMIC workers are dealing with in their private lives, Program Midwives2 and 5 both

discussed the extensive family obligations AMIC workers have. Program Midwife5 described how the tragic death of an AMIC worker's sister left her with the obligation of caring for her sister's young children. In light of this situation it is obvious that aspects of AMIC workers' home life would impact upon their role as an AMIC worker, especially in such traumatic events. Despite this, Program Midwife4 believes 'most' AMIC workers 'don't have big issues' at home, which she feels is similar to the program midwives. Yet, she concludes that 'burnout is probably more about the home life' which is an interesting alternate view to the burnout literature.

To add to examples of AMIC workers' significant obligations to and involvement with family and extended family, Program Midwife2 discussed the impact of looking after other people's children:

*Like they've always got other children in their homes, you know. Looking after someone else's babies. Um ... and I know that one of the girls just recently was, like she's had other family members in the house that have got babies, and so lack of sleep was huge for her.*

Although this example illustrates that this midwife was aware of what was going on in the AMIC worker's life, I would argue that this is not always the case and is largely dependent upon relationships and the amount of trust established. It is important to be mindful that in instances where meaningful relationships between co-workers have not been established, insight into the complexities the AMIC workers may be dealing with, along with the compromises they consequently make, are less likely to exist. As such, other staff within the hospital environment may not have an understanding as to why the AMIC workers do not fit the expectations of the ideal worker.

Despite this, there are noted limitations on what information about their private lives is disclosed to program midwives by AMIC workers, even when a meaningful relationship has been well established. Program Midwife5 discussed the 'nature' of Aboriginal women's lives and how although she considers herself to have a deep understanding of many issues facing AMIC workers and long standing relationships with many of them, there are still boundaries put in place by AMIC workers around when they disclose information to program midwives:

*... I think if you work with Aboriginal women, naturally their lives, not naturally, but a fact of their life is that there are going to be a lot of things going on. And so, I always felt close to them, and like we shared things, quite intimate kinds of stuff, gutsy life kind of stuff, but never past five o'clock at night.*

Through this passage it becomes evident that AMIC workers are able to create boundaries for themselves around the information they disclose and when, however it is in contrast to the boundaries expected within the ideal worker construct. This suggests that while the AMIC workers may feel safe discussing aspects of their private lives with the program midwives during official work hours, this does not extend past these times. This is also supported by Program Midwife5 describing how despite having asked AMIC workers to her home 'a lot of times' for different social occasions, 'they would never come.' She stated that 'we never crossed that line' and that 'there was never that crossing over of family and professional life.'

An understanding of the influence cultural responsibility and obligation has on AMIC workers and their ability to maintain boundaries between their private and public spheres was also touched on by program midwives. It may be that AMIC workers identify more strongly with their role within the community than their role within the hospital system. As put by Program Midwife3, there is 'this underlying fear of retribution, of cultural retribution if anything goes wrong, even if it's not their fault.' This clearly demonstrates that while boundaries may be maintained for the AMIC workers between themselves and the hospital system, when other obligations are involved there are no boundaries. As a program midwife working in partnership with AMIC workers, it is therefore important, as explained by Program Midwife3, that midwives have a deep understanding of other aspects of the AMIC workers lives that may be affecting them.

*... I think as well they've got to maintain their place within their community. Um ... and I know that they do have this um... this great fear of payback if anything happens within a pregnancy and birth and what have you. So yeah, yeah, you've constantly just got to have this um knowledge that ... you know ... that there's other things going on.*



Interestingly, when discussing these issues around boundaries, all three of these midwives made comparisons between AMIC workers and midwives. Program Midwife2 described how midwives are often able to leave problems at work whereas AMIC workers take them home with them. In another section of the interview Program Midwife6 also spoke about how during training midwives and nurses learn strategies on how to detach themselves from work, and how this may be a useful strategy for AMIC workers to engage in. She also acknowledged that in some situations a difference between AMIC workers and midwives was that AMIC workers may not want to or cannot, detach from a particular situation.

*... they can't get away from it. You know we go home and have our cup of tea. Where if they've got family in the project and they all know where they live, they can just come around and.... So I think that would be something that... or if something went wrong and, you know who's to know what's going to happen.*

From a Westernised perspective, this situation highlights the differences between midwives and AMIC workers, with midwives being able to disconnect themselves from work more easily than AMIC workers. It also demonstrates that despite instances of wanting to separate themselves from work, personal connections between AMIC workers and clients may make respite from being contacted outside of hours difficult. Program Midwife2 acknowledged that issues associated with the difficulty of separating spheres may be dangerous for the AMIC workers. As such, she explained that if something goes wrong between the AMIC worker and client within the private setting there is no knowing what the result may be:

*... she tells me that people knock on her door at eleven o'clock at night um you know with various problems that she's dealt with throughout the week, you just ... it's scary really. Like you just, it's sad.*

In contrast, Medical Practitioner1 offers a perspective on what an ideal worker looks like within this context. She describes the need for AMIC workers to disconnect themselves from their personal lives when at work, indicating that this is a sign of being dedicated to their paid employment, which in some ways takes precedence over other aspects of their lives:

*Some people are more dedicated to their work, some people are not that dedicated in their work. So you cannot put everybody in the same story, how much they are dedicated. But that's where some of the problems come in, so that AMIC worker may tell on me, or something. We cannot generalise but I think that we need to give AMIC workers that importance and tell them that they are special and "you are above, you have to rise above personal things, because you are in a position now" you know, "you have been chosen to do a different work, and you need to leave behind your family because if they [...] belong to a different group, if you're not comfortable don't make that connection, someone else can do it."*

This is making the claim that an 'ideal AMIC worker' is someone that is above the rest of their community, and by fulfilling their role within the health service in the way deemed most appropriate they will avoid the conflicts and associated difficulties that AMIC workers otherwise experience.

As raised in other chapters, instances of conflict relating to the AMIC workers' private lives or cultural and family obligations, also contribute to the misfit of the ideal worker construct and the AMIC workers' ability to separate their private and public spheres of life. Furthermore, there are enormous pressures on the AMIC workers to act in certain ways to adhere to the ideal worker construct, which are unrealistic.

### **Confidentiality**

The issue of confidentiality, particularly tied to the blurring of boundaries was a further issue raised by some program midwives. Again I argue that these issues arise because of external pressures from family and community that the AMIC workers are faced with. It must be noted that culturally, the rules AMIC workers are bound to in their official position in the mainstream often compromises their position in community. That is, the AMIC worker may have a cultural obligation to share information about a client or a client's family with others outside of the program, however because of their role in the mainstream they are bound to confidentiality protocols that prevent them from doing so. This compromise and the ways in which it may affect the AMIC worker's ability to perform within their role, and their social and emotional wellbeing, needs to be considered by others in the workplace, and

understood as another reason why the ideal worker construct is inappropriate in this context. Despite confidentiality rules being beneficial in many cases, I believe the program and its management need to have some level of understanding around what the confidentiality protocol means to AMIC workers. Perhaps there should be some specific supports built into the program to assist AMIC workers in dealing with issues that may compromise either their role as an AMIC worker or as a member of community. Confidentiality will be discussed in-depth in the emotional labour chapter, and the difficulty in adhering to the ideal worker construct realised.

### **Emotional Attachment**

It makes sense to understand many instances of blurring the boundaries as a consequence of emotional attachment. Although not all of the program midwives articulated it in this way, there were some who understood that the emotional attachment and commitment AMIC workers have to their clients is a reason why it can be difficult for them to detach from their paid work after hours. Program Midwife3 summarised this, appreciating that detaching from clients is a difficult thing for AMIC workers and may not even be something they want to do:

*... because they know all of these girls, and some of them, you know they call them Aunty and stuff, so whether they are sort of biologically Aunty/s or not, within the community they are seen as Aunties. Um... so I think yeah, um... they can't detach that way. Apart from probably not wanting to, and not knowing how to, I think they're just... it's all so entwined. That it would be very hard to, to do that.*

This passage highlights the extent of the relationships AMIC workers have with their clients. It also touches on the obligations some AMIC workers have to community members, with mention of the cultural title 'Aunty' that well respected or more distant relations (than what you would usually find in Western culture) are given. Also of interest here is that despite the midwives' ideal of being able to detach from such situations to prevent tiredness and the flow on effect from that, she believed that detaching may not necessarily be something that AMIC workers are interested in or know how to do. Her use of the word 'entwined' is very fitting, reflecting not only the AMIC workers relationships with their clients but also the co-existence of their two spheres.

Although most midwives of the program shared this view of AMIC workers having some form of attachment to their clients and community, Program Midwife4 had a slightly different perspective. Although this midwife demonstrated an understanding of some of the complexities that AMIC workers face in their work, the depth of her understanding appeared limited. As such, she understood that while AMIC workers *'take a lot on board'* they are *'professional about it, so they leave it at work.'* This reflects a notion of the ideal worker, whereby to be considered professional clear boundaries must be maintained.

Furthermore, Program Midwife6 mentioned this notion of professionalism and briefly describes what it means to maintain *'a little bit of professionalism in your job.'* To her it meant that you should not be too emotionally involved, for the sake of both the AMIC worker and her clients. She believed that if the AMIC workers do become too emotionally involved in outcomes *'it won't work out for the [clients]'* and the AMIC workers will be more likely to experience *'burnout.'*

#### **What is an 'ideal AMIC worker'?**

It is clearly evident from the interview data that there is misfit between the ideal worker construct and the reality of the AMIC worker role. The expectations that the ideal worker will maintain clear boundaries between their private and public spheres, along with remaining fully committed to the needs of the employing service, are undoubtedly both inappropriate and unuseful in terms of the role of the AMIC workers. As such, examples of what the 'ideal AMIC worker' may look like were suggested by a number of the AMIC workers, and offer a constructive perspective of how systems may better support and acknowledge the role.

Being able to separate work from home for the purpose of preventing burnout, rather than adhering to the expectations of the ideal worker construct, were alluded to by four of the six AMIC workers. There was some variation in perspectives, whereby two of the AMIC workers felt they were able to successfully separate themselves from work. AMIC1 acknowledged that while she tries to maintain *'separateness'* between spheres, she *'wouldn't say that all of the AMIC workers might work like that.'* She employs this strategy because she claims that she *'need[s] to work like that to look after [her] self.'* Similarly, AMIC4 stated that *'work is work, home is my*

*family*' and believes that this extends to times when she is on leave from work.

AMIC4 was the only AMIC worker that spoke about the effects of maintaining this separation whilst on leave, which is discussed in the Emotional Labour chapter. The main exception to the rule of the benefits of being able to separate spheres was that it is important to maintain the capacity of helping clients, family or friends who they feel obliged to help out of hours. This is also discussed in the Emotional Labour chapter, and is the one contradiction that the AMIC workers commonly made.

Medical Practitioner2 alluded to what an ideal environment that is supportive of AMIC workers may be. This practitioner described how one of the positive '*spill-over effects*' of the program was a cultural change within the maternity ward that it has been instrumental in:

*... it has brought a lot more flexibility to how we approach non-Aboriginal women as well. So really the Anangu Bibi has been a lead point in a whole cultural change for a maternity service that is very rural, very traditional, very dominated by doctors, and very process driven to a much more modern maternity service that includes a lot of trainees and young practitioners coming in that is much more attuned to the lives of Aboriginal women and how hard they are, and meeting their needs in pregnancy and childbirth and afterwards, and also providing a more inclusive holistic service that has a stronger relationship with the AMIC workers and with the midwives.*

This highlights that an ideal work environment that better encompasses the needs of clients and AMIC workers is different to a traditional midwifery service. Although other discourses that have emerged from the data do not indicate that the work environment is overly supportive of the program or AMIC workers, it is interesting that this participant believed they have seen this change. Additionally, I would argue that throughout their interview Medical Practitioner2 demonstrated a great level of insight and appreciation of the AMIC worker role and the challenges and systemic barriers they face in their daily work and lives. As such, Medical Practitioner2 gave a description of what they perceive as an 'ideal AMIC worker' in a program that is viewed as '*a more modern, multidisciplinary, multi-people building trust, which is in some ways more complex [than traditional midwifery], but is more actually more sustainable and more valuable in the long term*':

*... so I would see that a mother and her baby and her pregnancy at the centre of it, with strong Aboriginal input from the AMIC workers, a lot of psycho social and emotional understanding of the situation of mothers and sometimes being privy to information that the rest of us don't need to know so they can actually provide information about directions that we should be taking, and secondly so they can assist mothers to absorb and to be alongside them to re-discuss things so they can make good decisions.*

Furthermore, an 'ideal AMIC worker' could be described as someone who can address the needs of their clients, which may not be directly related to the medical aspects of their maternity care. The importance of understanding the other needs of clients, and clients' expectations that AMIC workers will also address some of these, is discussed in-depth throughout the thesis.

Another important aspect of the AMIC worker role, as considered by all AMIC workers, is that Aboriginal culture is always respected and dealt with appropriately. In the context of what an 'ideal AMIC worker' may look like, through the interview data it was suggested that it is someone that is able to work according to their own culture and cultural knowledge, whilst remaining respectful to differences between cultural groups and understanding that cultural appropriateness is largely transferrable across groups.

The most prominent discourse that arose from the AMIC worker interviews, which is related to an ideal work environment for AMIC workers, was some aspects of the hospital environment that allow AMIC workers to provide culturally appropriate care to clients. This was considered to be incredibly important to the AMIC workers and out of the ordinary for a mainstream organisation. Four main points were raised regarding dealing with culture within this setting, including allowing clients to take their placenta back to country after the birth of their child, smoking ceremonies within the hospital following the death of a patient, sensitivity around who is involved when it is 'women's business' and the hospital's employment of Nunkaries (traditional doctors).

The frequency in which many of the AMIC workers made mention of the importance of taking the placenta back to country after the birth of a child, along with their gratitude of being able to assist with this traditional practice signified a positive aspect of the service the organisation allows the AMIC workers to provide to their clients. It was made obvious through interviews with the AMIC workers that this practice is not common within mainstream organisations. Not only were the AMIC workers proud of being able to assist their clients with this practice, but also of giving clients the option of doing so (many of the young women who give birth at this hospital today are disconnected from their traditional culture and therefore do not engage in this practice):

*AMIC5: [The clients] can have their placenta after they've given birth to the baby and everything. And take it and bury it you know on country. Take it back and bury it, and that's their special spot ... but that's up to them if they want to do that.*

Throughout the interviews it became clear that this particular tradition exists across Aboriginal groups and is therefore important to many Aboriginal people. Providing clients with the option of taking their placenta back to country is a practical way the organisation is supportive of cultural needs.

Furthermore allowing traditional smoking ceremonies to be carried out within the hospital, following the death of an Aboriginal person, is another way the system supports the needs of some Aboriginal people, creating an environment clients and their families feel more comfortable in. The openness and flexibility of this hospital to conduct such ceremonies was touched on by several AMIC workers:

*AMIC3: So if a baby had passed away in the hospital, [Elders have] got the ability here to do the smoking ceremony.*

Smoking ceremonies are conducted by one of the Nunkaries employed by the hospital in the aim of cleansing the space. There have been many cases of Aboriginal people choosing not to access the services of this hospital after a death, however by conducting smoking ceremonies some hospital avoidance is overcome. One AMIC worker commented on the uniqueness of this hospital in allowing these traditional

practices and how despite *'it not work[ing] in every hospital [...] it works here in Port Augusta.'*

Another common discourse that emerged in relation to an ideal work environment, was around the program's ability to ensure 'women's business' is respected. Women's business in the maternal and infant health context relates to anything involved with a women's pregnancy and birth, and is an area that men are traditionally not allowed to be part of. In many instances, it is highly disrespectful for men to know about or be a part of anything related to the pregnancy and birth. For some women, this includes male doctors, which AMIC1 described:

*... respecting women's business. Like, um making sure that um that if she doesn't want a male doctor that she doesn't get a male doctor.*

Furthermore, the AMIC workers spoke about their satisfaction of having the choice of being able to engage a female obstetrician with their clients. For AMIC1 this was an important way of maintaining cultural sensitivity to clients within a mainstream health organisation:

*I mean that's part of our role of advocating you know, so it means, it's so great that we have a choice now and we can organise her to get in to see [Medical Practitioner] because you know, she wants a woman doctor. So that, that's one way of combating [being insensitive to women's business].*

Knowing your own limitations in knowledge about different Aboriginal cultures and when another AMIC worker is more appropriate was named as one factor that is important to being a good AMIC worker. As such, AMIC3 discussed this in the context of the importance of being from and understanding country and culture:

*I'm not really from this country and I don't like to take the traditional girls because you know I can't really work with them the best, because I don't know their language group. Because each group has kind of got their own ceremonial stuff, you know. I thought it would be better off if you get one of the workers from here to work with them.*



All of the AMIC workers spoke about this as an important strategy that they all try to maintain to remain respectful of individual clients' culture and needs. It highlights the diversity of clients that they work with and the need for them to remain flexible in the ways they work with each client. Being able to effectively communicate, advocate and be the cultural broker for a client, was alluded to by all AMIC workers and an example of it is demonstrated clearly in the following extract by AMIC6:

*... I can understand and talk a bit of Pitjantjatjara language, so when they go in there you know, I can advocate, well I did before, advocate for the midwife, cause there was one girl that was in there, she was from um... she was from up the lands, and she had no support whatsoever. So she was in there, poor girl, and um... she had the midwife in there and there was no communication happening with them. So, she asked if I could go in, and the girls said yeah that's ok, but she is very shy and very traditional. So you know, you're there telling her in language what the midwife is saying, so you're communicating. So just that cultural broker stuff.*

This passage also highlights the role of the AMIC worker in also advocating for the midwife, who may find it challenging dealing with clients from more remote locations that in this context often have more complex cultural needs. Most significantly though, it demonstrates the importance of understanding client needs, language, advocating, and being the cultural broker. As already mentioned, prioritising the individual needs of their clients, are considered important by all AMIC workers. AMIC4 discussed this in terms of being an 'urban Aboriginal' and how she felt this affects her perspectives around respecting differences in women's understandings and associated needs around women's business. For example, she stated that '*if the girls want their partners there, and the partners are willing to help the girls, the partners know why I am there and there is no shame business. I'm happy to [be there].*' This is touching on the topic of women's business traditionally being something that only women are involved in, and how more recently it is not uncommon for women to want their male partners to be present for the birth. AMIC4 again, demonstrated how it is the AMIC worker's role to follow the clients' desires, '*It's up to the girl, if she didn't want me there I wouldn't go there.*' However, there are many clients who maintain strong cultural practices around women's business, and so this is one aspect of the AMIC role that requires AMIC workers to remain flexible to the needs of each client. Furthermore, one example was spoken about whereby a past AMIC worker

(who is no longer employed in the program) was described as being a very 'traditional' woman who did not accept client's wishes of having their male partners present during the birth. This caused some dissonance within the program.

Similarly, Medical Practitioner2 made comment of what an ideal cross-cultural worker is:

*... when you are working across cultures sometimes you need to know what you need to know and you don't need to know everything and you shouldn't so it actually helps us to be much more culturally appropriate and appropriate with vulnerable people and respecting their privacy without barging in on things which Western culture is inclined to do.*

This highlights the importance of and the need to respect the cultural aspects of the AMIC worker role. It also describes what an 'ideal non-Aboriginal worker' should be.

### **Conclusion**

An 'ideal AMIC worker' may be argued to be someone that is able to work flexibly according to their own culture and cultural knowledge, respond to the needs of clients (which may not be medical), and to advocate for both the model and their clients.

There are many cultural and individual differences between AMIC workers, which highlights the importance of having AMIC workers employed within the program who have varying skill sets and experiences in relation to culture and clients' needs. It also negates the assumption that an ideal worker 'has one size that fits all', and raises the point that an ideal work environment may require a number of ideal workers who bring different 'ideal characteristics' to best negotiate that environment. Despite this, there are some cultural protocols that all of the AMIC workers follow and understand to be important. This can perhaps be generalised for all Aboriginal populations in Australia. For example, AMIC3 described that all AMIC workers understand that 'you DO NOT go and see an Aboriginal family when they've just had a death in their family.' Therefore, AMIC workers who are able to adhere to the diverse needs of their clients appropriately, without being obstructed by the pressures of the health service to act in a certain way, challenge the usefulness of the existing ideal worker construct that is so deeply embedded within this mainstream hospital system.

## CHAPTER 5: EMOTIONAL LABOUR

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Emotional Labour is a concept developed by Hochschild (1983) over 30 years ago from her study relating to service workers (including flight attendants and debt collectors) and their use of emotion-based skills when dealing with clients in the workplace. She defined emotional labour as the process of expecting workers to induce or suppress feelings in accordance with the rules and guidelines specified by the organisation (Hochschild, 1983). The concept has since been adapted to other areas (predominantly the health sector) and drawn on other factors that may influence or be related to emotional labour (including identity). The implications for understanding emotional labour and its potential positive and negative consequences are important for not only sustaining individual wellbeing, but also for developing strategies to improve workplaces by accommodating the needs of workers. This concept is particularly relevant to AMIC workers, as the literature demonstrates that emotional labour is closely related to obligatory community labour (known to affect Aboriginal health workers), and negative consequences of both of these phenomena include emotional exhaustion (which has been suggested to lead to burnout) (Williams, 2003).

In order to achieve emotional regulation, Hochschild (1983) argued that two types of acting are involved in emotional labour. Surface acting involves the person managing their expression of behaviour, in that they present their non-verbal cues in a way that is deemed appropriate for the context and that only they know they are acting. Simply put, surface acting relates to someone's outward behaviour. Contrary to this, deep acting involves the actor attempting to experience the emotion that they feel they are required to display. Hochschild (1979) described two ways in which deep acting can be achieved, the first 'exhorting feeling' - that is the ability to evoke or suppress an emotion actively, and the second 'trained imagination' - the ability to invoke thoughts, emotions and memories to provoke the appropriate emotion. Hence, deep acting can be understood to affect one's inner feelings as a result of a strong concern for customers or clients (Ashforth & Humphrey, 1993), and in this sense it is arguably not acting but authentic engagement.

Ashforth and Humphrey (1993) contributed to the ways in which emotional labour is understood by arguing for the importance of social and personal identities. They drew on social identity theory and suggested that the ways in which a person identifies with their role will influence how they are affected by emotional labour. For example, if someone identifies strongly with their role they will experience less negative effects on wellbeing (a negative consequence of emotional labour) and stronger positive effects (Ashforth & Humphrey, 1993). Furthermore, it is argued that emotional labour creates both internal (psychological) and external (organisational) pressures for the individual to identify with their service role (Ashforth & Humphrey, 1993), which may be related to the pressures associated with adhering to expectations of the ideal worker. These pressures can be overcome by various behavioural and cognitive defence mechanisms (Ashforth & Humphrey, 1993). However, the emotional risk associated with identifying with one's role may be that the perceived successes and failures in the role directly affect one's wellbeing (Ashforth & Humphrey, 1993). I argue that this is of relevance to AMIC workers.

A more recent definition of emotional labour has been offered by Brotheridge and Lee (2003), which focuses on expectations around appropriate emotional displays. Emotional labour has been defined as the effort of employees to 'regulate their emotional display in an attempt to meet organisationally-based expectations specific to their roles' (Brotheridge & Lee, 2003, p. 365). The expectations of the organisation indicate what the appropriate expression of emotions are for different contexts and can be specified formally or informally (National Aboriginal Community Controlled Health Organisation, 2013). When these expectations are not met by the required emotional display, emotional dissonance occurs and leads to emotional labour (National Aboriginal Community Controlled Health Organisation, 2013). As such, containing emotions in the workplace is related to fulfilling expectations of the ideal worker.

Williams (2003) noted that the duration and intensity of emotional labour can be altered through the autonomy and authority afforded to some occupational roles (such as doctors). This is not the case for Aboriginal health workers, because their role is to provide more in-depth and continual care for clients. However (Jin & Guy, 2009, p. 91) described that emotional labour may mediate job performance and that:

*... there is evidence that it [emotional labour] increases job satisfaction, security and self-esteem; increases pride in work; feelings of psychological well-being; task effectiveness; and a greater sense of community. In fact, worker autonomy influences the exercise of emotion work. In other words, in service work, individual performance is enhanced when workers perceive that they control the affective dimension of their jobs, rather than being dictated to by a set of employer-imposed display rules.*

Butler's notion of performativity and ambivalence are also helpful in understanding these concepts around emotional labour. Butler described performativity as '...that reiterative power of discourse to produces the phenomena that it regulates and constrains' (Butler, 1993, p.2). She argued that performativity involves a performance of gender roles and identities that are constructed or reconstructed within dominant discourses (1990). Through performative acts (types of authoritative speech) and associated manners, identity is revealed. Butler stressed that performativity is not voluntaristic; there are powerful discourses that regulate and constrain, and performative acts are enabled and reinforced by laws, institutions or societal norms.

Despite being dependent on reiterative performance, social norms and institutions are also open to disruption (Lovell, 2003) and can become ambivalent. Felluga (2006) explains that for Butler the distinction between the personal and the political, and public and private spheres of life are fictional and merely maintain an oppressive status quo. In the context of emotional labour this suggests that 'appropriate' emotional displays and discourses are reiterated by the institutions and social norms that have created them. Furthermore, if boundaries between different spheres of life do not exist, separating emotions from them is impossible.

Within this study the concept of performativity is therefore useful in interpreting the experiences and understandings of AMIC workers, especially in understanding their authentic engagement and in revealing ambivalence and subjective understandings of dominant medical and managerial discourses, policies and practices.

This may be relevant to AMIC workers when they feel a sense of autonomy and belonging within their work role. However, when considering the effect of existing

hierarchies and associated power relations (as described earlier in the Medicalisation Chapter) it is more likely that emotional labour is a source of exhaustion than a productive job performance mediator.

### **Emotional labour within the health-care setting**

The literature on emotional labour has received considerable attention within healthcare settings, particularly nursing, because of its significance to both the people delivering and receiving the healthcare (Pisaniello, Winefield, & Delfabbro, 2012). Nurses have been found to manage their emotions according to the needs of their patients in a number of caring settings (Mann, 2005), and understand it to be an important part of their nursing role in making patients feel ‘safe’, ‘comfortable’ and ‘at home’ (Smith & Gray, 2001). Because of the vast array of settings in which a nurse may work, it has been found that a nurse’s ability to manage emotion is of great importance (Mann, 2005). Emotional labour within this context has been described as the ‘almost invisible bond that the nurse cultivates with the patient’ and many nurses felt that their emotional labour performance even helps the patient to manage disclosures of an emotional nature (Smith & Gray, 2000 p. 41). The importance of emotional labour within the healthcare setting is therefore important to the patient journey. Despite expectations that organisations, nurses, and patients have about the ways in which nurses express their emotions, in the cases where nurses are unable to display the emotion deemed appropriate for the setting they may experience emotional dissonance. Dissonance in this context is not merely detachment, but rather a spill over of deep acting and being affected by the emotional content of the job.

Mann (2005) recognised the implications of having further understanding of what emotional labour means for the health-care sector, with specific interests in the associated benefits and costs for the carer and the patient. Based on existing research, a healthcare model of emotional labour emerged. This model differentiates between the types of emotional conflict that could surface as a result of events within the healthcare setting. It was suggested that ‘emotional dissonance’ and ‘emotional harmony’ are the two types of emotional conflict that nurses typically experience. I argue that ‘emotional harmony’ is an interesting term, as it suggests that everything is well when it is not necessarily the case. Emotional dissonance is described as the emotional management required when nurses ‘must suppress instinctive emotions

such as disgust, annoyance or frustration from the patient (and replace them with emotional displays that convey caring and concern)' (Mann, 2005) . On the other hand emotional harmony refers to situations when nurses 'instinctively identify with and feel for a patient's suffering and must manage their emotions so as to be detached enough to carry out their role' (Mann, 2005, p. 309) . These different emotional conflicts influence the different types of emotional labour performances of nurses, with emotional dissonance resulting in the suppression of inappropriate emotions (and replacement with appropriate emotions) or the suppression of unwanted emotions (and replacement with wanted emotions) (Mann, 2005) . Although the same type of emotional labour is a product of these performances, the consequences of each could differ. Further, emotional harmony leads to masking felt emotions rather than replacing them with others, which is thought to produce negative outcomes (Mann, 2005). Negative outcomes of emotional dissonance in this context include burnout and low self-esteem, with positive outcomes potentially including personal engagement with the patient, a better relationship and enhanced patient experience.

Mann (2005) suggests further research needs to be conducted to obtain an understanding of the negative outcomes of emotional harmony, but has suggested that detachment, objectivity, rationality and emotional protection are all negative outcomes of this emotional conflict. It must be noted that the skills required to deal with emotional labour are not adequately taught within health-care education (Gray, 2009; Mann, 2005), perhaps contributing to the likelihood that they will experience the negative effects of emotional labour.

#### **Implications for Aboriginal Health Workers**

There is limited literature on emotional labour for Aboriginal health workers in Australia. Williams (2003) is a prominent contributor, focusing specifically on components of emotional labour for Aboriginal health workers in different locations across South Australia. She suggests that in this context, emotional labour is linked to 'values of care, reciprocity and respect, and obligations to carry out cultural practices in terms of Aboriginal identity' (Williams, 2003, p. 32). Williams attributed Aboriginal health workers' common experience of grief to the wider experiences Aboriginal people have of poor health. On this basis, the associated emotions are described as an example of the complexity of emotional experiences of Aboriginal

health workers. Poor health and work histories of Aboriginal primary healthcare workers are also factors that Williams found to increase the likelihood that they will experience burnout. Furthermore, (Williams, 2003) demonstrated that it is difficult for Aboriginal health workers to adopt emotional neutrality to overcome the negative effects of these emotions.

Obligatory community labour is a concept that emerged from conversations Williams had with an Aboriginal interviewer, which applies the concept of emotional labour to situations facing Aboriginal people. Obligatory community labour in this context is specific to a person who identifies strongly with being Aboriginal or a part of the Aboriginal community and who has a responsibility for looking after family and community both during and after their official work hours (Williams, 2003).

Aboriginal people tend not to make distinctions between work they do with family and communities and work they do that is 'paid' or 'voluntary' (Williams, 2003), and as such are at risk of being over worked. It is evident that in the context of Aboriginal community and identity, obligatory community labour is also related to the concept of the ideal worker.

### **Burnout**

The concept of burnout has gained much interest since the mid-1970s within the field of stress research. Burnout is commonly understood to be a psychological syndrome resulting from chronic interpersonal stressors experienced at work (Maslach, Schaufeli, & Leiter, 2001). Schaufeli and Enzmann (2006, p. 36) described burnout more comprehensively through the following definition:

*Burnout is a persistent, negative, work-related state of mind in 'normal' individuals that is primarily characterised by exhaustion, which is accompanied by distress, a sense of reduced effectiveness, decreased motivation, and the development of dysfunctional attitudes and behaviours at work. This psychological condition develops gradually but may remain unnoticed for a long time for the individual involved. It results from a misfit between intentions and reality at the job. Often burnout is self-perpetuating because of inadequate coping strategies that are associated with the syndrome.*



The term emerged from the United States where it predominantly focused on people working in human services and education, in particular in jobs where the relationship between the provider and the recipient was central. The approach to burnout during this period was primarily concerned with an individual's 'relational transactions' in the workplace. In the 1990s the conceptualisation of the term extended beyond professions in human services and education to include occupations involving less intensive interactions with people (e.g. clerical and computer technology).

Burnout is multifaceted and defined by three recognised dimensions including emotional exhaustion, depersonalisation and a reduced level of personal accomplishments (Maslach, 1982). Emotional exhaustion has been considered one of the most important of these three dimensions. It refers to a depletion of emotional resources and lack of energy for one's work, and is the most widely reported within the burnout literature (Maslach et al., 2001). Emotional exhaustion relates to the stress aspect of burnout, but does not account for the relational facet of work.

Depersonalisation (also known as cynicism and disengagement) refers to instances when attempts are made to distance oneself from different aspects of the job and negative attitudes towards both people and their performance are adopted (Halbesleben & Buckley, 2004). It occurs in response to the emotional exhaustion experienced at work (Maslach et al., 2001). A reduced level of personal accomplishment (or inefficacy) refers to one's decreased perception of their ability to perform well on the job. It is self-evaluated and includes feelings of incompetence, lack of achievement and lack of productivity (Maslach et al., 2001). This dimension of burnout has been suggested to arise from a lack of resources rather than from having a direct relationship with either emotional exhaustion or depersonalisation (Maslach et al., 2001).

There are a number of different factors that influence whether and when burnout occurs. These are widely known as situational, and include job, occupational and organisational characteristics (Maslach et al., 2001), highlighting it as a very individualistic concept. When considering job characteristics, it is thought that a common response to work overload (that is too much work needing to be undertaken within pressured time frames) is burnout. Work overload has been found as being strongly related to the emotional exhaustion dimension of burnout. A high to

moderate correlation with burnout has also been found for both role conflict and role ambiguity. Role conflict takes place when there is a need to meet conflicting demands of the job. Whereas, role ambiguity arises from a lack of information required to perform a job well. Job demands, such as the severity of clients' problems, are another characteristic that have been found in some instances to be correlated with burnout.

Following the work of Maslach (1982), Leiter (1993) conducted research with healthcare workers and identified a number of factors that contribute to high job demand, which is understood to lead to emotional exhaustion and then depersonalisation. Leiter found that quantitative job demands (including work overload and hassles), qualitative job demands (including interpersonal conflict), as well as a lack of resources (including lack of social support, poor patient cooperation, lack of autonomy, and poor participation in decision making) influence the process of burnout (Leiter, 1993). Figure 1 shows the relationship between these identified factors.

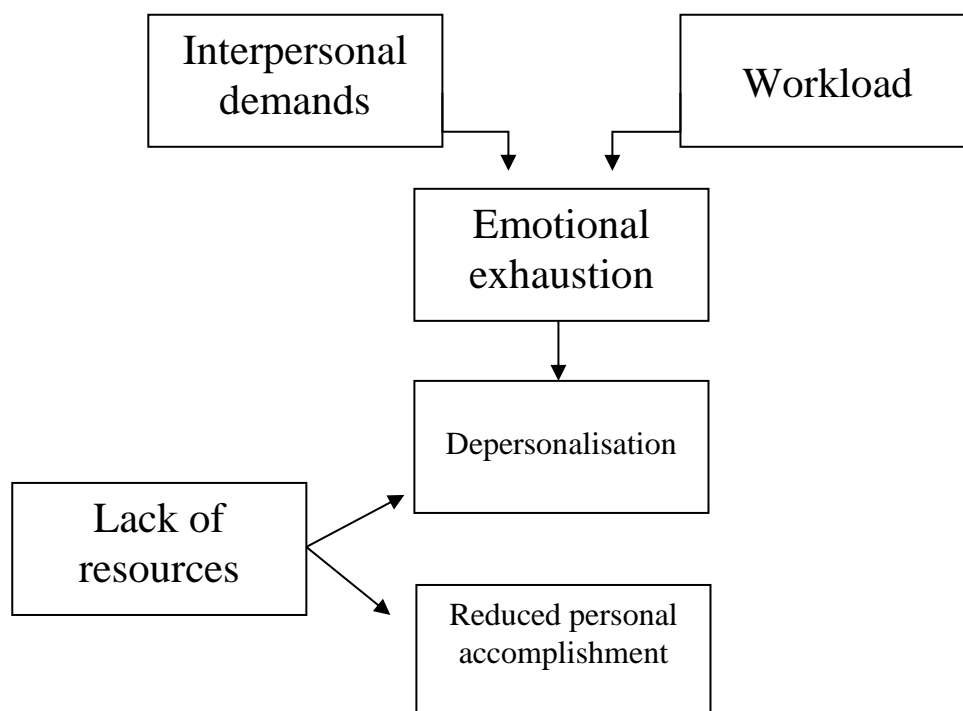


Figure 1: Leiter's process model of burnout (Leiter, 1993)

Reciprocity exists when both parties investments and outcomes of a relationship are in proportion (Adams, 1965). On an individual level it has been described as the case

when investments are equal to outcomes (Pritchard, 1969). Psychological distress resulting from a lack of reciprocity forms the basis of equity theory (Walster, Walster & Berscheid, 1978), from which it has been suggested may lead to burnout for people working in human services professions (Buunk & Schaufeli, 1993). Schaufeli (1999) developed a dual model (see Figure 2) in which a lack of reciprocity, at both the interpersonal and organisational levels, is proposed as a cause of burnout (Schaufeli et al. 1999; Schaufelie, Van Dierendonck, & Van Gorp, 1996).

In the health context, a lack of reciprocity refers to an unbalanced relationship between the healthcare professional who gives the care, and the client who receives the care. At the organisation level, it relates to the violation of the expectation employees have of an appropriate workload, esteem and dignity at work, as well as support from colleagues. Therefore, individual perceptions of reciprocity influence expectations of what are proportionate gains and investments, in relation to the organisation. When there is dissonance between these expectations, reciprocity is unbalanced and diminishes. This may lead to withdrawal from the organisation, including reduced commitment to the organisation, turnover and absenteeism. It may also lead to burnout (*ibid*). Schaufeli et al. (1996) tested this dual model (see Figure 2) successfully with two samples of nursing students.

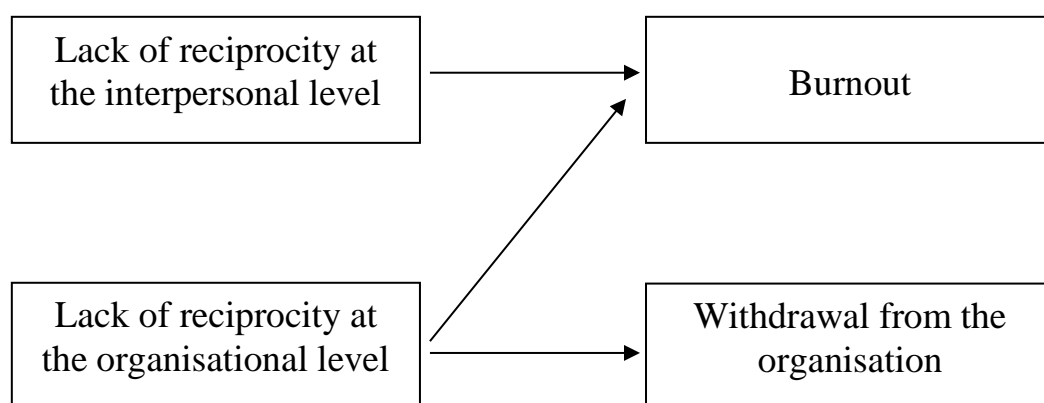


Figure 2: The dual-level social exchange model of burnout (Schaufeli et al., 1996)

Furthermore, a cross-cultural study demonstrated that burnout is correlated more strongly with a lack of support than with the perceived importance of support (Pines, Ben-Ari, Utasi, & Larson, 2002). There is also some evidence to suggest that social

support acts as a buffer against burnout. That is, where there is a high perception of social support, a weaker relationship to burnout will be found. Additionally, a lack of feedback, minimal participation in decision making and a lack of autonomy have all been found to be related to burnout (to different degrees).

Although it seems likely that the wider context of an organisation would be a factor influencing burnout, research has predominantly focused on the effect of the direct work context. Hierarchies, operating rules, resources and space distribution are all aspects of the larger work context and are influenced by particular social, cultural and economic powers. An understanding of how these factors interact with or impact upon an individual worker would be beneficial, particularly for workers engaged in cross-cultural work. These external factors are particularly important for Aboriginal health workers, when considering the negative impact of institutional and structural racism (which will be discussed in more detail below).

While it is recognised that burnout is related most strongly to situational factors, some individual factors have been demonstrated to have an influence. Most commonly, demographics and personality characteristics, along with job attitudes have been found to be related to burnout (Maslach et al., 2001).

When considering what demographic characteristics are related to burnout, age and formal education are the most predominant. A consistent finding within the literature is that a younger age (less than 30-40) is associated with burnout. As suggested by Maslach et al. (2001) age is confounded with work experience, it is likely that burnout is a risk factor early in one's career. Another common finding within burnout research is that a formal education (that is a higher level of education) is associated with higher levels of burnout than a lower level of education. In addition, sex has been found to be a predictor of burnout in some studies. A common finding has been that men score higher on cynicism (depersonalisation) than women, and that women score higher on emotional exhaustion than men. Gender occupational and role stereotypes may be an influential factor within these cases (for example a man in a managerial position, and woman as a nurse).

More recently, in a study looking at burnout in maternal healthcare workers in sub-Saharan Africa, it was found that as the number of children they had increased so did aspects of the personal accomplishment dimension (Thorsen, Tharp, & Meguid, 2011). A similar finding was found in earlier research that focused on burnout in nurse midwives (Cole Beaver, Sharp, & Cotsonis, 1986).

Personality characteristics that have been found to be associated with burnout include low levels of hardiness, an external locus of control, poor self-esteem and an avoidant coping style. It has been suggested that a combination of these factors makes up the characteristics of a stress-prone person (Semmer, 2003). The construct of hardiness or 'hardy personality' was put forward by Kobasa and Puccetti (1983), and concisely described by Garossa, Moreno-Jimenez, Liang and Gonzalez (2008, p. 419) 'as a distinctive and active way in understanding a person's relation with others, with goals, and with problems.' It is thought to reduce the negative effects of stress predominantly by two main characteristics including perceiving events more optimistically (Allfred and Smith, 1989; Wiebe, 1991 as cited in Gordon, 1977) and using specific coping strategies (Westman, 1990; William et al., 1992 as cited in Garossa et al. 2008). In one study, hardiness was found to explain a third of the variance in burnout in nurses (DePew, Gordon, Yoder & Goodwin, 1999). An external locus of control, that is attributing events and achievements to things other than oneself, has also been found to be related to burnout. Additionally, people experiencing burnout were found to cope with stressful situations in a passive, defensive way. Research on coping styles has found a consistent relationship with burnout.

### **Racism in the workplace**

Experiences of racism have been found to be significantly associated with poor mental health outcomes (Paradies, 2007) and to increase levels of emotional exhaustion (Maslach, Jackson, & Leiter, 1996). Williams (2003) also found racism to be a factor influencing emotional exhaustion for Aboriginal workers in South Australia.

Racism is a form of discrimination enacted through social processes of exclusion, oppression or marginalisation because of someone's membership to a socially defined

racial group (Krieger, 2001; McDonald, 2004; Paradies & Cunningham, 2012). Significantly more experiences of racism have been found for Aboriginal Australians as opposed to non-Aboriginal Australians (Paradies, 2007). Racist attitudes towards Aboriginal people are known to exist within Australian health services (McDonald, 2004) and are a legacy of racist ideologies formed during the colonisation of Australia. Institutional and structural racism is manifested in the policies, laws and practices that govern the country's dominant organisational systems. Inherent within these systems are cultural assumptions and advantages to the dominant group, while disadvantaging others (McDonald, 2004). Institutional racism in Australian health services includes a 'lack of interpreting services in regions where English is spoken as a second language, failure to fund cultural awareness programs for Western health professionals working in Aboriginal communities, failure to give priority to preventative health programs in Australia, and failure of policy makers to incorporate health programs into community development and self-determination frameworks' (McDonald, 2004, p. 259).

### **Avoiding burnout**

#### **Organisational Factors**

It is important to assess aspects of the work environment and job conditions that cause stress prior to designing appropriate stress interventions (Murphy, 1999). As such, Murphy described three necessary steps to achieving appropriate interventions to prevent burnout within organisations. Worker involvement was named as the first important protective organisational factor against burnout. Workers' desire to be involved with, along with actual involvement with, decision making processes is related to higher job satisfaction, greater autonomy, and improved organisational effectiveness (Murphy, 1999). Secondly, a commitment from management is also an important organisational intervention to prevent stress. Thirdly, a supportive organisational culture that promotes and reinforces interventions against stress is important. It is understood to be an outcome of good management commitment and recognises that culture is often slow to change (Murphy, 1999).

The facilitation of a supportive team culture through the provision of appropriate support methods was suggested by Dollard et al. (1999) as one way support could be

increased to Aboriginal health workers. Furthermore, Dollard et al. (1999) recommended that Aboriginal health workers be provided with regular opportunities to network with other Aboriginal health workers. This was suggested as being a particularly important support mechanism for Aboriginal health workers working in mainstream health services, as well as those working in rural and remote locations.

One way of dealing with issues of cultural isolation, including instances of institutional racism and prejudice, as suggested by Dollard et al. (1999) was to introduce cultural awareness training to all staff working with Aboriginal health workers. This was recommended to improve cross-cultural understandings and to increase support from supervisors, which is known to improve the effectiveness of teamwork.

Such factors include obligatory community labour, and has been found to be the most common reason for Aboriginal health workers in the Northern Territory leaving their jobs (Josif & Elderton, 1992). Furthermore, Dollard et al. (1999) suggested appropriate support mechanisms be put in place for Aboriginal health workers to protect them against the effects of negative client interaction (within both their private and public lives). In their report, Josif and Elderton (1992) recommended that by offering flexibility with employment processes, along with recognising Aboriginal health workers' beliefs and opinions, particularly in decision making, the number of stresses facing these workers would be reduced.

Furthermore, it was acknowledged that Aboriginal health workers deal with a high incidence of grief and loss. As such, appropriate counselling and debriefing services for Aboriginal health workers, both at work and also in a private setting (e.g. a counselling service) was recommended. In organisations where these services exist, they should be more widely promoted to Aboriginal health workers (Dollard et al., 1999). Additionally, Josif and Elderton (1992) recommended that organisations are understanding of Aboriginal health workers requirement of bereavement leave, and are supportive of their community and cultural requirements and responsibilities.

Both emotional labour and obligatory community labour can lead to emotional exhaustion, to which experiences of racism also contribute. Emotional exhaustion has

been argued to be the first stage of burnout. In-depth analyses into how these factors play out for AMIC workers will potentially suggest ways in which they can be protected from the negative consequences of emotional and obligatory community labour.

### **Analyses**

The AMIC workers frequently engage in emotional labour. Their cultural identity brings meaning to the role and enhances the emotional attachment they have with clients. The emotional labour they engage in is wide-ranging and extends beyond their official work hours. It also goes beyond professional boundaries of the public working sphere and can include obligatory community labour. The consequences of extensive emotional labour for AMIC workers include a difficulty in separating themselves from their work, instances of experiencing very negative effects of community backlash when something goes wrong, and the impact of this on one's mental wellbeing (including anxiety and depression) as a result of repeated exposure to stressful situations that are not dealt with appropriately in the workplace. Such instances are commonly referred to as burnout by the AMIC workers. While emotional engagement and attachment with clients is seen as a positive aspect of the *Anangu Bibi Birthing Program*, it is the manner in which the system recognises, or fails to recognise, the importance of this, along with how to best support the AMIC workers, that can be detrimental to them. As such, the following analyses demonstrate how the intensity and types of emotional labour undertaken by the AMIC workers challenges their ability to adhere to the ideal worker construct.

The data suggests there are a number of factors that contribute to emotional exhaustion among AMIC workers that are unique to this role in the program. These factors are complex and do not exist in isolation from each other. One of the common themes that frequently emerged is identifying as an Aboriginal person, which highlights the importance of Aboriginality for both the AMIC workers and their clients. Their narratives demonstrate that having an Aboriginal identity is at the core of the AMIC role, and the way an AMIC worker perceives their identity along with how they are perceived in the community, influences the way they engage with their role both during and out of their official work hours. As such, AMIC workers identify strongly with their clients and community, and while this can be a source of pride,



when negative events occur in the community, it can also contribute to experiences of stress and burnout. The following extract demonstrates this in direct relation to burnout:

*AMIC1: I think it does affect us more so. Because you know, it's because it is clients, the clients that we are looking after are us. You know, like part of our community. Part of who we are. So um, I think it affects us even more so, because when we don't, I guess when we don't succeed, or when there is a negative, or something happens, it really hits us because it's you know, it's part of us.*

The strength of the relationships AMIC workers have with clients and community would be constructed differently for each individual based on personal experiences. While I cannot speculate on how each AMIC worker identifies with their clients and the community, I can make comment on how important these relationships are to them. As demonstrated by AMIC1, the significance of these relationships are based on being Aboriginal women living similar lives, and being part of a close collective identity held by AMIC workers. This is something that other people in the work environment can never fully appreciate:

*AMIC1: ... it's the connection, it's the relationship. And only we can have a relationship. Only an Aboriginal woman can have a really good relationship with an Aboriginal woman. You know, and I'm not saying that's always the case, but the majority of times, it's because we live our lives no differently. Um, but also um, I mean you hope as AMIC workers we don't carry all that baggage, that you know we might be working with particular clients about, because some of the clients we work with are, sorry to say, very dysfunctional. And, but I think it's just that cultural understanding, you know, our way of thinking, just our whole way of life is so similar. So we can relate to them. You know. I don't know. That's kind of the only way I can really explain it. Whereas a midwife or a doctor or a GP or whoever, they've got no idea.*

Additionally, AMIC workers' identification with and subsequent understanding of the lives of their clients may be a factor that enhances the nature of the relationships they form and maintain with them. The following extract demonstrates the difficult lives of both the AMIC workers and clients, and how the AMIC workers have become good role models for young Aboriginal women in the community:

*AMIC1: I think because lots of us have backgrounds um that are very similar to maybe the clients that we've looked after, and we have fought our way out of those situations and become health professionals and been recognised as such, and I think we as AMIC workers are very resilient, because we have come through those trials. And who better to role model and teach these new ones that are coming up, these new mothers and, you know, young women who need our help. We've been there, done that.*

Furthermore, AMIC1 described how *'some of the AMIC workers they come from a lot of family problems or things like that, and you know they may have partners that haven't treated them very well.'* This is a situation clients also deal with, which was commented on frequently by participants of the study. AMIC3 also made comment on the difficulties the AMIC workers have faced, or continue to face in their lives because they are Aboriginal:

*Most of our life has been hard so we've learnt from a young age [...] just to keep going with it, 'cause if you just stop well that's when it all seems to fall apart. So just keep going with it and then talk through, I think you need to talk to somebody and not bottle it up.*

While these examples highlight sources of emotional labour that are associated with complex social situations, it was also noted that clients' perceptions of how Aboriginal the AMIC workers are affected their acceptance as AMIC workers and the relationships that they form. While AMIC3 described how it is *'hard for me'* because she comes from interstate and doesn't have any *'Aboriginal family over here'*, her main challenge is that *'no one thinks I'm Aboriginal.'* In contrast, AMIC4 discussed this concept of Aboriginality and how she has had experiences of being chosen by clients over other AMIC workers *'because I was the blackest.'* (Williams, 2003) found this to be a common experience and source of emotional labour for Aboriginal workers in South Australia.

### **Emotional attachment**

The significance of relationships developed between AMIC workers and their clients impacts upon the extent of emotional attachment that is developed between them. Analysis of both the AMIC worker and clients' narratives highlights the distinct,

complex, and ongoing character of emotional attachment and how such relationships shape the role and practices of these workers. Examples of this attachment are described by both AMIC workers and clients.

Many of the AMIC workers spoke about the attachments that they develop with their clients and how much happiness and satisfaction they get from their relationships and being part of their clients' journey:

*AMIC6: It's just you feel like it's a, you know a part of your family, so that when the girl delivers that's the best part, because it brings so much joy and you feel as though, you know, you've been a part of it.*

Furthermore, AMIC4 spoke about it being quite difficult to 'let them go' at the end of their time in the program, also highlighting the attachments AMIC workers establish with their clients:

*AMIC4: I think when you get to know the girls, you know, and yeah get that little sister big sister relationship happening, yeah... it's... I start missing the girls after a while.*

The extent of these relationships and the nature of the connection the AMIC workers have with their clients are highly valued and demonstrate the emotional attachment that can develop between the two. The AMIC workers discussed how after a client leaves the program it is very common for her to return to the ward to see the AMIC team and to 'show off' her baby. AMIC4 briefly touched on the specialness of her relationship with one of her clients:

*I've even had a baby that was named after me and I still babysit it.*

AMIC1 touched on the relationships she establishes with clients, and named the healthy outcomes that are achieved for her clients and their babies as being the best things about being an AMIC worker. This again highlights how AMIC workers investment in their relationships with clients has an impact on them emotionally:

*AMIC1: ... looking after that young girl and having her say thank you very much for looking after me and seeing her again even the next year, and the year after and the year after, because they want to show you photos of how big their baby's grown. Or you know, send you photos or just that connection with the woman. That relationship. I think that that's just unbelievable. You can't measure that. And, um, holding that fat healthy baby that's over 2,500 grams.*

The expression of emotional attachment was also demonstrated through reference to special forms of support offered to clients by the AMIC workers, including emotional support. Three examples from the data particularly stand out. For one client, this support also took the form of calming her down when she was flown to Adelaide with medical complications. This client described this situation as being frightening she was *'freaking out'* about the seriousness of going into very premature labour and being sent to Adelaide for specialist care. The same client spoke about receiving help with her depression from both the AMIC worker and program midwife, after the loss of a close family member. She described this period as being *'a really tough time'* and believes that *'if it wasn't for them I would have, I probably wouldn't have had him, probably wouldn't have been able to cope with it.'*

Another client, Client11, who was pregnant at the time of our interview, said that one of the best things about having her AMIC worker is that:

*She is there all of the time. Even if you just ring her out of the blue, she always takes time to listen to you.*

It would seem that these different forms of support strengthen the relationship developed between the AMIC workers and their clients. In this instance the constant availability of the AMIC worker was an important factor in the relationship.

*AMIC6: ... if a girl's got no support you know we are willing to go in, like us AMIC workers [...]. 'Cause I was the cultural broker there, and just made her feel a little bit comfortable and relaxed that oh well you know, there's an Aboriginal lady here ...*

As demonstrated in the above extract, being Aboriginal women is important to the client-AMIC worker relationship, because there is a mutual understanding of cultural

needs. Exploring other possible reasons for the development of this unique relationship, involving Aboriginal women caring for Aboriginal women, includes the types of issues which clients felt they were able to discuss with their AMIC workers. Often these discussions were only had with their AMIC workers, as they were around issues that the client may have felt embarrassed or otherwise uncomfortable talking about with other professionals. One client stated that her AMIC worker was *'really good [...] you can talk to her about anything [including] the way I was feeling.'* Remembering that many of these clients receive minimal social and emotional support from other people in their life, being able to disclose private information to an Aboriginal woman they could trust was valued highly. As noted by Medical Practitioner<sup>2</sup>, the relationship that is established between the AMIC worker and client is incredibly important for what information clients disclose and the types of support they are then able to receive from the AMIC workers:

*I think [the program] actually allows these women to open up and talk about a broader aspect of their lives and even just talking about it may be in one sense helpful for some women, for some women it will have little effect and for some it will actually take the lid off something that is really hard to put back in and will need a lot of therapy and counselling. I guess we would take the approach in general that while the outcomes may not be improved by those women immediately around that stuff, the process of having a place to put it and building trust with people who can hold that trust is really important. The AMIC workers themselves are an essential part of building that trust and an essential part of knowing those stories.*

This also demonstrates an understanding of the importance of the social model of health in improving outcomes for the clients of the program. AMIC<sup>3</sup> also spoke about how important establishing a *'connection with somebody that you trust'* is for clients *'especially when [they] don't have [their] family around.'* She believes the AMIC workers are the only people involved in the program that are able to offer this, and attributes it to the relationship AMIC workers develop *'from the start'* of a clients journey through to being present at the labour. Furthermore, despite having family support, Client<sup>2</sup> spoke about how she appreciated having the opportunity to talk to her AMIC worker about certain issues.

*Client2: When I'm feeling down or stressed out or whatever, I don't like talking to my family, I'd rather talk to [AMIC]. 'Cause it stresses them out and makes me worse.*

This raises another important point. It is well understood that relationships are complex and diverse for all people; however I would argue that for Aboriginal people relationships can be particularly multifaceted due to the history of colonisation and level of disadvantage seen in many communities. I believe it is an illustration of how complicated some people's lives are and how AMIC workers can be an external support to clients to help relieve any perceived burden on families.

AMIC2 also made the point that one way in which the AMIC workers' role differs to anyone else involved in the program is because *'we know these girls in the community, and we know them like to work with them, and I think that makes a difference.'* While *'we might not know every girl that comes on the program [...] we know their family, or family members [...] we know somebody.'* This clearly illustrates the point that relationships are central to the 'success' of the AMIC worker role and that they are embedded in community relationships in a distinct way, with important cultural norms and expectations surrounding them. As such, AMIC2 continued, the AMIC workers *'sit down with these people [...] sit down with their families, sit down with them in their homes'* which is not something she believes a *'midwife or nurse in the hospital'* can do. She believes that *'they would go and sit in somebody else's home or something like that'*, further highlighting the importance and extensiveness of the AMIC-client relationship and the extensiveness of the emotional labour undertaken and the need for authenticity in this. Ward Midwife1 also made comment about the importance of these relationships and how significant they are in improving client access to care:

*... perhaps [the AMIC workers] might not know where one of the girls is, but it will filter back to them that they've been staying at such and such house, you know it's a good um... white people on the ward probably don't get that information like the AMIC workers do. So it is of benefit, definitely.*

Medical Practitioner1 also acknowledged the importance of the AMIC-client relationship, and believes the AMIC role:

*... is a very positive role because they are, they know the patient much better. They go to their homes, they know their social set up, their financial set up, they know the politics around their family, they know their spouses, they know the rest of their families, they're aware of their position in society where they are, you know, so I think they are much more aware than we are of their hardships, or how can they be helped, because they are a part of that group themselves.*

While many women may develop relationships with other providers, the strength of the connection with AMIC workers is critical. Being involved with the clients' journey from the early stages of pregnancy through to eight weeks postnatal, AMIC2 described how important she understands the support of the AMIC workers is to clients. She believes that this relationship is particularly important *'when [clients] don't have [their] family around, [they] need that connection with somebody that [they] trust.'* Furthermore, observing the relationship AMIC workers establish with their clients was noted by Program Midwife1 as one of the best things about being involved in the birthing program, and *'to know that [the AMIC workers] feel good about caring for their own women, and [that] they are passionate about it too.'*

Another reason for extensive emotional investment many AMIC workers experience was given by AMIC1 who described that as an AMIC worker she feels she invests more because she is involved in maternal health and birthing, an area she highly values. Her descriptions of *'a new life growing'*, the importance of the mother who is *'carrying that baby, that new life'* and the value she places on *'this new little life who hasn't even seen the world yet'* all offer support to the claim that she is invested in maternal and infant healthcare. AMIC1 specifically describes reasons for this investment, which are reasons also shared by midwives (Ward Midwife1 describes looking after a pregnant woman as a *'huge thing'* because *'you've got the life of a mother and the life of the baby'*), explaining that as an AMIC worker she tries:

*... to teach that mother who is carrying that baby [... that] you really need to look after yourself for this reason and this reason, because it's all about the outcome of that little baby that's going to come. So it's not like you can change everything, you can't [...] I think you put so much more into it because the more women you teach, the more babies you change, the better outcomes, you know for everybody.*

This extract demonstrates that this AMIC worker is also highly invested in the wellbeing of her community, and is further reiterated in her statement that she *'think[s] people are seeing that we actually do make a big difference ... to the [...] woman's life, to that baby's life and hopefully to the community here in Port Augusta.'* Positive reinforcement for achieving good outcomes for women and their families was also spoken about by AMIC6 who is *'very proud'* when the program delivers a *'nice chumpy, healthy baby.'* It makes her *'feel as though [we've] made a difference.'* Furthermore, her investment in improving outcomes for community was demonstrated in her statements around improving Aboriginal women's uptake of antenatal care and involvement in the program, from their very early stages of pregnancy:

*... they're coming early, like we're getting some at six weeks, eight weeks, so you know, it makes you think that you're doing good and also you get your girl on the program and then we've had a girl that's been on our program three times, so three babies she has had on our program, so that's good because it makes you think, oh well we must be doing something right.*

#### **Contact made out of hours**

While the nature of the relationships formed between AMIC workers and clients of the program has been described, the extent of emotional labour the AMIC workers engage in must be explored to better understand the potential consequences. It is clear that AMIC workers engage in extensive and intensive emotional labour both during and after their official work hours.

Some AMIC workers were described by others in their working environment as going *'above and beyond'* the official expectations of their role. Client4 described how her AMIC worker attended an antenatal class with her, despite the class being held on a Saturday, during the AMIC worker's private time:

*She was always willing, I guess, to offer her services before you even had to ask for them. Like coming, setting up the appointment for the antenatal class and saying I'll come with you, and that was a Saturday morning. That was nine o'clock until one o'clock and that was her time. Yeah, her own personal time.*



The client went on to explain how this: *'show[s] that she's dedicated to her job and wants to help Aboriginal mothers and their families'*, and an understanding of the client's particular needs, in this instance, responding to the fact that the client's partner and family were unable to be there.

Furthermore, Program Midwife5 made a comment about the extensiveness of the relationships AMIC workers have with their clients. When asked what she thought makes AMIC workers feel valued by clients in their role, she stated that the relationship they have with clients and the *'feedback they get from women and their families'* was important. She went on to say that *'the value of that role'* is appreciated and understood by women and their families as *'not just a work thing.'* Program Midwife5 believes that AMIC workers *'really feel that role in their whole lives not just from eight thirty to five.'* This highlights not only the richness of the relationship, but also the lack of boundary between the private and public spheres.

The extensiveness of the emotional labour was also highlighted by AMIC workers who described being contacted outside of their official work hours by clients. AMIC6 also described how she often sees clients incidentally after hours, which is *'OK, but you know, they just expect more of you I think.'* She also explained how one client rang her at home at seven o'clock in the morning, to tell her that she was in labour, and how she rushed over to check on her only to establish the client was only in the very early stages of labour. AMIC3 recognised that the AMIC role is *'quite an emotional job,'* which was confirmed by AMIC4 who, when asked how much of her emotional self she put into her work, responded *'lots and lots.'* In one example she likened the relationship she develops with her clients as a *'little sister big sister relationship'* and consequently after the client's time in the program has come to an end, she *'start[s] missing the girls.'* This AMIC worker also described a situation where a grandmother *'rocked up on my door and told me that her granddaughter was pregnant and could I look after her.'* It was because the grandmother *'is a personal friend'* that she asked, but when the *'granddaughter had a traumatic birth'* it made this AMIC worker feel *'so sorry for that kid.'*

AMIC4 also stated that *'if you have a good rapport with community they'll always come back to you.'* This AMIC worker described a number of situations where she

has been approached in her home to assist pregnant Aboriginal women who have not yet sought medical advice. AMIC4 used this example to demonstrate why it is important to try to turn off from work at the end of the day. She continued on:

*So when they die you know, it really upsets you. So I think that you have to learn to keep work at work, even though you can take it home with you, like people knocking on your door and that. But sooner or later you have to say, I'm ... 'cause your house is your haven hey. And if you can't leave your work at work then you're heading for trouble yourself. This is the way I look at it. So I've just come to the, with me I've just always said work is work, home is my family. And yeah, I leave it at work.*

Clearly evident through this extract is the notion of how this AMIC worker acknowledges that she is emotionally affected when clients or babies pass away. Also raised, was the issue that while she understands the importance of creating barriers for herself between her private and public lives, she did not recognise the grandmother who came to her house after hours as breaking these barriers. Furthermore, another contradiction came in her statement saying that while she does not *'mind if the girls come around home, or ring me up I'll still take the time out to go see them. 'Cause some of them just need you know a friend, or, but no just leave it at work.'* Perhaps this AMIC worker does not consider being a client's friend as work. It may be an example where the AMIC worker recognises the emotional cost of this labour, has come up with a strategy for herself, but in practice understands it is very difficult to detach given the needs and nature of her clients.

AMIC4 described another instance when a fourteen year old *'came around home, like half past ten at night one night and said she was pregnant.'* She believes it is *'good'* that clients feel comfortable doing this because *'a lot of girls get shame and, so they don't want to say anything, but their mums or their nans will come and tell you, or their little boyfriends will tell.'* She would also *'rather they come knock on my door than not go to a doctor at all.'* This example demonstrates how the AMIC workers pick up the difficult work of a system that women do not feel comfortable engaging with. I argue that this is a poor solution and enables the system to avoid responsibility to change. As such, it seems the system should respect the AMIC workers ability to address something it is unable to.

AMIC1 also confirmed that while it is important to look after yourself, this can be difficult because of the relationship AMIC workers develop with their clients. When asked how much of herself emotionally she puts into her role she replied:

*Oh everything. Yep. I think sometimes too much. I think it's important that we try and look after ourselves so we are here for the long run. But um, I think we put everything into it. I think emotionally, um, I think sometimes as time goes on you get better at trying to protect yourself and that's really important. You have to do that. Um, but I think when we do work with a client um... we try and give our own.*

AMIC2 also explains how emotionally attached she gets to clients, particularly after sharing the experience of their birth. While it is *'really tiring when you have to stay up'* for the birth, *'you do it because you don't want to leave the girl'*, and because *'that girl trusts you and she wants you to be there.'* This AMIC worker also speaks of how *'you don't realise how emotionally attached you get to the girls'* and that when it comes to the labour it is a *'really emotional job'*, touching on what may be an important strategy of self-managing emotional attachment. She feels like during this time she needs to *'protect them'* and despite finding the experience *'too draining or whatever, too long [...] I'd have to stay there until the end,'* further supporting the extent of the emotional labour experienced by AMIC workers. As such, I argue that burnout is likely to be reduced if women were generally better supported by the maternity care system.

Additionally, AMIC5 explained how she believes AMIC workers *'put our whole into it [...] everything, I think when you step into this role and you get to know the reasons why you're here [...] you just put everything in it.'* This suggests that the real reasons are not attributed to having a paid job, rather working towards improved health outcomes for clients and their families. As demonstrated by (Josif & Elderton, 1992) in circumstances where Aboriginal health workers needed to take leave without pay, they were more concerned with negative social consequences of not being involved in certain cultural events than not receiving a wage. This highlights that money is not the most important aspect of life for Aboriginal workers. AMIC5 finalised this point by also stating that *'you have to sort of reserve yourself as well'* indicating the

recognition that it is important to maintain certain boundaries to protect yourself as an individual.

Some midwives alluded to instances of AMIC workers engaging in emotional labour, which although an outcome of emotional attachment, was not always spoken about in this way. Emotional labour was discussed in terms of working with dysfunctional families and women with highly complex issues. It was highlighted as being an issue in terms of the problems AMIC workers are constantly helping clients deal with, the difficulty in successfully overcoming some of these issues and the feelings of disempowerment experienced by AMIC workers when situations are not improved. The consequence of feeling emotionally and physically drained as a result of such emotional labour was again spoken about in terms of burnout. One midwife described the emotional labouring one AMIC worker engaged in as a result of an awful situation that one client was in:

*Program Midwife3: ... like within the program there's a lot of domestic violence and these girls just in these terrible relationships that they can't seem to get themselves out of. And that um ... and then they're bringing children into this relationship. And I think that's what [AMIC worker] was alluding to, that you know, after a while it just really gets to you. That you see this over and over and over again. And that um ... that these girls can't help themselves, and they really don't let you help them either. They just go back, go back to these men that beat the crap out of them.*

Through this example, it seems that emotional labouring is not always related directly to the emotional attachment an AMIC worker may have with a client. Rather, I would argue that it is about the AMIC workers strong desire to help their clients out of terrible situations that are detrimental to the health of themselves and their babies. Perhaps an AMIC worker's identity and desire to help Aboriginal women is enough to cause emotional involvement, which leads to labouring and then burnout. Although in some instances the AMIC workers may not be physically confronted or faced by clients and their issues when they are at home (or not in the work environment), it would seem that the intensity of the issues they are trying to help their clients deal with follow them constantly. In this way AMIC workers can become tired and potentially burntout.

While emotional attachment was recognised by many of the midwives as being a complex reality of the AMIC workers lives, the consequence of it was also noted. Stemming from the attachment AMIC workers have to clients who are family or who bring on them some obligation to community, there are clients (who do not necessarily fit in these categories) that have many complex issues. Program Midwife6 spoke about the attachment AMIC workers develop to these clients, which she perceives as being based predominantly on the extent of their needs, and believes that one of the many risks facing AMIC workers is in taking on *'too many complex clients at once.'* She relates this to the concept of burnout by stating *'it's going to get you eventually.'* This demonstrates that Program Midwife6 thinks about burnout in terms of being inevitable in these particular situations, rather than in a way that can be controlled or mediated for.

The strategy of setting and maintaining boundaries, as is expected within the ideal worker construct, is difficult for AMIC workers, particularly when taking into account their cultural obligations. Program Midwife5 made mention of cultural obligations being a reason why she thinks AMIC workers are *'enormously'* emotionally invested in their work and relationships with clients. She believes that *'it's like they don't know any boundaries in terms of being able to switch on and ...'* she attributes this to being *'the cultural stuff [...] I think it's that switching on and off.'* Giving a specific example of what this looks like, she describes how she often sees AMIC4 *'carting people's kids around Woolies'* in her own private time. From this discussion, Program Midwife5 concludes that:

*... the emotional investment is huge and [thinks] setting boundaries around that, culturally that is really hard.*

Despite this, AMIC4 describes how she has heard Aboriginal health workers explain that because of their role they *'always take [their] work home with [them], it follows [them] everywhere.'* This indicates that even if the AMIC workers wanted to withdraw, the relationships have a life of their own, which cannot always be controlled. However, she believes that *'you don't have to'* do this and that *'if you*

*don't draw that line then you don't have peace, you know you don't have a life other than work. And nobody works twenty-four hours a day. So you have to say no.'*

AMIC4 believes this, despite also opening her doors to clients in need after hours. Furthermore, AMIC6 described how difficult it is to maintain boundaries, and how *'it is a bit hard because I'm well known in the community and as soon as you go down to the street there are people wanting this, looking for a ride, and then I'll have to say "no, no, sorry I can't give you a ride".'* This highlights how complex this space really is, and while ideals around creating boundaries may be understood they may never truly be adopted by, or may in fact be impossible for the AMIC workers to achieve. It is a space filled with contradictions.

On the topic of confidentiality, AMIC1 expressed the difficulty she experiences when dealing with family. She described how *'it's really difficult sometimes when it's family members that you're looking after, and you can't actually tell your family [...] about things that aren't going too well.'* In such instances, she believes that *'you've just got to put on a brace face and a smile and that when you see family,'* and if they ask any questions reply *"everything's going ok" but it may not be really.'* This highlights that maintaining confidentiality means sometimes AMIC workers cannot access their usual sources of support, and can therefore be particularly challenging. AMIC1 describes this as *'probably the hardest'* aspect of being a member of the local Aboriginal community and responding to the needs of her role as an AMIC worker, particularly when the AMIC workers are *'working in an organisation where confidentiality is everything.'*

Confidentiality was raised again by AMIC1 as being a difficult protocol to manage. The difficulty, as described by AMIC1, stems from the relationships AMIC workers have with their clients. As such, *'culturally you know our, our mothers sisters are our mothers as well. And the family connections are so much stronger...'* AMIC1 uses this example to explain how as AMIC workers, it is *'really really hard to separate culture with how we work.'* She further elaborates this through one example of when *'young girls com[e] to you saying their pregnant but their mum doesn't even know. You know, and it's family.'* Additionally, she stated that:

*I've looked after clients that have um... had really sensitive things happen to them. And all you want to do is ring their mum and sit down and talk to them [...] or aunty or whoever it is and say, "look, this is what's happening, they need this extra care and everything else", but you just can't. You have to try and do that by yourself.*

Furthermore, another source of emotional labour for the AMIC workers stems from family and community conflicts outside of the program which impact upon their AMIC role. This was a dilemma described by all AMIC workers, and has emotional consequences for them. For example, AMIC4 described a situation where 'you've got to be really mindful, [...] if you go visit your girl, her family might not like you as an AMIC, might be fighting with one of your daughters and therefore they don't want you.' Situations like this were described by AMIC4 as being 'a bit hard' 'especially when the girls come in and complain about you because of your kids.' She elaborates further on this type of situation by describing a dilemma some AMIC workers were facing with their clients that was current at the time of the interview:

*... you know you pick [clients] up and they're ok. And then you get an AMIC worker you know, whose got teenage children or ... and there's a fight out in the community and then the AMIC girl, the client, comes in and says "oh I don't want her to be my AMIC worker anymore". And you know, being the other of these children you try and step back out of their lives, and it's like ... but then the [clients] come and complain about you because of your kids.*

Medical Practitioner2 spoke about the differences in obligations between Aboriginal and non-Aboriginal people, and how obligatory family labour for the AMIC workers can be a source of conflict that involves emotional labouring.

*The obligations in our non-Aboriginal society are on time and money and doing. Their obligations are often family, which can lead very easily to conflict, with the AMIC workers being in the middle.*

Additionally, conflicts in both the community and amongst family members are factors that impact upon the way the AMIC workers engage in their work emotionally.

*AMIC2: And that girl might not want to um ... she might not even want to talk to you or say anything to you. Not because it's you directly, but it's your family member in the community. And that sort of ... we've got to watch out for that. And sometimes we get girls on the program where, um ... we have to say no to that girl because of situations like that. But they still want to come on the program, but just not there with you because you're part of that family, you know.*

AMIC2 also made comment about how difficult it can be to commit to the AMIC role while adhering to cultural rules and belonging to the community at the same time. She said that it is particularly difficult when there are '*conflicts out in the community.*' She elaborates on these types of situations and how:

*... we still have to come into work the next day you know. There's no way we can ... like sometimes if something gets too difficult we might have a day off, try and sort things out with family in the community. Sometimes it might mean going to their houses and trying to sort things out with them. Just so that you can have peace of mind yourself at work you know. You know that somebody's not going to come up to the hospital and sort of ... make an idiot of you in front of everybody. Because sometimes that's what happens. You know, they come up and you know, they want to ... err ... make you shame in your workplace and things like that. So sometimes to avoid that you've got to go talk to them in their community. Um ... go to their houses, sort it out the best way you can. Um... err... it's really hard sometimes you know.*

Ward Midwife3 acknowledged the challenges facing AMIC workers in regards to family conflicts. She described how '*different families and different family connections*' could be the source of conflict, which she thinks, must be '*pretty challenging for [the AMIC workers].*'

This highlights the complexities of how conflicts in the community can impede the AMIC workers' ability to fulfil the requirements of their role within official work hours. It suggests that while an attempt is made at maintaining boundaries between the private and public spheres of life, this is particularly difficult. This AMIC worker described the pressure she felt in such situations as she tries to resolve differences outside of work so not to let them affect her during work hours. This also highlights that the AMIC workers are required to have great negotiating skills to maintain their role, showing yet another complexity of the role. AMIC2 went on to describe how the



program midwives are very supportive in such incidences where *'people wanted to come up to the hospital and argue with some of our girls'* and that she feels embarrassed when this does happen. The midwives take the AMIC workers out the back where clients and family *'can't see them.'* She describes how *'sometimes things get a bit much for us'* and there have been *'a few times [when] a few of us [AMIC workers] have gone in [...] and had a talk with our midwives, [...] a bit of tears and everything.'* AMIC2 acknowledges that while this is dealt with at work with the assistance of the program midwives, it is something that AMIC workers *'still have to deal with [...] when we get home at night.'*

#### **Recounting of sad stories of death**

A striking theme within the narratives of AMIC workers was the recounting of sad stories around death. These discussions highlight how relationships with clients and their families extend beyond the workplace and into the 'private' lives of the AMIC workers. In some ways these relationships can be perceived as lacking the boundaries assumed to be in place by the mainstream organisation. This lack of boundaries can be compounded by negative events such as a death or a negative birth outcome. For example feeling sorry for a client compounded by a personal relationship:

*AMIC4: And I think especially when you, like the grandmother that rocked up on my door and told me that her granddaughter was pregnant could I look after her. 'Cause I know the grandmother, she is a personal friend, so when the granddaughter had a traumatic birth it really just... yeah. I just really felt so sorry for that kid.*

Focusing on the impact negative events have on AMIC workers, which are more commonly experienced in Aboriginal communities, again highlights the complexities of the AMIC workers' obligations. This extract also demonstrates how AMIC workers engage in out of hours work and obligatory labour, and believe they have a responsibility that goes beyond the paid role of looking after family and other members of the Aboriginal community. As put by Program Midwife5, this obligation is extensive and often in conflict with the requirements of their AMIC role:

*... in terms of family commitments, so those um ... Aboriginal women, everyone of them that work in that program are connected to some of the sickest families in this community. So in terms of responsibility for supporting families and lots of children*

*and other people's children, to then have to make the commitment to be there at eight thirty and stay until five. That's in conflict really. Those family responsibilities are much bigger than, than what I feel to my, even my immediate family you know. It's a ... it would be difficult to do that and work a full time job.*

This obligation also stands for members of the community who are not involved with the program. In the following extract an AMIC worker discusses how she cared for a client (who was part of her extended family) who had come down from a remote area and advocated for her and her family while she was in the hospital. Not only does this demonstrate an extension of the AMIC worker outside of her AMIC role, but also shows how she felt obliged to advocate and support the client and the client's family because she was related to them. This example highlights many of the obligations and the extent of emotional labour that AMIC workers are often faced with, and also the complexities involved in having to fulfil different roles to meet the clients' needs.

*AMIC6: This is very deep, one of my cousins girl that came down from [a remote community], she wasn't on the program, but um ... we were up at the hospital and she came in and she was in labour plus she had the swine flu, and she came into the labour ward, all ready, and the obstetrician saying yep the baby's dead already, then I had to put with like you know, 'cause she was family, so it was like I had two hats on. I had to um ... you know be the health professional there, and um ... then I also had to take my hat off and put on my family hat. Because her um nanna was there, and partner, and it was so you know. And then um ... yeah, it's just mixed emotions, like you know. Yeah, so then yeah you put your hat back on and try and be the professional and health um advocate for her, because she ended up going down to Adelaide and six weeks after she died.*

Tragic situations like this are not uncommon for the AMIC workers, with many stories of death and sadness emerging from the interviews. AMIC3 described how in less than a year of being involved in the birthing program she had had 'one girl that's lost her baby. I've had another girl that's had her baby taken away from her [...] and another girl [...] whose] wounds broken down and has been broken down for four months.' AMIC3 also spoke about how difficult it was when a client died:

*... it was only like my first few weeks, and it was like my first client actually. And so that was really hard because I didn't know how to handle it. And I wasn't expecting*

*it, obviously. You know, because they were like, oh it doesn't happen very much. It happened for my first one so it was really hard. Actually, for about three or four weeks I was really down and really anxious to go see that family 'cause I thought I might have been getting blamed for it, and it was quite horrible.*

Such instances give insight into the poor state of Aboriginal health in general but also highlight the pervasive sense of grief and loss that is so often felt within Aboriginal communities. When thinking about this in relation to the AMIC workers, it is clear that they do not exist in isolation of what happens in the community and are constantly affected by the poor health and complex lives that exist for both their clients, their families and within the community. AMIC1 spoke about the common discourse of life expectancy in relation to Aboriginal health, and how to her, the statistics break down to an aunty, an uncle, a cousin, and that she also sees herself in that picture of poor life expectancy. Program Midwife1 made comment on this and how the AMIC worker have *'relatives just dropping like flies all around them all the time, in their forties and fifties and sixties.'* The high level of disadvantage impacts on the lives of clients, community members and AMIC workers on a daily basis. There are obviously a number of motivations that help drive the AMIC workers into engaging with these difficult situations, resulting in a lack of distinction around when their support is required, both as a paid worker and as a knowledgeable community member. Therefore, the AMIC workers community obligations extend beyond their paid hours of work as an AMIC worker and into their own 'voluntary' hours as a member of the Aboriginal community.

While acknowledging that the AMIC workers have obligations outside of their official role, and deal constantly with challenging and often emotionally difficult situations, it is important to highlight that this devastation also occurs within their own personal lives, in their own families. There are many examples given, primarily by program midwives, and the following example given by Program Midwife5, demonstrates the reality of such tragedies for the AMIC workers:

*[AMIC6]'s sister died in the time that we were, her um ... younger sister and left her with those three kids and a baby who was ... we looked after [AMIC6]'s sister, [Program Midwife1] and I and those girls, um in her pregnancy. And then she died before that baby was one. So ... you know we had a lot of things, a lot of um ... and I*

*think if you work with Aboriginal women, naturally their lives, not naturally, but a fact of their life is that there are going to be a lot of things going on.*

This provides further evidence of the distinct responsibilities AMIC workers have as members of families and communities, who have particular needs. With fewer older people in the community to care for the younger generations and assist with health issues, the AMIC workers find themselves fulfilling big roles both within their AMIC role and also in their private lives.

**Midwife attachment and experiences of emotional labour**

While the emotional labour AMIC workers engage with is both intensive and extensive as a result of their connections with family and community, the program midwives also spoke of the connection they feel from their role as midwives, to clients, the program and the community. Firstly, Program Midwife1 spoke of the importance of earning the respect of the AMIC workers, and how if *'you want to be in for the long haul'* you have to be prepared to make meaningful *'connections'* with people. She acknowledges that *'it takes a long time to develop relationships of trust'* but for *'Aboriginal people'* it is *'really important.'* This program midwife feels a strong sense of attachment to the *Anangu Bibi Birthing Program* and cried during the interview when considering how *'it's not just another job'* and requires individuals to *'feel really passionate about it and to want to make a difference'* to the health and wellbeing of Aboriginal women and their families. Furthermore, she described the challenges she faces as a program midwife in standing up to people who do not understand or fully appreciate the benefits of the program. The following extract highlights her deep involvement with and attachment to clients and her willingness to do things for clients that are not considered standard practice by the hospital:

*... people don't have it, you know. They don't care. And, the worst thing is to feel discarded. Or, you don't matter. You know, that's so dehumanising [pause]. And that's why we do things that people think are a bit frill less. We take photographs of their babies and give them a little album of all their beautiful babies and them, and, in the best possible light we can make it, I enjoy photography too of course, but you know. And we were able to get some extra funding just to kind of err I was, you know, through another source, just for those kind of little things, you know, that matter. That soften it [laugh] you know. That kind of make it like family [laugh], you know what I mean.*

Program Midwife5 describes the connection she feels to the local Aboriginal community. She speaks of this connection in relation to living in a small rural town whereby her '*... kids say how come you know every Aboriginal baby, don't you look after white babies? [laugh] Um ... so I think that that kind of social reward you get, feeling a bit connected to the community that you live in, I really like that.*'

Furthermore, she describes the knowledge the local Aboriginal community has of her and her family outside of work and how she finds comfort in this:

*So the women I've looked after, I know that they know my kids and they do know my kids and my car and stuff. And so I feel like we're quite safe in this community. I feel a bit like we would be a bit looked after in this community.*

Additionally, AMIC1 raised an issue that she sees as impacting upon the program midwives experiences of emotional labour. She discussed how program midwives are often '*pulled out to the ward or they're pulled out to do all these other jobs*' when the AMIC workers '*want them to ourselves.*' AMIC4 also touches on this discourse of ownership stating that '*... it's not like the program owns them now. It's like everyone owns the midwives.*' AMIC1 believes it would be '*great*' if the '*midwifery group practice*' that is often spoken about could be a reality, and the program midwives could '*only work in the model*' and '*work in this birthing program*' then:

*... I think then they would be more dedicated and more focused and you know, um not so exhausted and tired because they are doing everything else as well.*

While this demonstrates a program midwife's experience of being emotionally attached to clients and the community, and becoming worn down because of their investment in adhering to the needs of the maternity ward and birthing program, it is clearly not the same level or depth as that experienced by the AMIC workers.

#### **Structural barriers as a source of emotional labour**

Discourses around structural barriers emerged strongly from the AMIC workers, and were described as inhibiting the effectiveness of the program along with the AMIC workers sense of worth. Two of the most prominent discourses included difficulties with hierarchies and a lack of resources.

The AMIC workers commonly made negative references to the hierarchies associated with the birthing program (medical and bureaucratic), with terms such as ‘red tape’, ‘people that don’t get it’ and the ‘people who sit up stairs.’ These descriptions put an emphasis on the power afforded to these hierarchies and the feeling that they are out of reach. The use of these constructs may influence the extent of ‘othering’ between the program and management staff that is frequently alluded to by the AMIC workers.

Interestingly, despite it being management that AMIC workers seem to have the most trouble with, they do not refer to it as management, rather hierarchies and bureaucracy. AMIC3 named ‘*all of the bureaucracy that goes on*’ as the main challenge that she faces in her work, and how the messages she receives include:

*Oh “you girls can’t do this and you girls can’t do that”, oh “can you girls not do this” and “who done that” and yeah it’s like you know, you try to please everybody but you’re only here to please the girls, but you’ve got to please everyone. And sometimes it’s a bit hard to please everyone.*

Furthermore, AMIC1 named hierarchies and bureaucracies as the main challenge she faces in her work, particularly in terms of being restricted by what she can and cannot do within her role. To an extent this explains some aspects of the unpaid work that AMIC workers engage in, but also touches on the difficulties AMIC workers face in trying to care for clients within the structural boundaries of the hospital system.

*AMIC1: ... I think the worst thing for me is um... there’s so much that you want to do and you know, you know the short, you know I guess you know what you need to do to achieve it because, you know you’ve done it for so long. But it’s all the rigmarole, you know, having to go through hierarchy to ask permission and ... all of ... you know, I guess the red tape of you know, working in, for a big, you know organisation like Country Health SA. I find sometimes ... um ... you know, it’s fairly, some of the things that you want to do are quite common sense but you know, the tape, I guess the red tape and all of the things you need to go through to get that approved sometimes is disheartening.*

Ward Midwife2 also believes that while the AMIC workers ‘*have a valuable role,*’ ‘*as valuable as the midwives role*’ she has ‘*noted that they are not necessarily seen by*

*the hierarchy in the same light.* In contrast, Ward Midwife5 believes the program is 'supported by the hierarchy' and providing it receives continual support the program 'will be fine.' This demonstrates different understandings of the level of appreciation and support the *Anangu Bibi Birthing Program* is afforded by management.

Many of the AMIC workers view the hierarchies as impeding on the progress of the program, along with the quality of care they can provide and the effect this has on the health and wellbeing of their clients and families. One of the barriers AMIC1 was referring to in the above extract is access to basic resources required to facilitate a successful program. One such resource is car seats, which was touched on in the Medicalisation Chapter. I argue that having to justify the need for basic resources to a system that does not appreciate the nature of the work the AMIC workers engage in, is a source of emotional labour for the AMIC workers. Furthermore, AMIC1 also stated that it is:

*... the people that make all the decisions and that have all the money and ... um ... don't actually work within the team, don't get it.*

She also stated that:

*It's about working in a system that doesn't fully understand or appreciate what it's like to work with a disadvantaged group. You know, and having to combat um fighting with um ... people that just don't get it or ... people that just don't want to know.*

Ward Midwife2 also discusses the issues she has with bureaucracies in some depth and criticises current decision making processes:

*... an AMIC worker that is put in a bit of a compromising situation, then there might well be, well that can't happen again, you now and so a knee jerk reaction. No, we shouldn't make decisions like that. We need to discuss stuff. You know noting, because if you make a decision straight away you don't go back on it. You tend not to change it. So like, you know, all of a sudden you can't do this. But no you really need to, we should be discussing it. So a decision is made and we need to accept it, and I will often say, possibly behind my hand, well I've got an opinion about this. And like*

*no one's asked me. I don't expect to get my own way all the time, but I think that we should have a voice, and we don't have a voice. And I think the same happens with the, and it's got worse as time's gone by. And I suppose because at the moment one of my stock phrases is, bureaucracy is the only growth industry in Australia.*

This ward midwife also believes that the AMIC workers are *'in a situation where they have to try to do three things'* which she *'suspect[s] is hard, and there is a lot of compromise.'* She also *'hopes that they are not worn down and they can rise to the challenge.'* Interestingly, this participant raises the point that difficulties with management also impact upon ward midwives.

This highlights a divide between the program and ward staff and management groups. Not being consulted in regards to decisions affecting the program was another source of emotional labour for the AMIC workers, and midwives, with a top down approach having a negative influence on their sense of value. AMIC1 described how *'sometimes I think I feel valued, but other times ... I think I am actually taken advantage of.'* Furthermore, AMIC1 stated that she believes the hierarchies *'shouldn't be so quick to judge or quick to assume that they know, ... or to put people all in the one basket and think that is the way it is going to be.'* All of the groups interviewed identified a lack of staff input into decision-making as a source of angst.

#### **Discrimination as a source of emotional labour**

Experiences of discrimination were common amongst the AMIC workers and interview data demonstrates instances of emotional labouring as a consequence.

AMIC workers were found to experience a form of institutional discrimination based on their lack of acceptance by other hospital staff. Non-Aboriginal mainstream health professionals have been found to have a limited understanding of the role of Aboriginal health workers, which prevents them from engaging with important aspects of their work (Williams, 2003). A relevant situation spoken about by AMIC workers is the misconception by ward staff that the AMIC workers *'are just transport drivers'* [AMIC6]. AMIC2 also spoke about *'a few incidences [when] we were getting midwives and nurses coming up to us and saying "well she needs to be dropped off, so can you go and drop her off?" Like we were a taxi service or something.'* AMIC3 discussed this issue, and how *'because we go out in the car a lot,*



*[ward midwives have] got this mentality that we're driving around in the street because we're taking so long.* She believes that *'they seem to think that because we're gone for a few hours we're not doing the role properly'* which *'kind of gets on my nerves a bit [and] gets a bit annoying.'* In response the AMIC workers *'started digging [their] heels in.'* AMIC2 believes this situation is still occurring because *'there's not as much respect for us there as there should be.'*

AMIC2 spoke about not being recognised positively in the hospital for the work AMIC workers do. She said that she *'feels a bit of ... jealousy with some of the other midwives ... not our own midwives [but] midwives in the mainstream and ... some of the nursing staff'* which stems from a belief of midwives and nurses that *"I'm not going to listen to an AMIC worker, I've been here longer than them mob"*. AMIC2 said that although the AMIC workers *'try not to worry about'* comments like this, *'sometimes it hurts.'* Furthermore, she believes that this jealousy may also be a fear that ward midwives have, that the AMIC workers are *'there to take their job. But we're not, we're there to work with them.'* A strategy offered by this AMIC worker to overcome some of these frictions is if everyone *'work[ed] together we could make it a culturally appropriate place to give birth.'*

As such, dealing with staff on the ward was noted by this AMIC worker as one of the most significant challenges she faces as an AMIC worker. There have *'been a few incidents where I've had to stand up and say something'* to a member of ward staff to *'defend'* aspects of the AMIC worker role. AMIC2 finds this hard, and believes that the AMIC workers *'shouldn't have to defend [them]selves.'* She describes that there is:

*... a lot of bitchiness (mind my language) but yeah [laugh] that's what it's like. And sometimes it... it, I find that really challenging. Having to deal with um, them because they don't know, like the cultural side, we work culturally and you know we work both sides you know.*

Ward Midwife1 also described this jealousy, and how although it is not something that she has an issue with, does not believe that *'having AMIC workers on the ward would be of any benefit,'* rather a source of conflict between AMIC workers and ward

midwives. She believes that some of the older midwives *'might be a little bit put out if somebody that hasn't had any specific training, and I go like that [inverted commas] with training, um ... provides help to a woman.'* This gives further evidence to support the notion that some ward midwives are not supportive of the AMIC role, but also demonstrates differences between their views of AMIC workers.

Furthermore, Ward Midwife2 articulates the expectations ward midwives have of the AMIC workers, and how a failure to meet these can be problematic for the AMIC workers. She said that the AMIC workers *'can't be all things to all people so chances are they are not always going to be around'* and believes that the AMIC workers *'are the link'* and if they need to work in a flexible way to remain that link, *'it is important that that stays that way.'*

Yet, Ward Midwife3 stated that she believes the AMIC workers need to improve on assisting on the ward. She *'feel[s] that they could probably help out on the ward a bit more, just doing basic things like observations, taking blood pressures, because I know that they can do that but sometimes they don't do that.'* Reasons for AMIC workers' ward avoidance are often associated with feeling uncomfortable on the ward, which was not recognised by this midwife.

As already touched on in the Medicalisation Chapter, difficulties arise for AMIC workers when ward midwives discriminate against their limited clinical training. AMIC2 spoke about how this affects her when the ward midwives tell the AMIC workers that they *'don't want [them] around'* it *'makes [her] feel awful.'* AMIC2 described situations when she has been encouraged by the program midwives to go on to the ward when the program is not busy, to help the ward midwives with ward work. However the AMIC workers:

*... go on to the ward, and [the ward midwives] say to us "oh no we've got nothing for you to do, so can you go back to the office and just wait until we can find something for you to do". Now, you know what's that? They should be teaching us what they're doing. You know. As they go along, you know whatever they're doing ... Because that's what we see them doing to the other trainees you know. But we don't get that.*

*So ... a lot of us don't go up on the ward now to do that work, we'll go up with our own midwives you know.*

According to AMIC2 these situations have made the AMIC workers feel *'like [the ward midwives] haven't got the time to be bothered with us ... And it's sort of made us, err just not want to be working with them.'* She finds the most difficulty with *'the older workers of the hospital, they don't like to change their ways!'* which she finds to be *'a tough barrier in itself.'* AMIC3 also spoke about her experiences of working on the ward *'once a week for an hour or so'* and how:

*... every time I'd go out there a [ward] midwife would ... kind of ignore me or I'd be following her around like a lost puppy. And I just felt really uncomfortable and they weren't really, they were just doing their own thing. They got me to make a bed, and I thought "oh wow, I know how to make a bed" [laugh]. ... I don't think they understand our ... our you know, knowledge of where we are at or what we know. And what qualifications we've got I guess. They're not sure of what we can do. So I think that's a barrier.*

Another perspective of this was offered by Ward Midwife2 who spoke about similar experiences she had of working on the ward as a student midwife:

*That hour from seven fifteen to eight, eight thirty is sort of no man's land really. It's a time when I was a student midwife I wouldn't always come in because I'd say I'm not wasting my time to learn how to make beds, I learnt how to make beds in 1970.*

This suggests that the culture of a maternity ward is difficult for other staff to negotiate, and is not necessarily discriminatory towards AMIC workers or the program. Rather this is touching on the very structured processes of ward work, which are likely to be reinforced by older more 'traditional' midwives, who have been spoken about in this study as very inflexible and closed to new ways of doing things. Another discourse around feeling uncomfortable with working on the ward emerged from AMIC6. She named working on the ward as being one of the main challenges that she faces in her work. Her issues were around *'wondering how this midwife is going to, what is she going to think of you.'* AMIC6 describes instances of feeling discriminated by the ward midwives *'that don't belong in the team'*:

*... they don't even bother to say hello to you. And it makes you feel, you know, like oh you know, their worth more than, you know, you.*

Furthermore, AMIC3 spoke about how she gets angry with ward midwives 'downgrading' AMIC workers *'like they think I don't know what I know.'* She attributes this to a lack of understanding from the ward midwives around the AMIC role and how *'they just don't know why I'm there! And I just think you know, yeah, we could do a lot of good in there, but a lot of people just don't know what our role is or how we can help.'* AMIC5 described how the most difficult aspect of being an AMIC worker is *'getting the midwives and the other non-Aboriginal people that are working around us, to understand our ways.'* AMIC5 also expressed that *'the only time I feel that I want to give up is when ... the midwives don't understand us.'*

Ward Midwife1 stated that *'quite honestly I don't really see [the AMIC workers] on the ward.'* She described how *'they might be off collecting clients for appointments or taking their clients to appointments, but I don't see them very often coming and seeing their girls who may be admitted on the ward.'* This demonstrates that from this ward midwife's perspective, the AMIC workers are not often engaged in working on the ward. She offers one reason as to why they may not engage with working on the ward:

*... other midwives that aren't in the birthing project um they probably don't feel as supported and I think that's because some of the ward have had the negative image of the AMIC worker and so um, and people pick up on that and the AMIC workers have probably picked up on that or ... have been told through sources that they, you know were called and didn't come in or something like that, so they avoid that situation where they might be confronted by the midwife that rung them. But I think certainly within that um birthing project, the midwives in the birthing project um respect their role mostly.*

Furthermore, this midwife describes the role of the AMIC workers in the birthing suite *'as kind of like a doula, so they're there to provide the care that perhaps the midwife can't and offer that extra support.'* This ward midwife also spoke about a lack of respect she believes other ward midwives have for culture:

*There are certainly some midwives on the ward that don't respect different cultures as much. But I guess that's from their life experiences perhaps, and um perhaps their age as well.*

A lack of ward midwife's understanding of the importance of cultural aspects of the AMIC role was frequently mentioned by AMIC workers. Specifically, a lack of respect for culture from 'outside staff' but not the program midwives, was spoken about by AMIC2. In contrast, '*[program midwives] ask us if they're not sure about something culturally*', but '*we won't get that from the other midwives or nursing staff.*'

A lack of cultural appropriateness by the ward midwives was spoken about by AMIC5 in terms of being disrespectful. She described how '*sometimes [ward midwives will] talk to you without looking at you*' which she considers to be rude. Furthermore, '*you could ask them a question and they'll be doing things and I think that's rude ... we look at each other when we talk.*' This is something that really annoys AMIC5 and makes her feel like she is not important within the hospital setting. She attributes '*the way they speak, their body language*' as '*racism*' and '*being a racist.*'

Ward Midwife4 described a situation where she was accused by an AMIC worker '*of not providing cultural safety for the workforce.*' She said that this AMIC worker gave feedback '*to ... managers ... that we were very negative and we didn't participate [in a group activity] and that we were viewed as being racist and that really wasn't the case.*' As a result, she feels that her '*relationship now has really changed very dramatically with some AMIC workers here. Because I am very guarded, they have crossed the line with me that is going to take a lot of trust to get that back.*'

Obviously, racism in this context can be understood to be an issue that causes a high level of emotional labour for staff external to the program as well as the program staff. As such, Ward Midwife4 said that she '*had a couple of weekends where I didn't sleep very well thinking about all of this stuff, so I've gone through all of that myself to see what we could do to make, you know what's the extra mile I have to do to do that.*' She found some resolve in the fact that another AMIC worker reassured her that '*the person that spoke in the group, she doesn't speak for everybody.*'

This situation was also spoken about by Ward Midwife5, who described how the AMIC worker said that she *'has only felt culturally safe with two nursing staff in the [time] she has worked in this hospital.'* This midwife *'thought "you bitch". I looked at her, and I thought oh you poor thing [sarcasm], and I looked around at [program midwives] and they looked like they had been physically attacked, it was awful.'* This situation can also be understood as a source of conflict and dissonance with emotional costs between midwives and AMIC workers.

AMIC3 explained how she was affected emotionally through a negative encounter with ward midwives:

*And then I was like trying to look for the clock off book ... and there were like ten nurses in that room and none of them would answer me. And so I said it like three times really loudly, like 'excuse me, can anyone tell me where the book is'... and one of them just said 'no it's out there, look on the bookshelf.' And I didn't look properly apparently and she ended up coming out and yelling at me telling me that I'm having a man's look ... and to look properly, and she just kind of basically threw the book at me. And I just thought oh well that's really nice, and I ended up going home and crying my eyes out. Oh it was horrible, I didn't like it at all when I first started, I actually did want to quit because you know, the way I was getting treated.*

The emotional labour described in this example is a result of conflict between a ward midwife and AMIC worker. In contrast to the numerous conflicts between ward midwives and AMIC workers, only one instance of being disrespected by a program midwife was expressed. AMIC3 described the situation when a program midwife *'should have respected what I was saying and you know, let me handle it the way I was going to ... I thought she disrespected me because she wasn't listening to anything I was saying.'*

### **Consequences**

There are examples of positive consequences of emotional attachment and emotional labour that help AMIC workers to feel fulfilled in their role. These were most obviously revealed in AMIC workers responses to the question asking who values them in their role the most and why, as touched on earlier in the chapter. It is also

important to highlight the intensity of these relationships has been recognised by many involved in the program as being key to the program's success, as clients feel comfortable accessing services with the support of women they trust.

Yet it is known that obligatory community labour can lead to emotional exhaustion and burnout (Williams, 2003). It is clear that AMIC workers engage in caring responsibilities for their clients and clients' families outside of their official work hours. This along with the extent of their emotional attachment established to their clients may contribute to feelings of emotional exhaustion for reasons associated with tiredness and being stretched, but also due to the extent of their attachment to the clients they are working with. This emotional attachment can develop for a range of different reasons and can take on different forms, but its implications for the AMIC workers can be serious. For example, when AMIC workers are faced with complex situations concerning a client they have developed an attachment to, the negative feelings they develop as a consequence can be detrimental.

*AMIC3: One of the girls that I've just had, she's had her baby removed [put into care], and I kind of knew it was happening, like when she was pregnant, I kind of felt it coming, and I knew it was going to come, and I'm trying to prepare me and her. But when it happened, I don't know I felt really bad inside. You know. And then there was another time when a girl lost her baby, when she was like twenty weeks and she had to go to Adelaide and give birth to it and that ... but ... no I felt really bad, like really really bad for weeks, and I thought that the family was angry with me, and ... it was really really hard.*

Again, this AMIC worker expressed intense emotions in relation to what was happening to the first client she spoke of, as she states she was trying to prepare both herself and her client. While a psychological theoretical interpretation may equate this to 'deep acting', which was described in the literature review, such an interpretation seems inappropriate in this context. As an ideal worker she is expected to feign appropriate emotions, which seems impossible to achieve in these circumstances. Although there may have been a degree of surface acting involved, where the AMIC worker tried to display the emotions she felt appropriate for the client, I would suggest that her emotional involvement with the situation was such that she felt a real sense of guilt about the situation. Guilt was also felt in her discussion about the

second client, but in a different sense. The issues around blame emerged in this example and demonstrate how this is a very real concern for the AMIC workers. In this context blame can come from the client or the clients' family and be put onto the AMIC worker when something goes wrong, even if it is not the AMIC worker's fault. Emotional issues in this instance may not be directly related to the client and the clients' family, but rather attachment to the concern that there will be negative repercussions.

*AMIC3: Actually, for about three or four weeks I was really down and really anxious to go see that family 'cause I thought I might have been getting blamed for it, and it was quite horrible.*

It is clear that such negative feelings, identified here as depression and anxiety, may last for an extended period of time. A major focus of the burnout research is around the potential conceptual overlap of burnout, anxiety and depression (Leiter, Clark, & Durup, 1994; Maslach et al., 2001; Shirom & Ezrachi, 2003) and there are numerous examples throughout the data of such emotions being felt by the AMIC workers. AMIC6 also explained how as an AMIC worker she has been affected by what could be understood as an emotional rollercoaster. She described the following example as resilience, something she believes AMIC workers are good at:

*You can have your downfall and you feel you know, like ohhh crap, but you still go up on a high then because something else has happened. Like maybe if you've had to go to a baby's stillborn funeral, and then you feel so down. And then next week you might have you know, like a birth. So that brings you back up again.*

The fear of blame may also come from working with more traditional clients where cultural beliefs around birth remain very strong. In these instances the clients' family play a large role in whether or not the AMIC worker will be blamed for something that has gone wrong.

*AMIC3: It was the mother that I was more scared about because this girl was quite a traditional girl and so you know, I was more worried about the grandmother you know, with what she had to say. I was really really worried. But we ended up talking about everything and she was all fine with it. She wasn't blaming me thank goodness.*



In all instances of blame or the fear of blame, the AMIC worker needs to deal with the client and their family on a personal level. Again, this is not something that this mainstream organisation accounts for and is an extension of the AMIC role. Such examples negate the notion of an ideal worker for an AMIC worker, as she is deeply involved with relationships and community politics. Community backlash and conflicts are negative aspects of community politics that the AMIC workers have to deal with outside of the workplace.

*AMIC3: Also if anything happens we've got the backlash from the whole community, you know. So, it's not only that one person, it's the whole community. And so that's the hard thing about it as well. And it's hard to, you know, repair that damage.*

The AMIC workers' experiences of backlash are real, not only a fear, and they are often concerned with the consequences of being threatened or harassed by clients. The complexities of such situations are no doubt extremely draining on the workers, with instances of AMIC workers having to hide in safe places of the hospital as a protection against angry clients and their families. One concern is what AMIC workers do to protect themselves in these situations when they are not at work. It is obvious that in such instances the emotional involvement of the AMIC worker goes beyond their role within the organisation.

AMIC2 further elaborated on how the AMIC workers have to '*be careful*' if '*we're arguing with somebody, it might be somebody [related to the client] it's their family as well you know.*' Aside from issues directly associated with being family, there are instances when AMIC workers need to '*be careful of what we say because we might be offending [...] what they believe.*' AMIC2 spoke about this in relation to doing something wrong and how it will go '*back to the community.*'

Ward Midwife1 demonstrated her understanding of the conflicts AMIC workers have with families in the community. She described this as being an issue when it comes to being on call for a birth, and how the availability of an AMIC worker may be influenced by community conflict:

*I guess it depends because some families don't get along with other families. And if one of the AMIC workers doesn't get along with ... that's a cultural thing you know.*

Additionally, there was one example of a program midwife inappropriately dealing with a client which was spoken of by both AMIC workers and program midwives as a situation that had the potential to be very damaging to the client-AMIC relationship. During a home visit, the midwife insulted the client and her living environment in a way that was offensive to the client. The AMIC3 worker described how *'we could have gotten into a lot of trouble'* and how it *'could have gotten me into a lot of crap there from the community'*, highlighting how the negative consequences of the midwife's behaviour would have affected the AMIC worker, not the program midwife, in the case that the client acted on the situation. As the AMIC worker explained during the interview, *'you need to build on that relationship [with clients] before you're going to say anything.'* This clearly highlights that AMIC workers can not only experience negative consequences from clients and community through their own interactions with them, but are also blamed for negative situations that others have created.

While setting boundaries may seem like a reasonable strategy to overcoming some of these issues, there are consequences of doing so, as described by AMIC4:

*AMIC4: ... when I go on leave anywhere I don't, I don't ... my work colleagues say "oh [name of AMIC worker] gee you're stuck up ... seen you the other day and ..." and I say "no I waved to you once, but I'm on leave, I don't have nothing to do with work." I don't ... even if I go down the street and the girls say "oh [AMIC worker] can you come and..." and I say "no I'm not working today, you come and see me Monday." You know, 'cause you have to say that otherwise you'd always be doing it.*

As evident in this extract, when this AMIC worker puts boundaries in place for herself to separate herself from work during her time off, she receives backlash from other AMIC workers for 'slacking off'. This poses the extent of the dilemma facing AMIC workers regarding the reality of setting successful boundaries and suggests that boundaries cannot be maintained. Yet this AMIC worker, AMIC4, also described in detail the importance of setting boundaries and stated:

*... if I have to take it home [...] then working with this program I would have been burntout years ago.*

I would argue that while AMIC workers spoke commonly of taking a similar approach to separating spheres, the other experiences this AMIC worker has had may affect her approach, in regards to her nursing training (where establishing and maintaining boundaries is emphasised) and other emotionally demanding professional roles.

### **Burnout**

The AMIC workers all discussed burnout as being a concern for them, although none disclosed that they had themselves experienced it. While AMIC1 described how *'I am nearly there now'* in terms of being burntout, and AMIC3 described herself as having *'not as yet'* experienced burnout, the other four AMIC workers clearly stated that burnout was not something they had seen nor experienced as AMIC workers within the program. Despite this, Program Midwife5 explained how she has seen AMIC workers experience burnout, and queried that *'it's hard to know whether it was to do [with] the job or is it everything else.'* While none of the AMIC workers interviewed in this study reported experiencing burnout, it may be the case that those who have are no longer working in the program. She acknowledged that *'it's so hard'* for the AMIC workers *'because what they are dealing with is so big, in terms of their whole lives and then trying to work.'* She believed that it is likely to be a *'combination of [the job] and whatever is going on in their lives'* which she understood *'is the same for all of us.'* Program Midwife5 understands that *'it's hard having kids, even if life is dandy for you'* and that *'working and having kids and stuff is hard.'* Program Midwife2 also acknowledges that she has seen AMIC workers affected by burnout, which occurs when *'they just can't cope with the workload.'* Consequently, she believes it is *'just so important to have down time away from ... your work.'*

Program Midwife5 makes the distinction of how burnout may more likely affect AMIC workers than other people working in the setting, and how she believes that they *'are resilient just to survive'*:

*I think it is probably even more so for an AMIC worker because, well the potential for it is there because of that constant kind of stress that I was talking about earlier. You*

*know of, a new model of care and trying to fit into a mainstream organisation so ... I think the burnout is high in Aboriginal health workers working in Aboriginal Community Controlled Health Services, then it's going to be even higher [for AMIC workers]... this is even a bigger ask I think.*

Aside from potential burnout issues that may be associated with a new model of care 'trying to fit into a mainstream organisation' it was recognised by AMIC workers that burnout affects AMIC workers differently than other people working within the health sector. AMIC2 believes that 'we do do a lot more in our jobs' and that it 'sometimes amazes me what we do.' She attributes the differences between the AMIC role and other roles in the health sector whereby AMIC workers doing 'a lot more [...] we're a lot more out in the community, [...] you know when it comes to birth and things, we're in the hospital a lot too.'

Similarly, AMIC1 explained her belief that burnout affects AMIC workers differently to others working in the healthcare system through the recognition that 'we're emotionally more connected and we're there through the whole thing.' Furthermore, AMIC1 touches on how emotionally invested she is in making a difference in her work, and how this may be a risk factor in becoming burntout. She said:

*... maybe I am too passionate. Or um too ambitious about this area. But I sort of think, if I don't do it then who is going to?*

However, similarities were drawn between the AMIC worker role and the role of Aboriginal health workers. As AMIC1 stated 'I know [that] any AMIC worker or any Aboriginal health worker, when they first start they put their all into it' which is something she experienced firsthand in her AMIC role. AMIC1 went on to say that you have to realise that 'sometimes you need to protect yourself' when working in these roles, 'because you still work in the community and you can't go down to Woolies because someone is asking you a question when you're doing your shopping, in your personal time' and 'you can't constantly have that all the time.' She believes that 'you have to have time to yourself [...] otherwise you will burnout.' For the AMIC workers this time out ranged from leaving town for the weekend to going for walks after work.

Burnout was further recognised as having the potential of affecting AMIC workers because of their attachment to the community. As AMIC1 clearly stated, *'it affects us even more so, because when we don't [...] succeed, or when there is a negative, or something happens, it really hits us because it's [...] part of us.'* AMIC3 further supports the notion of AMIC workers being affected by burnout more than other roles in the health sector because *'we're emotionally more connected and we're there through the whole thing.'* She attributes the extent of her emotional attachment to not having *'learnt to [...] draw] the boundary line yet'* and as such sees the need for *'a burnout system'* to help protect AMIC workers from the negative effects of emotional labour.

AMIC2 understands that *'you could get burntout if you didn't watch out for yourself'* but along with AMIC6, believes that having a caseload system helps to prevent burnout. AMIC2 described that if she had more than a certain number of clients, she *'might be a bit burntout'* but believes that by caseloading and training, *'maybe I'll be able to get better than that and hopefully not burn myself out too much.'* Similarly, AMIC6 does not think AMIC workers get burntout *'because we have caseloads'* and that *'you won't take twenty girls with you know lots of issues.'* Despite clients *'all'* having *'lots of issue'* AMIC6 believes that when it comes to clients *'with really complex issues you share it around.'*

Program Midwife5 recognised that burnout is also relevant to the program midwives. One cause of burnout for these women, as she explains is associated with:

*... the constant battles [with the ward and the hospital] of you know, we were always looking after those AMIC workers; there was always friction amongst the us and them kind of stuff. It was just a bit wearing after a long time. I felt like I needed a break. I felt a bit burntout and like I needed a break.*

She also believes from her experiences that while she does not *'find it hard to do'*, working with Aboriginal people is *'wearing work.'* While she enjoys her role working with the AMIC workers, she was the only program midwife who acknowledged some of the challenges she faces working within the program and the *'constant, every day dealing with [...] working Aboriginal people as clients and then Aboriginal people as*

*your own co-workers, as a non-Aboriginal person and trying to fit in, in mainstream services.’ She believes that this ‘is hard to do’ and she is unsure about whether or not ‘there is a lot of support for that.’*

Furthermore, Medical Practitioner2 responded to the question asking about whether or not they believe burnout is something that affects AMIC workers with a great level of insight:

*I probably see burnout at three different levels. One might be that they are frustrated with working with the non-Aboriginal community and that gets quite hard over a long period of time. Secondly, that the personal stories of trauma and hardships that mothers bring along, you can actually reach a point in which you need to withdraw from that to recuperate yourself. And if there is no job progression, if there are no ongoing challenges the job can become quite boring. So that’s why once again having a pathway towards further skills is really important.*

This participant’s view notes the complexities AMIC workers face with obligatory community labour, the extensive emotional labour they engage with through dealing with clients living in difficult situations, as well as the responsibility of the system to encourage job progression. By highlighting all three aspects that potentially contribute to AMIC workers experiences of burnout, this participant is not only demonstrating a deep understanding of the AMIC workers roles, but also summarises the key areas that put AMIC workers at risk of burning out.

#### **Protective strategies for burnout**

The concept of ‘looking after yourself’ was named by many of the AMIC workers as being an important protective factor against the various stages of burnout. This concept took different forms and meant different things for the AMIC workers, though many of the strategies were related in one way or another. The idea of separating the private and public spheres of life emerged from the data quite strongly, but does not seem achievable for some. Interwoven throughout this discussion are Western constructs around appropriate and useful ways of looking after yourself that may or may not fit with each AMIC workers’ worldviews or lifestyle.

The idea of separating work life from home life was recurring, and many of the AMIC workers understood this as being an important strategy in preventing burnout. One AMIC worker discussed this in terms of having to *'turn yourself off'* when she gets home at the end of a work day. This notion is really focusing on both having the ability to turn off and being in an environment that supports this need. The following extract comments on the issue in relation to turning off as being variable amongst the AMIC workers and how for this AMIC worker it is necessary in her continuation in her role:

*AMIC1: There is a separateness, and I wouldn't say that all of the AMIC workers might work like that. But I need to work like that to look after myself, otherwise I wouldn't be able to do this for that long.*

Looking after yourself was also discussed by AMIC1 as being something learnt. She also discusses trying to switch off completely when she gets home from work, making the distinction that home time is her family time:

*... personally I find that I have to really look after myself. Um, and I guess 'cause of this sort of work, I've worked in this sort of work for such a long time now, and I've had a past in working with girls with domestic violence in crisis situations and ... learnt a long time ago, that you know, work was work, and home was home. Um... so I, I do try and switch off completely when work's finished. That that's it. That's my family time now, you know. Um, but also, err ... I like doing things for myself. I like to pamper myself sometimes.*

Doing something nice for herself is one technique that this AMIC worker has to protect herself from burnout. Having weekends away was also mentioned by AMIC1 as a strategy she engages with to protect herself.

From a Western point of view, being able to switch off and spend time with your family is a strategy largely considered to be a good thing. However, for AMIC workers, some of the clients they work with are relatives, and therefore I would argue that switching off from paid employment is not a simple task, and may also have negative repercussions. Despite this, there may be levels of being able to disconnect themselves from community and work as a way of looking after themselves. For

example, by making themselves unavailable to clients after hours (when it's not a labour or emergency) but having family members know that they are available for them in the capacity of a relative, to offer advice or support. The following extract is relating to keeping yourself partly separate from community, rather than being completely removed.

*AMIC1: And I think, 'cause I've done that quite a bit through the past eight years, I think that's what actually helps me to go on, and also that um as much as I work in the community I don't, I'm not, I try not to sink myself into the community.*

Interestingly, this AMIC worker begins to say that she doesn't sink herself into the community, but shifts to *I'm not* and then *I try not to*. This progression is a possible indication that although ideally she may like to keep herself removed, in reality all she can do is to '*try not to*' sink into the community. This is a fascinating use of words, and I cannot help but imagine what sinking into the community might mean for this AMIC worker (being overwhelmed, drowning, immersion). I would assume that it is a negative connotation relating to being so much a part of the community that it, in some ways, becomes burdensome to the AMIC worker. This is very much a double bind, because without the community life for this AMIC worker would be completely different.

On reflection of this concept of looking after yourself, I would argue that techniques and strategies vary in their usefulness and suitability for each AMIC worker. However, whatever the case for each AMIC worker, I think it is important for them to be conscious of the potential usefulness of being able to create separate boundaries, and to tailor these boundaries to their own needs. For those AMIC workers who are from the community and have strong ties to community, cutting themselves off after hours may be detrimental to both them and the way they are perceived by community members. Perhaps there is the possibility to reframe what 'cutting yourself off' means, and promote it as a time for rest or for refreshing. For those AMIC workers who do not have the same deep connection to the community, it may be easier for them to adopt some of the more Westernised strategies for looking after themselves. Another consideration of this may be that for an AMIC worker who is not from the community, it may be important for them to build the trust and respect of community



members which they may feel requires them to extend themselves and their availability beyond their official paid work hours. I believe the degree of connection to community plays a very influential role in determining these factors.

I have been discussing coping mechanisms in terms of separating yourself from community and community members' needs out of work hours, however I feel that I have overlooked the strategy of winding down after a work day as being a technique to try and relax the workers and help them to step away from the day's events. If an AMIC worker has been working closely with a client who they have a strong relationship with, for them to try and forget about it or leave it at work when they go home, negative feelings such as guilt may overcome them. Perhaps it would be sensible to think about ways in which AMIC workers can learn to live with constant emotional labour, in a way that is not detrimental to any aspect of their life. Engaging with psychologically meditative practices such as mindfulness (which can be achieved through creative practices such as art making) may be something that can be incorporated into the program as a way of supporting the AMIC workers. In-depth debriefing processes were spoken about as a potentially useful technique.

Whilst exploring this notion of separateness and leaving work related issues at work, we enter into quite unclear territory where, while it seems like the ideal thing to do, we must ask if it is really possible and in what ways do the AMIC workers view it. There is one extract in which an AMIC worker contradicts herself while discussing this separation:

*Um... no, I just leave the work at work. If the girls, I don't mind if the girls come around home, or ring me up I'll still take time out to go and see them. 'Cause some of them just need you know a friend, or, but no just leave it at work. Yeah.*

Despite stating that she leaves work at work, this AMIC worker also admits to assisting the clients 'after hours' in different capacities. Aside from the contradiction, the interesting point to make here is that she does not seem to view this extra contact with clients as being work. This indicates that although she understands leaving work at work is important, her boundary is often stretched and perhaps even blurred.

The extent of emotional attachment AMIC workers have with their clients and to improving health outcomes for their community, can be understood as being factors that protect them from experiences of burnout. Despite AMIC1 describing how she *'is never energetic'* and is *'always tired'* she finds energy in her role as an AMIC worker because:

*... it's about the woman, it's about that little baby, it's about making a difference for them. That's where I, I don't know, I guess thinking about that work and I don't know, it does something inside of you, and you think oh no I can get up again and do it again the next day and the next day and the next day. I don't know you have to have a passion for it I think, and enjoy it, you know. Um, I think that's what keeps you going.*

AMIC2 also spoke about finding energy in her role because *'you just feel that you have to help, help [clients] as much as you can.'* Similarly, AMIC3 believes that she is able to find energy in her role because *'I'm very passionate'* about *'health and women and babies.'*

Strategies to overcoming the negative emotional affects of community conflict include appropriate client delegation amongst the program staff. This was spoken about by AMIC2 who acknowledged that *'sometimes you might have a family in the community that's arguing with one of the girls in the program'* and that client may *'not even want to talk to you or say anything to you ... not because it's you directly, but it's your family member out in the community.'* Or in other cases, the AMIC workers may *'have to say no to that girl because of situations like that'*, and when the clients *'still want to come on the program'* the AMIC workers assign the client to an AMIC worker who is not involved. As AMIC2 highlighted, being *'part of [the] family'* that is in conflict or *'at differences'* with the client's family can be a source of emotional labour, however engaging in appropriate strategies with other AMIC workers to best manage such situations, helps to overcome negative emotional outcomes. AMIC2 believes the team works really well *'like that'* and:

*... sometimes not only [with addressing] arguments like that, it could be any other little disagreement you know. Um ... but like I said it's good that we can come back,*

*have a meeting and can say well, another girl might say “nah I’ll take her” and, “you know, you can have this girl here” or something like that.*

Caseloading was another protective strategy against burnout, which was described in some detail by AMIC6:

*... we have caseloads. So we’re given girls in a, and we know if it’s too much. Like we will say, this is too much. And some girls have complex issues you know, where you spend you know the whole day down at Centrelink with them. But that’s, yeah that can be ... even though you’ve got one client for the day but you’ve spent all that quality time with them ... yeah but um ... so that we don’t get burntout yeah we caseload. And we share around you know, if we know there’s girls that have got complex issues well you won’t take twenty girls with you know lots of issues. I mean they all have lots of issues, but the ones with really complex issues you share it around.*

This again touches on the complexities of client lives and needs, the flexible requirements of the AMIC role and the importance of sharing difficult cases amongst the AMIC workers to prevent burnout. Another strategy for preventing burnout was the importance of debriefing. AMIC3 described how after a difficult situation involving a client, she ‘*think[s] we need a debriefing system*’ because she ‘*could have taken that home and bottled it all up [and] been a big mess.*’ It was ‘*the support of the team [that] helped me get through that.*’ Similarly, AMIC6 spoke about the importance of debriefing with the team:

*... especially when there is a bad experience, having someone there like, ‘cause sometimes you might not want to talk to the other AMIC workers or midwife. You need someone else. So making sure you know, that that person is accessible when you need it.*

A reason for not wanting to talk to a member of the program staff was that ‘*you might just feel uncomfortable talking to them*’, which was more likely with a midwife rather than an AMIC worker, because the midwife does ‘*not really understand the cultural side of things ... where you’re coming from.*’

Despite debriefing being named as an important and appropriate strategy to prevent burnout, AMIC1 spoke about her belief debriefing not being sufficient in some situations:

*And I think you know as AMIC workers there's lots of situations that we have and we do talk to our Midwives, talk to each other, but you know perhaps we need more. I think some of the AMIC workers may feel that you know, I know I have in the past, felt like I actually needed more than that.*

Strategies were also suggested to overcome difficulties associated with structural barriers facing the program. AMIC1 spoke about a way to overcome issues around being left out of decision-making processes. She emphasised, that having an advocate for the program on higher level management committees has the potential to improve the outcomes of decision making processes to benefit the program:

*I think within Port Augusta we need a team leader. And we need someone who is going to advocate to the higher ... basically we all work on the ground, but we don't have a lot of say in the decision making process of things. I mean I am on the management committee, and I can feed back into them, but I don't make the decisions. And you know, they've got the project team too, and they don't even make the decisions you know. So, it would be good to have someone that really took on board our portfolio totally on its own. You know, it sits up with Country Health but, um, under somebody that looks after us ... Just to have someone up there that makes those decision, signs the cheques and everything else, totally focused on this model. That would be great.*

Furthermore, Ward Midwife2 made a suggestion around how to sustain the program. She believes *'it needs a higher profile, and it needs to tell the world how good it is so that people can be positive about it. And so that the hierarchy, nursing management, whatever can embrace it as good and not be negative about it. I think that is key.'*

Ward Midwife3 believes that AMIC workers could overcome some of the problems they have with staff on the ward if they *'sat [ward staff] down and explained the situation.'* Furthermore, if the AMIC workers *'were a bit more involved in patient care on the ward then that would reflect back on the midwives and other staff on the*

*ward'* and promote both the role of the AMIC worker along with advocate for the clients.

As discussed earlier in this chapter, structural barriers of the organisation that fail to account for the needs and views of the AMIC workers is a source of emotional labour. Putting processes in place to overcome some of the difficulties and negative effects of these barriers is another relatively simple way to achieve a more productive and supportive work environment for the AMIC workers and program midwives.

### **Conclusion**

This chapter has demonstrated that a balance of emotional labour (specifically attachment to clients and to the role) is important. While it is recognised that aspects of emotional attachment contribute to the AMIC workers ability to meet client needs, I argue that it also contributes to the positive meanings associated with the AMIC worker role. However, the analyses have revealed that currently the negative consequences of emotional labour, in terms of emotional attachment, outweigh the positives. The data also reveals that AMIC workers do not 'fake' emotion as other emotional workers are advised to do.

The main source of emotional labour has been shown to stem from the blurring of boundaries. Through midwives different interpretations and understanding of what is difficult for AMIC workers, the blurring of boundaries were shown to occur in two different ways. It may be a consequence of the established relationships that AMIC workers have with clients and families, and the obligations that follow. Or it could be because of their desire to respond to clients needs in the aim of improving health outcomes for women with the most complex needs. Whatever the motivations behind the AMIC workers' emotional involvement and/or attachment with their clients and their clients' families, it is common that the AMIC workers take these affiliations and subsequent issues with them beyond the workplace. A number of these factors were recognised by midwives, and demonstrated by AMIC workers, as contributing to tiredness and burnout for the AMIC workers.

Another source of emotional labour is the value placed on biomedical approaches to pregnancy as opposed to the social and emotional. This was also highlighted in the

Medicalisation Chapter, however within this chapter the emotional cost of this to the AMIC workers is revealed. An appreciation of other approaches to pregnancy and childbirth at a systemic level may assist in reducing the emotional labour in this instance.

Finally, emotional labour that results from a lack of respect has been shown to be detrimental to AMIC workers feelings of self-worth and acceptance within the hospital system. While I argue that this largely stems from people's lack of understanding about the program and the role of the AMIC workers, there are instances of racial discrimination. Overcoming this lack of respect and the negative experiences of emotional labour that are associated with it is critical to creating a work environment conducive of respectful relationships and feeling valued. Extending awareness about the program and the role of the AMIC worker, at both the hospital and community level, may be one way to address issues associated with this source of emotional labour.

I suggest that many of the factors contributing to the negative aspects of emotional labour (particularly when it is in excess or overwhelming) can be addressed at a systems level, whereby the emotional labour AMIC workers engage in is recognised and appropriate supports offered. It was recognised by the AMIC workers that a useful strategy to assist in overcoming the negative consequences of emotional labour, specifically burnout, is creating and maintaining boundaries between the private and public spheres of life. However, I argue that while the AMIC workers understand this to be a useful protective strategy against burnout, it is difficult to achieve and they are unable to protect themselves well. As there are no formal debriefing or counselling services available to the AMIC workers to assist in dealing with the blurring of such boundaries, it is an important recommendation of this study that an investment be made in this area for the best interests of the AMIC workers, and the sustainability of the program.

## CHAPTER 6: PARTNERSHIPS

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Despite Australia having a world-class healthcare system, access to and utilisation of healthcare by Aboriginal peoples is poor. The very high levels of morbidity and mortality for Aboriginal Australians is the basis for their greater need for health services (2-3 times more) compared with non-Aboriginal Australians, yet this population only access services at 1.1 times the rate (Rizzo et al., 2012). Improving both access to and quality of healthcare for Aboriginal Australians has been the focus of a number of national policy initiatives in recent decades, including the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* (2003), and the recently released *National Aboriginal and Torres Strait Islander Health Plan 2013-2023* (Australian Government, 2013). Both documents recognise that collaborative models of healthcare are critical to improving the health of Aboriginal people. Building partnerships between Aboriginal people and communities, service providers and government agencies is a key principle underpinning both documents (Rizzo et al., 2012). Government agencies are increasingly allocating funding based on the requirement for services to work in partnership with other services or relevant agencies, both within and outside of the Aboriginal health sector. Examples include the consortia funded under the National Partnership Agreement on Preventative Health (with partnerships being established across settings including communities, early childhood education and care environments, schools and workplaces), which has since been abolished by the Abbott Government, and the Victorian Primary Healthcare Partnerships Scheme (all partnerships including hospitals, community, health, local government and divisions of general practice, and some extending to mental health services and other agencies who address specific local issues, including the police).

Primary healthcare, particularly in the Aboriginal health sector, is leading the way in partnerships. It has been established that effective partnerships require the engagement of Aboriginal people in all levels of decision-making in relation to health planning and delivery. Different levels of partnership include a greater collaboration between individual team members, between service providers, between different sectors (e.g. social services and health), between providers and government agencies, and between service providers and communities. It is recognised that partnerships

remove barriers to good healthcare, assist in producing high quality evidence around appropriate health interventions, and facilitate effective community engagement (Rizzo et al., 2012). One priority for achieving equal access to healthcare and services is to encourage the development of a culturally respectful and non-discriminatory health system (Rizzo et al., 2012). Partnerships can improve cultural competencies which have the potential to reduce discrimination (Australian Human Rights Commission, 2012; Walker & Sonn, 2010) and are particularly important in the context of Aboriginal health because racism has been found to decrease Aboriginal people's access to healthcare when experienced within health services (Webber & Williams, 2008).

In the Aboriginal health sector, although difficult to measure, consortia and partnership approaches to implementing healthcare models have been associated with a number of positive outcomes in service improvements at an organisational and a service-delivery level (Australian Government, 2013). An example of this includes the Healthy for Life Program implemented by the Australian Government in 2006, which aimed to improve the quality of services for chronic disease and maternal and child health in Aboriginal primary healthcare services across Australia. Formal partnerships and consortia delivered the Healthy for Life Program across 61 sites in Australia in order to provide better access to limited resources through existing or new relationships, to create change at a regional or health system level, and to improve organisational capacity (Wallace, 2009). The facilitation process included a continuous quality improvement orientation through a Plan-Do-Study-Act approach for each site. The program's implementation used two structured phases ('Knowing your starting point' and 'Service delivery and periodic review'), which were integral to strengthening processes and partnerships across sites involved in the program. A number of reporting outcomes have been developed as part of the program, which are reported on, either six or twelve monthly (depending on the indicator). An evaluation of the program in 2009, found that partnerships had been created and strengthened over time, with positive outcomes reported across a number of factors, including the development of working relationships (a factor described in the evaluation as critical to achieving long term health outcomes), increased access to senior health workers, workforce capacity building (including creating training and professional development opportunities, particularly in rural and remote areas where workforce



recruitment can be difficult), prevention of healthcare staff working in isolation in the community, and building sustainability in the workforce (including increased access to a skilled workforce). Through the positive outcome of workforce capacity building, it was found that Aboriginal healthcare staff had an increased capacity to provide care to their community and Aboriginal employment has increased (Wallace, 2009).

The evaluation of the Healthy for Life Program made a number of recommendations for possible criteria to enable partnerships to be successful, and articulated that effective partnerships require respectful relationships and commitment to finding common ground and advocating for each other's role (Wallace, 2009). Wallace (2009) attributed healthy working relationships, shared goals, clear role definition (including decision making authority), and mechanisms for effective communication to successful partnerships. These factors do not just appear, rather they need to be developed, enabled, and require a sustained commitment to encourage the realisation that meaningful partnerships involve a restructure of existing models of care.

Furthermore, a commitment to reciprocity between Aboriginal and non-Aboriginal organisations was identified as an important component of partnerships that was considered a highly valued outcome by some of the participating services. Examples of this commitment included non-Aboriginal partners increased cultural competence and increased access to specialised healthcare for Aboriginal communities (Wallace, 2009). Within the context of Aboriginal maternal and infant healthcare, successful partnerships between staff also rely on respectful relationships (Kildea & Van Wagner, 2012).

### **Partnerships in antenatal care**

Within the maternity care setting, a definition of collaboration between maternity care providers has been developed as a first step to establishing successful collaborations (NHMRC, 2010a). This definition refers to a collaboration that allows a woman to be cared for in a way that respects her wishes around her pregnancy and childbirth, while maximising the safety for her and her child (NHMRC, 2010a). The delivery of safe services is largely dependent upon collaboration between health workers at all levels (Australian Health Ministers Advisory Council, 2008), which has been recognised and promoted by both the Australian College of Midwives (2008) and the Royal

Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG 2009a;b as cited in NHMRC, 2010a, p. 8).

Through consultations with maternity care providers and consumers, existing maternity services, and a review of the literature, the NHMRC has identified the key elements of maternity care collaboration. While some elements have been incorporated into many maternity services across Australia, NHMRC suggest services should aim to incorporate them all. These elements (NHMRC, 2010a, p. 13) include:

- Woman-centred care and communication
- Communication among professionals
- Awareness of disciplines and autonomy
- Responsibility and accountability
- Co-operation and co-ordination
- Mutual trust and respect
- Policy, procedures and protocols
- Interprofessional learning
- Organisational support
- Systems to maximise collaboration and achieve good patient outcomes

For collaborations to be successful, it has been recognised that the two most important factors are mutual respect and trust, which all other elements are dependent upon (NHMRC, 2010a). The professional expertise of a team is best utilised when trust and an understanding of professional skills and knowledge has been established. Furthermore, mutual trust and respect within the maternity setting improves productivity, supports innovation (both individual and group), and decreases the need for individuals to monitor each other's practice (McWilliam et al., 2003). A lack of trust is currently a major barrier in the successful collaborations around maternity care in Australia, with a shift in this culture being identified as the way in which this needs to change (NHMRC, 2010a). Furthermore, the NHMRC consultations in 2009 found that trust and respect cannot be assumed but need to be earned (NHMRC, 2010a).

Cultural safety in midwifery practice is another important aspect of effective collaboration in this context, whereby midwives are expected to provide culturally

safe care (Merskin, 2008). While there is some ambiguity around what aspects of Aboriginal cultural training in Australia create change in individual thinking, there is some evidence to suggest that a model of cultural safety may improve cross-cultural interactions (Downing, Kowal, & Paradies, 2011). Specifically, a cultural safety framework improves the delivery of maternity services to Aboriginal women living in remote Australian communities (Kruske, Kildea, & Barclay, 2006). The cultural safety framework was developed in New Zealand in response to the negative impact colonial processes and structures were having on Maori health (Downing et al., 2011).

In the context of midwifery and nursing, cultural safety has been identified as a framework to enable recognition of power imbalances inherent in the relationships between healthcare providers and clients (Merskin, 2008). Specifically, cultural safety aims to highlight the possible detriment power imbalances or unsafe relationships can have (Merskin, 2008). In terms of maternity care, the uniqueness of a relationship between woman and midwife must be recognised as an important part of the process in moving towards cultural safety (Merskin, 2008). The professional culture of the midwife and the personal culture of the woman come together during unique interactions (Charlesworth & Baird, 2007) and likely promote the development of trust between the two (Equal Opportunity for Women in the Workforce Agency, 2012). Subsequently, positive partnerships have the opportunity to be formed (Merskin, 2008).

Considering the inequities in access and utilisation by Aboriginal women of maternal infant healthcare, the formation of partnerships to inform the design and implementation of policy and service provision is important (Australian Human Rights Commission, 2013). It is understood that primary models of maternity care may vary according to the individual needs of a community, and that continuity of care can be improved through caseload and team models (NHMRC, 2010a). Programs adopting partnerships between midwives and Aboriginal health workers have been recognised as a useful strategy for the delivery of appropriate maternity care for Aboriginal women (Australian Human Rights Commission, 2013). An integrated team approach to antenatal care, including the employment of an Aboriginal health worker, which is delivered in a culturally safe environment, has been found to

increase access to antenatal care and was associated with fewer preterm births among Indigenous women in Townsville (Panaretto et al., 2005).

Another model that has taken an integrated team approach to maternity care is the *Aboriginal Maternal Infant Health Strategy* in New South Wales, which involves a partnership between Aboriginal health workers or education officers and midwives. Together this team provides continuity of care within a maternal outreach service delivering antenatal and postnatal care across six regions of New South Wales to women and their families (2006). While it is recognised that continuity of care models are beneficial to birthing outcomes, this model does not cover the birthing period. The *Strong Women, Strong Babies, Strong Culture Program* commenced in 1993 in the Northern Territory and includes community-based workers working in partnership with midwives. The Aboriginal women provide the cultural care and the midwives the clinical care. Through this model the importance of acknowledging both knowledge systems is recognised (d'Espaignet, Measey, Carnegie, & Mackerras, 2003).

Literature reviews have identified a number of other partnership models around the country that aim to address some of the inequities in Aboriginal maternal infant health (Herceg, 2005; Kildea & Van Wagner, 2012).

Aligning with the findings of Wallace (2009) about what is important in primary healthcare, and more generally partnerships, a recent review of maternity service models in Australia found that one key element of a successful program is the adoption of a partnership model that integrates Aboriginal and Western knowledge and is respectful of Aboriginal people and their culture (Kildea & Van Wagner, 2012). The *Anangu Bibi Regional Family Birthing Program* was included in this review, with reference made to the importance of the intercultural partnerships between AMIC workers and midwives (Stamp et al., 2007). These partnerships were developed on two-way learning and mutual respect, and were found to maintain cultural safety, respect for community and further develop clinical skills (Lewis, Baeza, & Alexander, 2008). Relationships based on trust and respect are also important between all providers and women (Wilson, 2009). Specifically, dynamic partnerships between services and Aboriginal women that incorporate Aboriginal women's views and experiences are critical to the delivery of quality antenatal care

(Wilson, 2009). Relationships between Aboriginal clients and a midwife and/or Aboriginal health worker that were based on trust and respect, positively influenced Aboriginal women's likelihood of accessing antenatal care, accepting advice, in some cases behaviour change, improved self-care and self-esteem as well as support with managing non-medical concerns (Wilson, 2009).

### **Analyses**

Partnerships between various personnel involved in the *Anangu Bibi Birthing Program* were described as being critical to the success of the model. Partnerships within the context of the birthing program are between AMIC workers, midwives and medical practitioners, however in reality most participants of this study focused on the partnerships between the AMIC workers and program midwives. This section will discuss the discourses around partnerships in relation to what constitutes a partnership, why they are valuable and how they assist in overcoming various difficulties associated with the AMIC role and the program.

#### **What constitutes a partnership**

The relationships that the AMIC workers have with one another are important in creating a supportive environment. AMIC2 discusses the nature of her relationship with another AMIC worker and how it makes her feel supported in her role:

*... it's good cause AMIC1's been around for a while, and I don't know, she's like a big sister really [laugh]. And you know that she wants to look after you, you know, 'cause she's always um, she's always saying that she's gonna look out for us. And if we need any help with anything she says you know "come and see me" and stuff like that.*

This extract clearly describes a supportive team environment that the AMIC workers feel protected in. It also highlights that these relationships protect AMIC workers from potential issues they may have within the program. Difficulties that AMIC workers had were most often related to other staff members, although there were some instances of the relationships between AMIC workers buffering both internal and external issues (including client related issues). In this example, AMIC2 demonstrated how she feels a senior AMIC worker can advocate for the AMIC workers in situations in which they may feel vulnerable or uncomfortable in. Other

examples of the strength and nature of these relationships have been described in other chapters, through which it is evident that these relationships are highly valued.

Partnerships between AMIC workers and program midwives were the most frequently described. All clients interviewed viewed this partnership as important, and believed it existed respectfully between program midwives and AMIC workers (despite one example given of the partnership not working). Client1 believes that it is *'better that [the AMIC workers and program midwives] do things together rather than apart'* because it means that as a client you *'get to know them evenly instead of [...] not knowing the other one properly.'* Furthermore, Client5 described how *'it seems like there is an understanding between the midwives and AMIC workers'* which is helpful because they *'know what they can do to help, and they seem more than happy to do those things to help.'* Client5 recognises that AMIC workers help not only the pregnant woman, but that *'they are also happy to do the things that make it easier for the midwife as well.'* Client4 offers further support for this, and described how she believes that *'both workers would complement the role.'*

Program Midwife1 became emotional when discussing the nature of these partnerships and related them to:

*... walking down the road arm in arm [...] Or, um, on one of those double dinky bikes [...] tandem bikes.*

AMIC6 believes that *'respect goes both ways, we respect them, they respect us.'* I argue that a source of this respect comes from having the same motivation of wanting *'to make a difference [...] for Aboriginal people' [AMIC1].* AMIC1 also believes that the *'midwives that are in the program are there because they want to be there. They're there because they want to work with Aboriginal women.'* She believes that *'they are really deep people'* and *'different'* to others in the hospital environment. Furthermore, AMIC1 believes that the program midwives *'really take on board, and really listen [...] and they really want to learn about other culture.'* AMIC1 is talking of a belief that a successful partnership requires a genuine interest in the health and wellbeing of Aboriginal women, and the willingness to learn from the AMIC workers. Similarly, Ward Midwife4 supported this in her statement that program midwives

*'have got a special interest in that type of work.'* These sentiments were consistent across most interviews.

Listening and being respectful of culture were also named as two important aspects of establishing and maintaining meaningful partnerships. Program Midwife2 suggests that the partnership between AMIC workers and program midwives can primarily be described as *'a midwife listening'*, which was further iterated by Program Midwife1 who believes one of the greatest challenges she faces working within the program is learning to:

*... use our ears in proportion to the two and our mouths in proportion to the one. So, say less and listen more. That's one of the biggest challenges. And I think another challenge is that, err, to come to the program not thinking we know everything or have anything to prove or worry about having every t crossed and i dotted.*

This point is also touching on hierarchies of knowledge, and how program midwives have learnt to appreciate and accept that their ways of doing things are not the only ways, and in many instances may be inappropriate or less effective than the approaches of the AMIC workers. This is despite their clinical training and the dominance of Western approaches to maternity care. Additionally, it raises the notion of an ideal worker for a program midwife. That is somebody who has the responsibility of adhering to relevant clinical processes, including clinical observations, which may take precedence over other aspects of a client's life, as prescribed by and expected of their position within the organisation.

Program Midwife2 described a mutual respect shared between program midwives and AMIC workers that allows them to *'communicate openly between each other and express umm ... you know your feelings on a subject without there being any you know, offense taken.'* Aside from being a strategy for creating a safe space that overcomes potential instances of conflict, it again highlights the importance of listening to each other and respecting the expertise and knowledge each brings to the team. As such, *'if [an AMIC worker] wanted to say something to me about something, ... I would listen and ... in return they would listen to things that I've got to say about it.'* Client2 also recognised that *'talking'* and *'communication'* are two factors that the

AMIC workers and program midwives do well that contribute to the success of the partnership. This was further supported by Client4 who understands that *'certainly the sharing of information'* within the partnership is a good thing, particularly when she did not get the opportunity to see both the AMIC worker and program midwife at the same time.

Furthermore, Program Midwife2 believes that *'the most important thing is that we listen to each other, and don't just go gung ho'* according to what the program midwives feel is important. She also emphasised her belief that *'the partnership is important because it is led by the AMIC workers'* and described how:

*... they know [...] how things work in the Aboriginal community and that, you know today is not a good day to go out and see these girls because there is sorry business happening.*

As such, the program midwives are able to take the AMIC workers' lead on when it is appropriate to consult with a client, and to be patient in respecting a client's cues. For example Program Midwife2 describes how the midwives may feel *'like we need to see this girl today, it has to be done NOW'* but has learnt that *'it just doesn't happen like that.'* She believes that program midwives *'learn to be patient'* and understand that *'you can't give up when things don't happen straight away.'* And *'if it doesn't happen this morning, it might happen this afternoon or later in the week.'* This is touching on concepts of time, and how different understandings of time can be a cause of tension between Aboriginal and Western cultures in the context of health care generally. Partnerships can be understood in this case as a buffer against the negative effects of what I will name as hierarchies of time, whereby Western concepts of time and efficiency are typically dominant within these types of organisations and systems. Partnerships facilitate flexibility, which is seen as a key factor in providing culturally secure care.

Furthermore, Program Midwife2 suggests that working in partnerships is a strategy for effective collaboration and problem solving within the birthing program. She believes that *'it is hard to pin point why [or how the partnership] works'*, but puts it down to *'just the listening and getting together as a group of people'* including *'case*



*conferencing and those opportunities where there is learning and being able to give [the AMIC workers] the opportunity to actually ask questions.*’ Again this illuminates some of the difficulties AMIC workers have had in the past in relation to difficulties expressing their beliefs and opinions within the hospital setting, and suggests partnerships with the program midwives offer them a safe space in which to express their views on best practice, including advocating for the needs of their clients. It also creates an environment where AMIC workers can feel comfortable asking questions they may otherwise feel uncomfortable voicing. As such, partnerships help to counteract the dominance of medical hierarchies and medicalisation of pregnancy.

Partnerships with midwives create a nurturing environment that the AMIC workers feel comfortable in and I would suggest acts as a buffer against burnout and staff turnover.

*AMIC2: We’ve got the midwives standing by us. We’ve got one another. Plus we’ve got the support of the Advisory Group. You know, it’s really good.*

While the Advisory Group was not commonly mentioned in interviews, they are a group of local Aboriginal women who give cultural advice to the program, and were established to act as an external feedback loop to support the appropriate development of the program. This group advocates for the AMIC workers and the program within the community, and it is important to acknowledge the role they play in supporting the AMIC workers. The Advisory Group was not mentioned in relation to partnerships in any of the interviews.

Many participants expressed the belief that AMIC workers and program midwives cannot do their jobs without each other. In this way, the partnership is about valuing both cultural and clinical knowledge, and respecting each other for their contributions. Client7 recognised that the partnership works because *‘the AMIC worker, being an Aboriginal person, would have knowledge [...] and skill and be able to work with that [client] [...] and offer] more of that support.’* While she believes the AMIC workers *‘were not as medical as the midwives’* she is sure that they are constantly learning that over time, and *‘would have that medical knowledge and skill now.’* Despite her

positive reference to partnerships, this quote also suggests that Client7 thinks that clinical knowledge is more important than cultural knowledge.

It was recognised by program midwives that the AMIC workers are the experts of Aboriginal business, and that the program midwives' role in the partnership is to take a step back and let the AMIC workers take the lead on issues associated with Aboriginal culture. Program Midwife2 recognised that program midwives need to be *'open to watching how Aboriginal people work together'* and to try not to *'come with expectations.'* Program Midwife2 also spoke about the realisation of *'I saw that yesterday, and I'm hearing it today and I [thought] oh I need to get right out of this [...] 'cause these girls know how to do it right.'* As such, she believes that *'the partnership is just so vital [and] we can teach them all of the clinical stuff, which [...] ultimately means not a lot if we don't listen to their advice on the cultural side of things.'* This demonstrates a commitment to cultural knowledge being valued as much as clinical, in regards to clients accessing maternity care. A significant cultural learning experience that this program midwife had through her close relationship with one of the AMIC workers was:

*... she said, a government car pulling up in front of an Aboriginal house often means welfare, and welfare they associate with taking their kids away, um ... And so all of those things you know. We don't, I didn't think of that. When she explained it it was like... you know. It's seriously scary. You know, for them, for the Aboriginal people living in that ...*

This highlights that when working cross culturally it is important to be reflexive and unassuming. As such, a situation that may seem non-threatening to a program midwife may in fact be threatening to an Aboriginal person. The AMIC-midwife partnership is vital to help protect all parties from unnecessary and unintentional harm. Furthermore, Medical Practitioner1 appreciates that the AMIC workers *'are more aware of [clients'] cultural needs, and sometimes we can't see it their way. [The AMIC workers] can explain it to you.'*

Furthermore, Program Midwife6 alluded to the partnership enabling AMIC workers to teach the program midwives about appropriate cultural practice. *'If I'm doing*

*something that's not right they quickly tell you that you're not doing it right or culturally appropriate.* She believes that she *'get[s] along with most of them'* and that they are able to *'talk openly about patients and get things sorted out for them.'* Program Midwife3 also discussed how there is *'a cultural knowledge deficit on [the program midwives] part.'* She believes that *'it's very easy for me to work in partnership with them because [...] I need them to do the job that I want to do, and I think they need us for them to do the job that they want to do.'* In this way, the partnership can be understood as the lattice between two knowledge bases.

The AMIC workers spoke about the partnership as something that developed as program midwives came to appreciate and value the role of the AMIC workers. In this way the AMIC workers had to earn the respect of the program midwives initially. The partnerships did not automatically evolve over time to become equal. AMIC6 made comment on how the program midwives came to realise they need the AMIC workers to do their job. She described how *'all of us AMIC workers went away one day and the [program midwives] said "no we can't do it without you. We had no clients in." 'Cause you know, they didn't know where to start to look for these girls.'* Program Midwife3 offered further support for this:

*... if we've got an address for a girl, and we'll go out to that address and they're not there, well we wouldn't know where to go and find them. Whereas they know. They know where to find them. And they go and find them.*

AMIC2 believes that the program midwives are *'more aware of the cultural side, than the other staff on [the maternity] ward'* and *'when they're not sure of something they'll come and ask us.'* She believes that valuing each other in this way is important and understands that *'it's not just one way [...] they're teaching us, but we're also teaching them.'* Furthermore, AMIC1 describes her perceptions of this partnership and touches on the factors important to making it work:

*... they don't look down at me because I've got an Aboriginal health workers certificate and they may have a uni degree, you know in midwifery, um that distinction isn't made. It's equal partnership, 'cause they can recognise that I actually bring something to this, and without me they can't do what they need to do either ... And also, um it's reciprocated in the same sense that [...] I look at them as*

*my equal as well. And I know that I can't do what I want to do for my women or for the women in my community without them either.*

Clearly, not making distinctions between qualifications and recognising that both the AMIC workers and program midwives bring something important to the partnership is crucial in establishing and maintaining a sense of equality. AMIC1 stated that *'equality is really important'* and that she is *'a big one for talking about partnership[s]'* which are a *'a great thing.'* Because of the partnership, the program midwives *'view me as an equal.'*

Medical Practitioner2 summarises what *'any true partnership'* between an AMIC worker and program midwife requires:

*... a really strong AMIC worker who can talk about the cultural aspects, take the leadership to the wider Aboriginal community and argue that case. The two of them need to work together to be able to show and have mutual respect for each other.*

Ward Midwife1 believes that while there is *'definitely a relationship between the [ward midwives] and AMIC workers'* the *'birthing project midwives certainly know the AMIC workers better.'*

The AMIC workers did not mention the partnership involving ward midwives. As such, the most significant partnership can be understood to exist between the AMIC workers and program midwives. This is an important finding as it suggests the partnership approach has not been fully implemented and it may be important to address this for the sustainability of the program. It reinforces that hierarchies are still very much present within the hospital setting and what is needed is system wide change.

Partnerships between AMIC workers and medical practitioners who have some involvement with the program were spoken about less frequently than those with program midwives. AMIC1 acknowledged the sense of equality she has with Medical Practitioner2, who she has worked with *'for a long time.'* She feels that this medical practitioner *'gives me respect ... as an equal, in the sense of ... what we're trying to accomplish for Aboriginal women.'* Again, having a shared goal of improving health

outcomes for the clients of the program is apparent, and an important factor in establishing partnerships and mutual respect.

Further reinforcing this point, Program Midwife4 stated that people working within the program *'all want the same outcome, healthy babies and good birth weights.'* Consequently, she believes that *'when the AMIC workers want to speak to doctors they will and they'll just take everything they say on board.'* She understands that an indicator of partnerships *'work[ing] well'*, is the fact that the *Anangu Bibi Birthing Program* is *'helping these girls.'*

A partnership between AMIC workers, program midwives, and medical practitioners was spoken about by all three parties. Medical Practitioner1 spoke about the value of working in a group partnership and the importance of collaboration:

*... sometimes if we need to see a patient and the patient is not available we call the AMIC worker and the midwife, and the three of us decide how to go about it. So it's like a little conference on how to deal with it.*

Ward Midwife1 stated that Medical Practitioner1 *'is great with the birthing project girls and [...] has a lot of trust in them [which is evident because they] quite often let [program staff] work quite independently.'* Furthermore, Ward Midwife4 believes that *'Medical Practitioner1 has been paramount in being involved in the program earlier on, and [...] has a great relationship with the AMIC workers and also the project midwives and also other doctors.'*

AMIC6 expressed her belief that:

*... we wouldn't be able to do it without midwives and the doctors. And I think they wouldn't be able to do it without us because of the cultural knowledge and background. So I see it as equal, everyone is working together.*

Again, this raises the importance of sharing knowledges and valuing the expertise that each group contributes to the partnership. As such, AMIC5 described how *'we're learning their skills and they're learning ours, and we need to be able to work closer*

*together and have that good relationship with each other.* Client4 noted how Medical Practitioner1 is crucial to the partnership and *'obviously put[s] a lot of trust into the midwives as well.'* AMIC1 discussed how forming these partnerships are made:

*... a lot easier if the doctors are willing to um take on board what the midwives say too. 'Cause that's a different, you know there's me and there's us and the midwives, and there's us and the doctors. But also it needs to happen between the midwives and the doctors as well.*

To establish successful partnerships between the three groups, it is therefore important that medical practitioners also have mutual respect for the program midwives. This was also mentioned by Program Midwife5 who described the importance of *'participating in [client] care in an equal partnership with the doctor and midwife.'*

Furthermore, Ward Midwife3 believes that while *'the midwives and doctors work closely together [...] with the medical stuff [...] the [program] midwife and AMIC worker work together to look after the big picture.'* The big picture in this context refers to the broader context of the clients' lives. As such Ward Midwife3 believes that the partnership exists mostly between the doctor and midwife even though it *'probably shouldn't be like that.'* Interestingly, although the AMIC workers recognised the partnership between doctors and midwives, they perceived the partnership between AMIC workers and program midwives to be more prevalent and more important. This variation speaks to important changes that have been made within the working environment.

While Program Midwife3 *'would say it's definitely a partnership between program midwives and AMIC workers'* she believes a partnership that includes the medical practitioner depends on who the medical practitioner is. This was further supported by Ward Midwife5 who when asked if a partnership exists responded *'yes and no'* and believes it exists with *'Medical Practitioner1 yes, but [another medical practitioner] I don't know how much.'* Clearly, partnerships are dependent on personalities and subsequent interactions, and cannot be forced. At the time of interviews, individuals involved in the program spoke about being able to work successfully because of the partnerships with one another. The data strongly supports the importance of

partnerships between AMIC workers, program midwives and medical practitioners. However, it became apparent that many were largely referring to partnerships between program midwives and AMIC worker, and that meaningful partnerships between all relevant parties are yet to be achieved.

***The importance of mutual respect***

Mutual respect is considered crucial to the success of the program. This was described in detail by Program Midwife2 who demonstrates an appreciation of the importance of establishing meaningful respect:

*... if we haven't got respect for each other in the program then you know, it it's doomed to fail really I think. You know, just respecting other people's rights for better health outcomes, but also respecting the other AMIC workers points of view um ... you know, we're guided by what they say about some of the women, about the care that the women need.*

An important factor in establishing this respect is the understanding and recognition of the importance of the AMIC role and its requirements. Program Midwife5 believes that *'you can't respect [the AMIC workers] if you don't really understand them.'* There was recognition that *'clarity around roles [in the program] has been a bit of an issue'* particularly the AMIC role, and it is *'a really important thing'* to *'acknowledg[e] that role [and] understand [...] it and being able to work within that.'* This reinforces the importance of clearly defining the role of the AMIC workers and promoting understandings of their role requirements. I argue that an understanding of Aboriginal culture and relevant protocols is not an area that can be easily defined or clearly understood in this context, but a staff member can and should have an appreciation of these knowledges.

As such, mutual respect may not happen between program midwives and AMIC workers who have had less experience working in the program. While Program Midwife6 believes that mutual respect happens *'most of the time'*, it is less likely to happen with *'the junior [AMIC workers]'* because of their *'lack of confidence.'* She attributes this lack of confidence to *'not knowing, not understanding and still learning the trade'*, suggesting time and experience in the field is a factor influencing the

establishment of mutual respect. Alternatively, this suggests that the AMIC workers may not be receiving enough support or advocacy by experienced midwives.

Furthermore, a discourse around respect needing to be earned emerged from the interview with Program Midwife3. She described how if a member of the program is perceived as not doing their job properly, difficulties in establishing mutual respect will be encountered. She expresses this by using the phrase *'do your head in.'* While her description may be interpreted as slightly patronising of AMIC workers, by acknowledging that they likely have the same issues with program midwives her understanding of mutual frustration was revealed:

*... it's about earning your respect both ways. You know like, some of the AMIC workers who, you know, can do your head in. And there are others who just do a really great job. And I suppose they look at us the same way.*

Ward Midwife4 spoke about mutual respect as being *'excellent,'* and *'a mutual respect and it's a mutual partnership'* is what *'we try and promote. The AMIC workers have great antenatal skills, great social skills, great communication skills, so ... and they can teach the midwives and also the midwives on the ward, a lot about managing and working with Aboriginal clients. So there is mutual trust and mutual respect that has, it wasn't there initially, it had to be, it is a thing that had to be developed over time.'* Interestingly, these views were not expressed by the AMIC workers and are perhaps reflective of a *'rhetoric of respect'* that does not necessarily exist in practice.

One program midwife acknowledged that failing to show respect to AMIC workers can cause clients to disengage:

*Program Midwife4: ... if you're dealing with a client and you're not showing respect to an AMIC worker, it will come out, and the client might not want you as a midwife because you might have said something abruptly, 'cause it's happened to me.*

This example was spoken about in-depth in Chapter 5, but it is important to mention again here for the purposes of demonstrating the significance of mutual respect.



AMIC1 also commented on mutual respect and the importance of staff demonstrating mutual respect for each other in front of clients:

*... mutual respect to me has to happen, and is so important because um ... if the client doesn't see us showing us respect for each other or working in partnership or working as equals ... it just downplays everything ... 'Cause otherwise she won't feel the trust, you know ... of the people who are supposed to be looking after her.*

This demonstrates the significance of being mutually respectful of each other in the program. Not only is it important in establishing and maintaining meaningful relationships and partnerships between staff, but also in sustaining client engagement and satisfaction with the program. Trust was named as an important aspect of mutual respect that needs to be made visible to clients.

#### **The value of partnerships**

Partnerships are valuable because they create a supportive and comfortable environment for clients to access appropriate maternity care. This environment is not restricted to the hospital setting, but exists wherever the program midwife and AMIC worker are working together. Program Midwife1 described this and the importance of mutual respect in creating a safe environment for the client when transporting them. She believes this is when clients often disclose very personal information, and it is when *'the gems happen'*.

*Program Midwife1: It's private and confidential and something will get asked or some little question about you know domestic violence, you know those little things come up. And I'll tell you what, bad luck to you if you miss it, you know 'cause that's when you [learn] about how to get a bit sensitive about how you deal with this person.*

Furthermore, she described how traveling in the car *'is the best place to get a conversation because everyone is looking out here and over here but the talking goes on.'* Program Midwife1 understands that *'for Aboriginal people that's really important.'* In this context, mutual respect is vital in creating a non-judgmental environment where clients can feel comfortable. These types of environments may also be understood as neutral safe spaces.

An outcome of establishing an appropriate maternity care environment for Aboriginal women is their desire to have access to or be cared for by the *Anangu Bibi Birthing Program*. As such, Program Midwife2 believes the partnerships are responsible for establishing a caring environment that clients want to be part of:

*I feel like we're doing a really good job when you've got people knocking at your door saying 'I'm an Aboriginal girl, I'm pregnant, I've heard that you guys would look after me' ... And we've had quite a few ... we're getting a lot of self-referrals from people that have heard about the program ... And even like last week I had a girl who had her birth with us, and her niece was pregnant. And her partner said 'have you got this girl, have you heard about her, she's my niece she's actually pregnant, I'd really like for you to look after her.' And I think you know, that's great. And the girls that've been, like we've got girls now who have had their second and third babies with us, and they ring and say, "oh I'm having another baby, can I be on your program?"*

Furthermore, Program Midwife1 recognised that because of this supportive environment:

*... people want to come back for their second and third and fourth kids ... especially third. Well, we're up to third at the minute. And they say, they come to the hospital and they the girls will say, well we know our mob will be looking after us up there, you know.*

She described this as being '*the BEST thing*' about the program. Program Midwife6 believes the significance of the partnership in creating a supportive environment for clients, is most evident during their labour and childbirth. Client1 confirmed this was a time that she felt they worked best together. During these times, she believes the AMIC workers '*are really good with helping the girls [to] breathe through their pain and [in] keeping them calm when they're in labour*' and '*explaining that everything is natural and normal.*' The program midwives balance the partnership in this context because they '*concentrate on the medical side of things.*' In this way she believes the partnership is conducive of a safe environment that clients can feel comfortable birthing in. Furthermore, Program Midwife1 discussed the value of the partnership in creating a relaxed environment for the clients during their labour and birth:

*... sometimes there's girls who haven't got anybody so they want their AMIC worker in there, thank you very much. But they're not Doulas. I mean, they could be and sometimes they are, but that's not their total role. And the midwife, it's very hard for a midwife to be the Doula, to be this to be that, to be worrying about whether we need to call the doctor yet, or anything, or not. Or ... nah nah nah this is normal, let's just go with the flow, let's just keep the mother relaxed. You know what I mean. You need to have a team of people getting a woman to birth safely [laugh].*

Additionally, Program Midwife6 spoke about her experiences of establishing relationships with clients and how prior to the program there was a 'gap' and 'Aboriginal people were scared to come to hospital because they didn't understand what was going on.' An understood success of the program in this context is improving how comfortable clients feel accessing this space, which is obviously a result of relationships that can be established and maintained:

*... when you first meet them, some girls barely talk to you, and by the end of it you know they're telling you everything and they're quite happy for us to do our midwifery checks which includes, you know, inspecting areas that they don't usually show, and once they've had the baby they feel more comfortable with us and they're happy. You know one girl said, 'oh no wait until so and so is on and she can check.' You know you just build up that relationship so that embarrassment and shame is not so bad.*

The established partnerships within the program facilitate the positive experiences clients have. Program Midwife5 believes the success of the program is determined by how satisfied clients are with their care. It has already been established that many of the clients that access the program have complex needs and often experience a high level of disadvantage, and Program Midwife5 believes that because the program creates an environment where they feel nurtured and respected, clients want to be involved in the program during their subsequent pregnancies.

*... I think it's made a huge difference to young Aboriginal girls in terms of their experience of pregnancy and births. So that might not be churned out as outcomes in terms of um birth weights, and then because of the social determinants I don't think a single program can ever ... yeah that's too big of ask. But in terms of um ... the*

*experience that women have, and I think for lots of those young girls it's one of the nicest experiences they've ever had in their whole lives, and that coming into that program and feeling part of that sort of family and feeling special and nurtured, for some of those young girls that's the first time that's ever happened to them. Yeah. And then when you see them come back for their second baby or third baby, they're quite different. They're quite changed in that time and I think that's because they've been nurtured in that first time. Yeah. And you know the women just keep coming back. They come back and back and back looking for that program.*

Discourses around the partnership improving health outcomes have been subtly explored throughout this section, however Program Midwife6 believes a direct relationship exists. When asked directly if she thinks the partnership has improved health outcomes of the program, she stated:

*Definitely. I think a lot more girls are coming to appointments and looking after themselves a bit better and even just getting education about stuff that they probably didn't understand you know why it's good to stop smoking and why it's good to stop drinking and stuff during pregnancy and I think it helps also afterwards if things don't quite go to plan, like if they've already got that little bit of education so they understand a bit more about what's going on. And I think the AMIC workers help empower the girls to be an advocate for themselves, giving them that ... so when they're making consent they're not just going 'yep', they're making more of an informed consent because they actually understand what's going on.*

This extract is important to explore because it highlights the importance the partnership has in encouraging clients to access the birthing program, and in creating an environment that promotes education about healthy pregnancy and encourages self-advocacy, which they may take with them into parenting and life beyond the program. Furthermore, Program Midwife5 talks about the partnership improving 'basic healthcare' and subsequent health outcomes. She believes improved 'access to that healthcare has been through those AMIC workers' who have 'delivered a lot of that basic healthcare themselves.' Program Midwife5 thinks that is 'what's made the difference', which can only happen 'because you see [the clients].'

Similarly, Ward Midwife2 believes a partnership exists and 'I think the fact that one of the main doctors is really involved in it [has] actually helped to [improve]

*outcomes for Aboriginal women and their babies.* Program Midwife3 also recognises that the partnership and appropriate sharing of information and care, improves the health outcomes for clients:

*... I suppose [the AMIC workers] bring um a lot of information about um ... family and culture [...] certainly a lot of um stuff that the girl probably wouldn't tell us, they would tell them. So, I think that's how the partnership works, we share information and that way, we also share care, and then um ... yeah that way you get a better outcome at the end I suppose.*

The significance of establishing mutual respect for each person involved in the program has been described. However, negative consequences of a breakdown of this respect have not been considered in-depth. Medical Practitioner2, gave insight into how and why they believe this would impact negatively upon clients of the program:

*Any hospital or community health system, if there is not mutual respect between the staff there is a breakdown of mutual respect for the patient. The patient is the most disempowered person in the system so unless you treat other people who are your equals or within your professional group equally, you are at some point not going to treat the patient with the right respect at some point, because they are the least empowered.*

Therefore, the significance of supporting the establishment and maintenance of these partnerships clearly extends to the positive impact they can have on the client.

Finally, Medical Practitioner2 summarises how aspects of the partnerships have contributed to the success of program:

*I think it is very successful. And I think the critical things to its success have been passionate women working as AMIC workers with high skill levels, flexible midwives with excellent skill levels and excellent interpersonal skills. And then a supportive environment for it to flourish in. And a number of other people will have contributed in terms of management and all those other things. You know, as they say a success story has many mothers; a disaster often has no mother. So in reality lots of people have contributed to this, and there has been a lot of good will. And there have been a*

*lot of ideas and would have been some difficult moments when people have actually had the strength to work through them.*

Again this implies that the partnership is still largely between the AMIC workers and program midwives.

### **Partnerships are a strategy for dealing with challenges**

Partnerships between birthing program staff members can be understood as a positive buffer against many of the challenges that arise. One such challenge is conflict between staff. AMIC1 described how she believes ‘... *if we didn’t have that partnership or that equality between [...] the team members, we’d be fighting with each other and not getting anywhere and the clients would be missing out. They wouldn’t even see the advantage of [the program].*’ This clearly defines how partnerships can prevent conflicts and being dismissive of the program.

Additionally, partnerships were described as overcoming challenges associated with having unrealistic workloads. Analyses of the AMIC-midwife partnerships revealed how work is shared between both those within a two-way partnership and also amongst those within the entire team. The nature of the small team means that confidential discussions can be had within the team about clients and their specific circumstances. In this way, when the workload becomes overwhelming for one person, there are other members of the team who are potentially able to assist them with addressing the issue. I argue that because, in many instances, clients’ needs are complex and difficult to address, the benefits of sharing the workload with other team members through these partnerships is particularly useful. This can be understood as one strategy that alleviates some of the issues around feeling pressures from the expectation to undertake a large workload as an individual.

### **Conclusion**

Good partnerships do exist within the *Anangu Bibi Birthing Program*, with the most significant being between the AMIC workers and program midwives. The successful establishment and maintenance of these partnerships requires mutual respect for each other. Mutual respect in the program involves having a genuine interest in the health and wellbeing of Aboriginal women, a willingness to listen and communicate well, to understand and appreciate that each individual contributes something unique and

important to the partnership, to view each other as equals (and disengage with any pre-existing power relations) and to understand that without each other a successful program would not exist. These partnerships enable non-Aboriginal staff to be respectful even of things they do not (cannot) fully understand. It also allows them to follow the AMIC workers lead on dealing with clients, their families and the local Aboriginal community in a safe and appropriate way. The partnership is also an important vehicle for the AMIC workers to learn more about clinical aspects of maternity care from the program midwives and medical practitioners.

A distinct part of the analysis is the lack of partnerships between AMIC workers and ward midwives. Typically these relationships were not of the same nature as between the AMIC workers and program midwives, and were often more problematic. Partnerships with hospital management were not mentioned which further highlights the significance of the partnerships that were described throughout the interviews. Although not analysed in this thesis, partnerships may be a protective factor against many of the challenges AMIC workers face in regards to bureaucracies, the unrealistic expectations of the health service and the dominance of the medical model.

A number of benefits of good partnerships have been revealed and explored. It has been recognised that these partnerships buffer many of the challenges that AMIC workers and program midwives face within their roles. Perhaps most significant, is the ability of these partnerships to create a respectful bridge through which both cultural and clinical knowledges are both appreciated and better understood. Additionally, the partnerships may support the acceptance of the birthing program within a mainstream hospital. This has been described as crucial to changing a systemic culture that has not been overly open to or accepting of working appropriately across cultures. I argue that by buffering all of these complexities, the extent of emotional labouring is reduced and subsequent incidence of burnout and staff turnover minimised. Strong discourses emerged around the important role the partnerships play in creating a supportive maternity care environment that clients feel comfortable accessing, and how critical this is in improving maternity outcomes for these women. Acknowledging the significance of this partnership and supporting it appropriately, is therefore crucial to the continued success of the birthing program, including client outcomes as well as staff satisfaction and effectiveness.

## CHAPTER 7: DISCUSSION

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In this final chapter I explain how this research contributes to improved understanding of the role of Aboriginal Maternal Infant Care (AMIC) workers and the spectrum of care they provide. Despite the role being in existence for some time, there has been very little analysis of the complexities of the role and the difficulties workers face when trying to cope with the competing demands of work, family and community life. In this chapter, I will summarise the contributions made by this thesis and the strengths and limitations of the research. Following that, theoretically informed recommendations for policy and practice are offered, and future research priorities identified.

### **Contributions made by this research**

The qualitative approach of this research afforded the opportunity to engage with a range of relevant social theories. My analyses expand these theories through an in-depth exploration of the particular subjective understandings of the AMIC worker role within a mainstream hospital setting. Four theoretical lenses helped to draw out relevant themes and provided useful frameworks for thinking through the issues, these are discussed below.

### **Medicalisation**

This research identified a number of challenges for AMIC workers resulting from the dominance of the medical model. The most prominent is that medicalised approaches to healthcare do not value alternative understandings of health and health systems; rather they prioritise Western medical knowledge and give preference to credentialed hierarchies. This creates an environment where AMIC workers may not feel valued or respected, and challenges the formation of true partnerships, a fundamental principle on which the program is based.

Several participants identified strategies for overcoming the impact of medical dominance. These included allowing the AMIC workers to be the experts on client needs, respecting AMIC workers' knowledge of culture and community, understanding that they have a number of obligations to community and family (which are mostly positive influences that reflect the level of trust instilled in them by clients) and allowing AMIC workers to advocate for the most appropriate delivery of maternity care. The analyses also revealed the importance of local advocates to effect change within the



medical work environment to make the workplace and healthcare system more accommodating for others. These advocates were typically medical practitioners and midwives, affirming the embedded power relationships in the current maternity system.

In summary, the medically dominant paradigm for structuring maternity care dictates the type of knowledge that is valued. Therefore, Aboriginal knowledges around pregnancy and childbirth are largely rejected and the contributions of AMIC workers begin from a position in which they are fundamentally under-appreciated.

### **Emotional Labour**

There have been very few examinations of experiences of emotional labour from an Aboriginal perspective. My thesis extends current understandings of this theory and offers new insights into the ways that Aboriginal women perform a caring role within a work setting. My analyses indicate that cultural considerations and obligations appear to heighten AMIC workers' experiences of emotional labour. They also suggest that the relational nature of gender and Indigeneity are important influences on subjective experiences and meanings of work for these women.

My analyses reveal that emotional labour is large and unavoidable for the AMIC workers in many ways. Emotional labour is experienced in trying to negotiate and demonstrate relevance in a highly medicalised workplace (as described earlier). This includes dealing with a lack of acceptance by other staff (including discrimination) and difficulties adhering to protocols that may be in conflict with other approaches to health care (such as allowing many family members to be present at the birth or supporting women to take their placenta home).

Another way that emotional labour perpetuates itself for the AMIC workers is through the obligations and commitment they have to clients, family and the community. As emphasised by all AMIC workers, they are not removed, and cannot easily remove themselves - nor should they be expected to - from their clients' lives because of their positioning as Aboriginal women within the community. AMIC workers will always feel a responsibility for clients beyond their paid role, regardless of whether they may in fact be related to them. This is associated with cultural responsibilities and protocols that AMIC workers identify with, both beyond and within their roles. The extent to

which emotional labour is experienced by the AMIC workers is further amplified by the extreme social disadvantage and poor health outcomes experienced by many clients.

The extent of the emotional labour that AMIC workers engage in has the potential to pose challenges when trying to separate their private and public spheres of life. From this thesis, it was clear that this is particularly apparent for women living in a small community (where people often have closely woven networks), and especially for AMIC workers whose obligations extend to wider family and community both culturally and through their official work role. Having the opportunity to separate these spheres was often rare and challenging, both within and outside of their homes.

With the emotional labour resulting from client and community expectations also comes the constant emotional labouring around the fear of community backlash if something goes wrong (i.e. if a client is unhappy with the way they have been treated or if a baby dies). Many examples of this were given throughout the interviews, which highlights a dimension of emotional labour that has not previously been recognised within this context. This was described as an unwavering constant threat to the AMIC workers that affects the way they work. It is important for non-Aboriginal people to recognise this and understand that this is different to Western notions of emotional labour.

My analyses revealed that in most instances the emotional labour experienced by the AMIC workers is invisible to the contemporary hospital service, its staff and even some clients. This makes it a difficult phenomenon to discuss and therefore address, further contributing to the impact of the emotional labour on the AMIC workers. While I have demonstrated the relevance of this theory for AMIC workers, the findings are likely to have wider resonance for a range of caring roles within the field of Aboriginal health.

#### **Ideal worker**

The literature describes how the expectations of an ideal worker became embedded throughout organisations and institutions historically. This thesis offers an extension of theories around the ideal worker by applying them to AMIC workers and the expectations a mainstream health organisation has of them. This is a useful way of thinking about the roots of many of the challenges facing the AMIC workers, and creates a framework for deepening understandings around concepts of time, the misfit

of these expectations with the flexibility required in the role, and the other commitments and obligations AMIC workers have to both clients and community outside of their official paid role.

My analyses have also shown that the nature of pregnancy care and the AMIC worker role are not a good fit for the ideal worker model. Pregnancy and childbirth present a number of challenges to this model related to both the Westernised concepts of medicalisation (which determine the many requirements and expectations of institutional time) and the flexibility required for the delivery of appropriate care (particularly for Aboriginal women). This is compounded by a large disconnect between the ideal worker concept and Aboriginal identities. It is apparent that relationships, responsibilities and accountabilities never cease between the AMIC workers, their clients and families, which is in strong contrast to the expectations set by the system. Ironically, it is these ties that the maternity care system often relies upon to engage women, yet the system also fails to recognise the importance of connections and the time required to build and maintain relationships.

Through my analyses it was clear that flexibility of the AMIC role (both in time and trust) is required to engage women in antenatal care. The inability of the ideal worker model to allow for AMIC workers to fully commit to the needs of their clients in these ways is a potential threat to the sustainability of the program. It is important for the health system to recognise these challenges and acknowledge that care is not confined to the walls of the hospital, allowing for better recognition of their dedication to improving the maternal and infant health outcomes of their clients and families. If this level of understanding and appreciation was reached and operationalised, it would represent a big step forward in the way AMIC workers are valued.

### **Partnerships**

Partnerships are critical to maintaining the program's ability to engage Aboriginal women in maternity care, and this was recognised by many informants. The most important partnership is between the AMIC workers and program midwives. This requires a mutual respect for each other (on both a professional and personal level) and a shared commitment to improving the delivery of care for clients of the program.

My analyses identified a number of critical factors for the formation of partnerships with AMIC workers. These included valuing the social approach to maternity care, appreciating that emotional labour has particular challenges and expectations for AMIC workers that are different to others involved in delivering care, and understanding that ideal worker expectations (particularly aspects of being an Aboriginal woman that interact with these notions) create challenges and unrealistic expectations for the AMIC workers. When consideration of all of these elements occurs, successful partnerships can be formed and maintained.

This thesis identified a number of benefits of having established and respectful partnerships between AMIC workers and program midwives. Foremost, the partnerships enabled AMIC workers to feel more comfortable in their work environment. As a result a new workforce and career pathway was established, and the AMIC workers felt they could confidently advocate for their clients. This resulted in improvements in the delivery of appropriate care of clients, which seemed to increase the recognition and value given to the AMIC worker role. The partnership model also afforded a different approach to caring for women, which is likely to have increased the number of women accessing care, with numerous examples of women returning for subsequent pregnancy care. I argue that within the system there needs to be greater recognition of potential benefits of partnerships.

Partnerships extending beyond these two roles are also critical to the sustainability of the program. There is a need to strengthen partnerships between AMIC workers and medical practitioners, ward midwives and others in the environment (including staff on other wards as well as those in management roles), as well as with other relevant professionals located outside of the hospital (including social workers and early-years support workers). Partnerships are also required between organisations (including the hospital and community controlled health centres) and the local community.

Recognition that the *Anangu Bibi Birthing Program* itself is of value, that the roles of those involved are important, and that care needs to be provided in different ways (including more community-based engagement strategies and remaining flexible to the needs of clients) would assist with the development of partnerships beyond the program.

I argue that a substantial investment should be made to encourage the formation and maintenance of partnerships across these groups.

### **Sustainability**

The main theories identified and explored in this thesis have highlighted a number of factors that make the AMIC worker role sustainable (e.g. partnerships and advocacy) as well as those that create challenges for the program's long-term sustainability (e.g. burnout and lack of understanding of the program). The analyses illuminate both the extent and the consequences of the demands placed on AMIC workers, which are complex and layered. They largely relate to the number of obligations of AMIC workers have, both within and beyond their AMIC role. Negotiating these identities and the varying expectations (of hospital, client and community) is extremely challenging for the AMIC workers and should be acknowledged as a means of showing support to these women. I strongly argue that better recognition of these complexities and appropriate support to deal with them is the type of commitment required to sustain the AMIC role.

### **Strengths and limitations of the study**

This study has a number of strengths and possible limitations. The qualitative nature of the research is a major strength as it enabled an in-depth exploration of a number of themes that have not previously been examined in this context. This approach highlights the uniqueness of the research question, gives priority to voices previously unheard and allows subjective experiences to be highlighted.

I invested a substantial amount of time in establishing relationships with the program and wider community, a factor critical to being able to undertake research with Aboriginal communities respectfully. This resulted in permission to interview clients (which took some negotiation to protect the over-researching of local families, following the commencement of the Aboriginal Families Study) and was essential in establishing a level of trust that improved the quality and depth of the data. Participants were mostly very willing to be interviewed for the study and eager to contribute their perspectives. I assert that this would not have been the case had these relationships not existed.

The time invested in these relationships was vital to sustaining meaningful collaborations. My commitment to maintaining a meaningful collaboration amongst

leaders of the local Aboriginal community and stakeholders from local health services was an additional strength of the study. Regular consultation with local Aboriginal community representatives, including the Aboriginal Reference Group, as well as local stakeholders was critical to the research process. These activities allowed interview data to be interpreted soundly, allowed the Aboriginal Reference Group to have some input into the direction of the research and ensured research processes were appropriate and sensitive to local needs. All of these elements are important to conducting respectful research within Aboriginal communities. Collaborations with these groups and program staff also made the dissemination process more meaningful for all involved. The recommendations of the study were taken back to these groups for cross-checking of accuracy and to gauge how useful they are in practical terms.

Additionally, the study provides a number of examples of reflexivity and reciprocity. These include those that related to the research processes (i.e. acting on findings that may have benefited the AMIC workers as they emerged) and to sharing of research skills with members of the Aboriginal Reference Group. This is in line with the NHMRC guidelines for conducting ethical research with Aboriginal people (NHMRC, 2007). My research created opportunities for AMIC workers to gain experience in research skills. I co-authored a paper with an AMIC worker (Stuart-Butler & Kirkham, 2010), contributed to two documents created for the program that were disseminated across South Australia (including an information booklet '*Aboriginal Women Caring for Aboriginal Women: Aboriginal Family Birthing Program*' and a document that was used to help justify the continuation of the program when funding cuts were announced '*AMIC workers: better understanding of their role and improving support for them*'), and co-presented the results of this study with an AMIC worker at a national conference ('*Walking in the Worlds of the AMIC workers*' April 2013, Public Health Association of Australia: Social Inclusion and Complex Needs, Canberra). My work also helped to inform the state-wide evaluation of the implementation of AMIC workers in maternity settings across South Australia.

I also acknowledge a number of possible limitations. For some categories of participants, I used purposive recruitment, which has the potential to mean that I did not access the the full range of views. This is of concern mainly for the recruitment of clients of the program and for ward midwives. Initially I was not permitted by the

program's Steering Committee to interview clients due to concerns about research overload, as another study documenting Aboriginal women's experiences of maternity care had already been granted permission for interviews during the timeframe of my research. A year later I reapplied and was given approval to interview clients on the condition that staff of the *Anangu Bibi Birthing Program* would determine the clients that I could approach to participate. I understand that the clients selected by the program staff for my study were thought to be less at risk of medical and/or social problems. Considering that many clients have a vast number of complexities in their lives, this was thought to be the most ethical, appropriate and sensitive way of recruiting a potentially challenging sample. Indeed, of the 11 clients that I approached to participate in the study, none refused. It is possible that the clients interviewed had more positive experiences of the program than others. However, I do not believe that this is a major source of bias in my study, as within the sample there was still a wide range of views expressed, including negative experiences of the program.

Similarly, permission to recruit ward midwives was gained later in the study when I submitted an amendment to my initial research and ethics proposal. Recruitment of ward midwives was not purposive (i.e. including those who may be positive and those who may be negative, or more versus less experience), rather dependent upon who the ward manager felt appropriate for me to interview. It is therefore possible that the views expressed in my data are not reflective of the entire ward staff, as there may have been a concern that some views would be damaging to the program. Nevertheless I argue that the results of the study are rich and expose enough of the opinions and understandings that are problematic for the program and the AMIC workers. However, it remains possible that there may be other problems influencing the sustainability of the program that I did not identify.

Another potential limitation is the pre-existing relationships I had with a number of participants of the study (AMIC workers and program midwives). While this may have created a social desirability response bias, that is the tendency to respond to questions in a 'favourable' way, which threatens the validity of the interview data (Collins, Shattell, & Thomas, 2005; Hewitt, 2007) I argue that it is actually a strength of the project (as I described in-depth in the Methodology Chapter) considering the nature of the research and the importance of maintaining relationships and trust. I strongly argue that without

the relationships I had already established with the local community this research would not have been possible.

### **Conclusion and recommendations**

There are several recommendations that can be made to improve the practice of the *Anangu Bibi Regional Family Birthing Program* at a number of levels. These have been shared with local stakeholders, program staff and community members through forums and the dissemination of a short briefing document (Appendix D). Foremost, strategies that support the development of positive relationships between health professionals will help to ensure the sustainability of this model of care. These include training in cultural safety and promoting awareness of systemic issues that create challenges for AMIC workers. Substantial investments into both of these factors are crucial to improving the establishment and sustainability of true partnerships.

A number of essential resources to improve the working environment for AMIC workers have also been identified. Of greatest need is a dedicated physical space for the program that is conducive of a culturally safe and respectful environment. This is somewhere women can feel comfortable and supported (i.e. a space to bring children, have access to appropriate information, feel safe having private conversations). Other identified needs include built-in debriefing processes within teams in the program, which would allow the AMIC workers to refresh and gain support. Additionally, greater assistance for staff (through both funding and bureaucratic support) to access the necessary resources, including transport, car seats and personal items for women would improve the sustainability of the program and contribute to a greater sense of value of the program.

Strategies that improve the recognition of the program and role of the AMIC workers are also required across a range of settings. This could include regular team-building exercises on the ward as well as in-services with hospital staff that describe the original vision of the program and the rationale for the partnership approach, and that provide examples of the daily activities of AMIC workers so as to increase awareness around the complexities of client lives and the AMIC worker role. Within the community, greater promotion of the program through better community awareness would encourage better recognition of the range of support activities the AMIC workers



provide. This could be achieved through promotion of the program at community events, through the local Aboriginal radio station (including information sessions promoted through Umeewarra Radio) and promotion through community outreach activities (including handouts at sporting activities or health promotion events) as well as at local health centres and clinics.

The policy implications of this research have relevance to the ongoing implementation of the program at a state-wide level and relate to the transferability of the results to other healthcare settings. Achieving optimal support for Aboriginal staff in the maternity system will require a number of system-level changes. These include addressing the organisational barriers that prevent the AMIC workers from fulfilling the requirements of their role, including time restraints given to client visitation and limited resources to support appropriate care of clients (e.g. adequate transport and social support). I suggest that change could be achieved by instilling greater trust in the AMIC workers and valuing their contribution to improving Aboriginal women's access to maternity care. This should also entail supporting them to have greater autonomy within their role and not be restricted by unhelpful structural rules that inhibit this, better valuing their time, remunerating them appropriately (i.e. through a paid on-call roster and recognising the importance of community engagement), supporting them with further training and professional development opportunities, and including AMIC representatives at the decision-making level of the organisation.

Through changes to the appropriateness of service delivery, health systems are able to improve the health of Aboriginal people. This study has identified some of the key factors affecting the AMIC worker's ability to fulfil their defined roles, so they are able to deliver suitable maternal and infant healthcare to their local community. These include autonomy within their work role to meet the needs of their clients, and flexibility to respond to their extensive obligations (both community and cultural). These are likely to be similar to other Aboriginal health workers or those with a caring role, highlighting the transferability of these results to other healthcare settings.

This study has highlighted a number of areas for future research. There is a need to further explore the experiences and consequences of emotional labour for Aboriginal people. Such research needs to be preceded by appropriate community consultation and

should be based on community priorities. My findings confirmed that emotional labour is both real and large, raising the question of how to rejuvenate AMIC workers and give respite to those affected. While the psychology literature suggests emotional restraint is one way of dealing with this (Ashforth & Humphrey, 1993) I argue for the need to determine different ways of addressing this for Aboriginal people. My results have revealed that the nature of extended family relationships and cultural obligations are critical to the AMIC worker role and as such withdrawal is not a useful strategy for dealing with emotional labour. I have also demonstrated that these relationships and obligations can act as buffers against the negative aspects of emotional labour and burnout, and as such need to be considered in all of their complexities. The Western way of avoiding burnout is therefore not a feasible option and I argue that this approach is immoral, as it essentially requires an individual to reject their cultural identity. Extended thinking and research within this field, particularly around strategies that assist Aboriginal workers to manage the challenges associated with emotional labour is a critical area for future research and would have wider implications for the Aboriginal workforce in the health system and beyond.

Another important area for future translational research is identifying ways to sustain and strengthen partnerships. As such, my final recommendation is for future research to explore the possibility of measuring both the effects of partnerships on maternal and infant health outcomes, and the best ways to support them. While difficult to measure, I argue that evidence demonstrating the significance of these relationships will help to support the development, adoption and sustainability of partnership models within the health sector (and possibly beyond). As demonstrated and acknowledged throughout this entire thesis, partnerships are the critical factor that can be attributed to the success of the *Anangu Bibi Birthing Program*. It is partnerships that have helped to establish the AMIC caring role as it exists, buffer the interfaces between medical and Aboriginal understandings of pregnancy and childbirth, overcome challenges with ideal worker expectations, and prevent some of the negative consequences of emotional labour. I argue that undertaking research that indicates further benefits of partnership models is a critical step to addressing the unacceptable health disparities that continue to exist between Australia's Aboriginal and non-Aboriginal populations.

The original vision of the *Aboriginal Regional Family Birthing Program* was to address poor perinatal health through a model that involves Aboriginal people as an equal partner in the delivery of care. The research undertaken in this thesis has shed light on the fact that AMIC workers still have limited power in the system, are not considered by all as equal partners, their cultural knowledge is not always respected and valued, and they are not well supported to deal with the complexities of their role. Until these false assurances are addressed with a serious and sustained commitment, I argue we will continue to perpetuate many of the injustices responsible for the continuing poor state of Aboriginal health.

## APPENDIX A: PARTICIPANT INFORMATION

### **Study information sheet for participants. For you to keep.**

#### **Background**

Good healthcare for women in pregnancy improves birth outcomes. Although more Aboriginal women than non-Aboriginal women are having babies that are of low birth weight and that have poor health, there is evidence that programs specifically targeted to Aboriginal women improve outcomes. Such programs in South Australia include the *Anangu Bibi Regional Family Birthing Program* and the *Aboriginal Regional Family Birthing Program*.

Aboriginal Maternal Infant Care (AMIC) workers have been widely recognised as being critical to the success of these programs. The AMIC workers work together with the , other healthcare providers, and clients of the program to deliver culturally appropriate care. An evaluation of these programs in 2007 drew attention to the importance of the role of AMIC workers and provided some description of the role. However, there is more that needs to be understood about this relatively new role to further build capacity and resilience in AMIC workers, and to be able to repeat the success of the program in other locations.

#### **Why we want to do the study**

This study seeks to explore the understandings of the AMIC workers, and past clients of the program, about:

- How the AMIC workers balance their clinical skills with cultural knowledge and culture protocols;
- What the processes of the AMIC workers in developing trust and responding to the needs of individual women are;
- How the AMIC workers do all of this whilst belonging to the community at the same time.

We want to find out and build on this information so that we can improve people's understanding of the AMIC workers' roles. This research aims to keep Indigenous knowledge, leadership, values and worldviews central to its processes. A key part of the research includes the formation of a reference group including community members, AMIC workers and Aboriginal researchers, to guide the researchers in appropriate research processes, interpretation of findings and reporting of results.

#### **What are the possible benefits of the study?**

We hope that this research will provide a clearer definition of the AMIC worker role and acknowledge how complex the role is. In the long term, this information may help to make the AMIC workers roles more sustainable. This information may also help to support other programs where roles similar to the AMIC worker exist. However, it is unlikely that there will be any immediate benefits to participants themselves.

#### **How can this research benefit Aboriginal people?**

This research is largely about documenting and acknowledging success stories, and we aim to further value the role of the AMIC workers. In the long term, this project aims to improve the sustainability of the role of the AMIC workers, and in doing so, will help Aboriginal women (AMIC workers and clients) in the future. Additionally, the research may assist with capacity building and empowerment, further promoting resilience in AMIC workers as well as promoting the optimum delivery of care for Aboriginal women.

#### **Who can take part?**

This study aims to talk with AMIC workers, and other healthcare providers involved in the birthing program and Aboriginal women who have been involved in the programs in the past. Women who are currently accessing the program (that is they are pregnant, or are still having check-ups) will not be able to take part.

**What is involved if I decide to participate?**

Participating in this study involves being interviewed. The interview will take between one and two hours to complete and will include asking some questions about your views of the role of AMIC workers. Specifically, we are interested in your views about how AMIC workers approach the challenges and opportunities of their roles.

If you are interested in taking part you will be able to discuss the research with the Investigators and then be asked to complete and sign a consent form. We will then organise a time and location that is convenient for you to conduct the interview. Depending on whether or not you participate in your own time or during your work hours, either yourself or your workplace will be compensated for the time required to participate in this study. With your permission we would like to tape record the interview.

To make the interview process more comfortable for you, you will have the option of having someone else attend the interview. This could be an Aboriginal woman who understands the project and comes with the interviewer or a friend of yours who would help you to feel more comfortable, or you can attend by yourself.

The information collected will remain confidential and no individual will be identified. The information will be stored in a secure place and the study team will be the only people able to access it.

**Do I have to take part?**

No, you do not have to take part. You can say NO at any time. If you decide to participate and then change your mind, you do not have to do the interview. You can also stop the interview at any time, and you can skip any questions if you don't want to answer them. You will not be treated differently if you do or do not choose to participate.

**How will the information be used?**

The knowledge gained from this study will be shared with communities and mainstream healthcare decision makers. The most appropriate way to share this information will be decided on with the guidance of the reference group. Short written reports, meetings or forums may be some of the ways in which we share the information. A copy of the interview transcript will be provided to you if you would like it.

**For more information contact:**

Ms Renae Kirkham, Chief Investigator  
The University of Adelaide, Spencer Gulf Rural Health School, Port Augusta Hospital SA 5700  
Mobile: 0419 819 130    Office: (08) 8641 2799    Email: [renae.kirkham@adelaide.edu.au](mailto:renae.kirkham@adelaide.edu.au)

Dr Alice Rumbold	Mobile: 0411 269 831
Associate Professor Vivienne Moore	Office: (08) 8303 4605
Dr Elizabeth Hoom	

**If you would like further information about the rights of participants or have any concerns or complaints, please contact:**

Ethics Administration Officer,  
Research Ethics and Compliance Unit  
Research Branch  
University of Adelaide SA 5005  
Phone: (08) 8303 4417

## APPENDIX B: PARTICIPANT CONSENT FORM

### Walking in the Worlds of the AMIC Workers

#### *CONSENT FORM*

**Full Name:**.....

**DOB:** ...../ ...../ .....

**Before signing this consent form you should make sure you have read or had the information sheet explained to you and understand what it means to be a part of this study. You do not have to take part in this study. You can say no.**

- I have read or had the information sheet explained to me. Yes  No
  
- I understand that this interview is about talking about what I think about the AMIC workers roles. Yes  No
  
- I am satisfied that any questions I have asked about the study have been answered. Yes  No
  
- I understand that I can withdraw (stop participating) from the study at any time. Yes  No
  
- I understand that participating in this study will not affect my health or other aspects of my life. Yes  No
  
- I understand that the information I give the study will be confidential and that my name will not be identified in any part of the study. Yes  No
  
- I agree to be interviewed for this study. Yes  No
  
- I consent to my voice being recorded in the interview. Yes  No
  
- I would like to be given a copy of the interview transcript. Yes  No
  
- I understand that Aboriginal knowledge and cultural heritage is owned by Aboriginal people and that this will be acknowledged in the research findings and dissemination of the results. Yes  No

**Participant**

**Full name:**

\_\_\_\_\_

**Signature:**

\_\_\_\_\_

**Date:**

\_\_\_\_\_

**Best Contact Details:**

\_\_\_\_\_

**Witness**

**Full name:**

\_\_\_\_\_

**Signature:**

\_\_\_\_\_

**Date:**

\_\_\_\_\_

**Best Contact Details:**

\_\_\_\_\_

## APPENDIX C: INTERVIEW SCHEDULES

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### **General Interview Schedule** informing interviews for all four participant groups

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As this project involves in-depth interviews that aim to gain rich data from individuals about their experiences and perceptions of AMIC workers, the interview schedule will be very flexible and have the scope to be directed by interviewees (according to what they feel is necessary to discuss around the topic). In stating this, questions asked by the interviewer will adhere to the guiding and prompting questions, and if there is anything the interviewee feels they want or need to discuss, they will be free to do so.

### **Guiding Interview Questions**

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Can you explain your history and experiences with the program (to date)?  
 How long have you been/ were you (if client) involved with the program?  
 Tell me what it is like to be involved in the program.  
 What are the best things about the program?  
 What are the different things about the program you like?  
 How do/did you cope with being involved in the program?  
 Are there aspects of the program that could be changed to improve your experience with the program?  
 Do you think the AMIC workers are valued in the program (valued by the program itself, those within it and people outside)?  
 Do you think the AMIC workers are valued by/within community? Why/why not?  
 How do the AMIC workers develop trust and respond to the needs of individual women and the health service?  
 How do the AMIC workers balance and negotiate working with and between the clinical aspects of their work and culture?  
 How do the AMIC workers do this whilst belonging to the community at the same time?  
 What factors do you think influence the success of the program?  
 What do you think the AMIC workers do well in the program?  
 What are the challenges that you believe face the AMIC workers and how do they deal with these?  
 Is there anything you feel could be improved in the program?  
 Is there anything you feel could be improved in the program to help the AMIC workers in their roles?  
 Do you think people in the community know much about the program and the AMIC workers role? If not, do you think this should be improved? How would it help (AMIC workers, community, women and the program)?  
 What are the main barriers that AMIC workers face in their work?  
 How do they overcome these barriers?  
 What do you see as being facilitators for AMIC workers in their work?  
 How do you think AMIC workers can best be supported in their roles?  
 How do you think resilience can best be built in the AMIC workers?

### **Questions specific to Program Midwife and AMIC Worker Schedule:**

How do your thoughts differ from when you started working in the program?

- Thoughts about your role
- Thoughts about other roles
- Thoughts about how the program runs
- Have things changed/improved since inception?

Do you believe the program is growing stronger?

What do you believe makes the program work in this location? Do you believe it works differently in other locations? Why/why not?

What helps you with your role?

What challenges do you face in your day-to-day role?

**Questions specific to Program:**

What is it about working with AMIC workers and others in the program that you like?  
Would you like to see more AMIC workers in the program?  
What challenges do you think the AMIC workers face?  
What do you think are their strategies for overcoming these?  
Do you think they are affected by burnout often?  
What are your concerns about the sustainability of their role?  
How do you think the role could be further sustained?  
Do you believe the workers are resilient?

**Questions specific to AMIC Workers:**

What is it about working with midwives and others in the program that you like?  
What is the best thing about being an AMIC worker?  
What are some of the challenges you face?  
What are your strategies for overcoming these?  
Do you ever feel the effects of burnout?  
What are your experiences with working with family/close friends?  
Do you believe AMIC workers are resilient?  
Do you believe you are resilient?

**Questions specific to Clients:**

Do you think having an AMIC worker made your contact with the health system easier/more comfortable?  
How many of your antenatal appointments did you attend?  
Do you think you would have attended that many if AMIC workers were not involved in the program?  
What was it about having an AMIC worker that you liked/ didn't like?  
How do you think the AMIC workers are able to work in the hospital setting, encourage Aboriginal women to come to their appointments?  
How do you think the AMIC workers are able to work in the hospital doing their jobs and belong to the community at the same time?  
How do you think the AMIC workers cope when something bad happens either in their work or in the community (how does this affect how they work and how they deal with community)?  
What was good about the way the AMIC workers communicated and worked with you?



## **Interview Schedule for AMIC Workers**

**Thank** the participant.

Read the **information sheet**? Are there any **questions**?

**Consent forms**- Provide the participant with two consent forms (one for their own reference and one for study records). Explain that the consent forms are a requirement of the University of Adelaide and Aboriginal Health Council Human Ethics Committees. I will be the only person that will see these forms, and once I have signed the witness section on the consent form I will seal the document in an envelope and give the participant a code number. The envelope will be stored in a secure place.

I am really interested in and strongly value your views, opinions and stories, and want you to feel you can be **open to discuss** any of these along the way. Throughout the interview I will ask some **guiding questions**, this will give you the opportunity to talk about what you feel is important. Please feel free to raise any issues that you think are important that I do not cover. I think that the interview will go for about an hour.

I would like to **tape record** the interview... no one will listen to the tape except me. The reason I would like to use the tape recorder so that I can record all of what you say in the right way. I want to make sure that I get your word for word account, this way I shouldn't misinterpret anything you say. Do I have your permission to use the recorder? I will also be taking notes of things you have to say during the interview. If you feel uncomfortable at any time during the interview you can choose to not answer questions, withdraw from the interview or we can stop.

All interview content will remain confidential and you will not be named publicly for anything you say during this interview.

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### **Commence Interview**

As you know, I am really interested in your role as an AMIC worker in the birthing program believe your work is so important and that we need to better understand how you do what you do as an AMIC worker to better recognise and support you in your role.

I am hoping we can start by you telling me your story of being an AMIC worker. I am really interested in your journey and experiences. I am really interested in your journey, experiences, thoughts and interactions with the program and its staff.

**I believe you have been an AMIC worker for some time now. How long exactly?**

**Why was it that you chose to become an AMIC worker?**

**What interested you in the role?**

**Do you think you've always been interested in women's business, particularly birthing?**

**Can you describe a 'typical day' as an AMIC worker?**

**Can you describe a situation that is a good example of what an AMIC worker does?**

**What are the best things about being an AMIC worker?**

**What are the worst things about being an AMIC worker?**

**What are the challenges you face in your work?**

**Have there been times when you have felt you no longer want to be an AMIC worker?**

**What sort of things do you want them to know, to be able to know, to make that better? That is what is it about working with a disadvantage group. Or what are the special things that people should be aware of?**

**Have there been times when being a member of community, when I say community I mean Aboriginal community, um that has compromised your role as an AMIC worker?**

**How do you juggle all of these sorts of different difficulties or challenges? What do you do?**

**How do you find working with midwives or other healthcare workers on the ward?**

**What are some of your experiences with working with other staff? What are some of the strengths or challenges, how are differences resolved- if you have differences with different individuals?**

**What sort of characteristics make, do you think makes a good midwife for the program?**

**Do you ever find yourself disagreeing with midwives in the program?**

Strengths/challenges, positives/negatives, how are differences resolved

What do you think makes these relationships work/not work?

**Do you ever disagree with them?**

**Do you feel you are able to work in partnership with them? Who? Why?**

**How do you think you are viewed by other healthcare professionals (midwives, doctors etc.)?**

**The program is often described as involving a partnership between the doctors, midwives and AMIC workers. Do you agree with this? Why? How?**

**I often hear that ‘mutual respect for each role’ is critical to the program. What are your thoughts about this? Do you think it is important? Does it happen?**

**Do you feel the midwives and other healthcare workers in the program are respectful of culture? What are your experiences of teaching them the things they need to know in their work in order to be culturally appropriate to clients and families you work with?**

**Some people say that it must be hard to commit to being an AMIC worker whilst adhering to cultural rules and belonging to the community at the same time.**

**Do you agree with this statement?**

**Do you feel this is a challenge in your own work? How do you manage to do this?**

**What are your thoughts about AMIC workers aligning their work with culture, community and the needs of the health service? Do you think they/you do this? If so, how and do they/you do it well?**

**On the topic of culture, how do you manage the complexities around culture and birthing?**

In your experience, do you think there are differences in beliefs between generations?

How do you find working with different cultural groups and their beliefs in general, and those different to your own background?

Are there many differences here in Port Augusta? Can you accommodate for everyone?

Working across a number of different cultural groups then, do you find the women have similar cultural rules and needs?

**What type of cultural practices are you able to adhere to within the hospital setting?**

**Do you think the women you see are happy with these? What else could be done to make their experience more culturally appropriate?**

**Do you feel valued as an AMIC worker?**

**Who do you feel values you and your role as an AMIC worker the most? (family, community, colleagues in the program, health service?)**

**What makes you feel valued by them?**

**Do you feel supported as an AMIC worker?**

**Who do you feel supports you the most in your role as an AMIC worker?**

**Are there any different supports you would like to help you in your role as an AMIC worker?**

**Do you have a mentor or someone you feel comfortable going to when you need support?**

**How could you be better supported in your role?**

**Do you think the training prepared you well for what it takes to be an AMIC worker?**

**If you were asked to describe to someone training to be an AMIC worker how to best juggle different aspects around dealing sensitively about culture in your work, what would you tell them?**

**Do you think the AMIC role is sustainable?**

**How do you find energy in your role as an AMIC worker?**

**How do you wind down at the end of the work day?**

**What do you think may assist in making the role of AMIC workers sustainable for the future?**

**Perceptions and experiences of burnout**

**We often hear the term ‘burnout’, especially for Aboriginal health workers.**

**Do you think there are issues associated with burnout specific to an AMIC worker?**

**Do you think that burnout affects AMIC workers differently to other roles in the health sector or other roles you might have had in the past?**

**Have you experienced ‘burnout’ in your role as an AMIC worker?**

What leads to ‘burnout’?

How do you think this could be prevented?

From your experience how do you think people deal with ‘burnout’?

**I often hear the term ‘resilience’ when talking about Aboriginal health workers in general. Is this something you think AMIC workers are good at (being resilient)?**

If so how do they do this / What makes an AMIC worker resilient?

Is it something you see as important to being a good AMIC worker?

**Has the AMIC worker role changed since your involvement in program?**

**Definition of the AMIC worker role**

**How do you see your role as an AMIC worker?**

How would you describe your role as an AMIC worker?

What are your main responsibilities?

What do you feel is most important in your work?

What are the most important aspects of being an AMIC worker?

What do AMIC workers offer the program that no one else in the program does?

What do you think about the belief that AMIC workers are the cultural brokers of the program?

**What is unique about the role?**

**Do you think your role as an AMIC worker has changed over time?**

If so how?

Has the program changed leading to change in AMIC worker roles?

Have people’s ideas of the role of the AMIC workers changed?

**How do you suggest the AMIC worker role be better acknowledged?**

**How do you suggest the AMIC worker role be better resourced?**

**How do you suggest the AMIC worker role be developed?**

**I understand the program is being rolled out to other locations. Do you think it will work?**

**How could the rollout be improved?**

**What are the main factors as you see as being critical to the success of the rollout?**

**Suggestions of how role could be improved/changes to program to support role?**

**The birthing program is often talked about as being ‘successful’. Do you agree with this? If so, what do you see as being critical to the success of the model? What do you perceive to be the keys to success? How could it be improved?**

**What improvements do you think could be made to the program to better meet your needs as an AMIC worker?**

**What are your thoughts on birthing in the bush?**

Do you think we should be considering alternative ways of allowing women to birth?

What role do you believe the father has in the birth? Is this changing?

Who do you think is the most appropriate escort for the woman?

Do you think some women avoid the hospital system all together to birth? How many do you think do this and why?

**What are the best things about being an AMIC worker?**

**Where do you see yourself in the future?**

Do you mind if I ask you some personal questions?

- Age
- Any children
- Cultural Group

**Thank you so much for sharing your story of being an AMIC worker with me. I really appreciate the time you have taken to share this with me. I am just going to take a few minutes to check over the topics I wanted to cover with you. If you want to take this time to think about anything else you may want to talk about...**

## **Interview Schedule for Clients**

**Thank** the participant.

Read the **information sheet**? Are there any **questions**?

**Consent forms**- Provide the participant with two consent forms (one for their own reference and one for study records). Explain that the consent forms are a requirement of the University of Adelaide and Aboriginal Health Council Human Ethics Committees. I will be the only person that will see these forms, and once I have signed the witness section on the consent form I will seal the document in an envelope and give the participant a code number. The envelope will be stored in a secure place.

I am really interested in and strongly value your views, opinions and stories, and want you to feel you can be **open to discuss** any of these along the way. Throughout the interview I will ask some **guiding questions**, this will give you the opportunity to talk about what you feel is important. Please feel free to raise any issues that you think are important that I do not cover. I think that the interview will go for about an hour.

I would like to **tape record** the interview... no one will listen to the tape except me. The reason I would like to use the tape recorder so that I can record all of what you say in the right way. I want to make sure that I get your word for word account, this way I shouldn't misinterpret anything you say. Do I have your permission to use the recorder? I will also be taking notes of things you have to say during the interview. If you feel uncomfortable at any time during the interview you can choose to not answer questions, withdraw from the interview or we can stop.

All interview content will remain confidential and you will not be named publicly for anything you say during this interview.

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### **Commence Interview**

As you know, I am really interested in the roles of the AMIC workers in the birthing program. I believe their work is so important and that we need to better understand how they do what they do as AMIC workers to better recognise and support them in their role. I hope that this understanding can also benefit the women like you who access the program when they are pregnant.

**I am hoping we can start by you telling me your story of being a client of the birthing program, focusing mainly on your thoughts around the AMIC workers. I am really interested in your journey and experiences.**

**So you were pregnant in 20 \_\_\_\_, how old is your baby now?**

**What is your baby's name?**

**How many children do you have?**

**Was this your first time in the program?**

### **Individual Journey**

**I believe your AMIC worker was \_\_\_\_\_. Can you tell me a bit about your experiences with the program and working with this AMIC worker.**

**How did you find out about the birthing program?**

**Did you have a choice between the birthing program and the normal hospital service?**

**What made you decide to go with the birthing program?**

**How did you meet your AMIC worker?**

**Did you choose your AMIC worker or was she chosen for you?**

**Had you heard of the AMIC workers before?**

**Who else did you need to help you with your pregnancy?**

**Did you need them more than an AMIC worker?**

**If you were going to have another baby what would you want to be different from last time?**

**Relationships can always be very up and down. What was your experience of your relationship with your AMIC worker?**

**What did this relationship mean to you?**

**Did your AMIC worker give you special things/do special things for you?**

**What special things do/did you get from her that you don't get from anyone else?**

**How was talking to an AMIC worker different to talking to someone close to you?**

**Were there things you talked to her about that you didn't speak to anyone else about?**  
**Did you talk about other things apart from the pregnancy?**  
**What did you do differently with your AMIC worker than with your family?**  
**Were there things you might have like that you didn't get from your AMIC worker?**  
**What does your family think about your AMIC worker? Did they like her and what she did for you?**  
**How does your AMIC worker fit in the community?**

**How did you like your midwife?**  
**What was the best thing about having her help care for you during your pregnancy?**  
**In comparison to the midwife what did the AMIC worker do?**  
**What did you do differently with your midwife than with your AMIC worker or family?**

**How did you find being involved in the program?**  
**What were some of the best things of being involved in the program?**  
**Were there any bad things about being involved in the program?**  
**What were some of the best things about having an AMIC worker?**  
**What were some of the things you think your AMIC worker does well?**  
**Were there any bad things about having an AMIC worker?**

**Did your AMIC worker teach you things other than about your pregnancy?**  
**If you've had another experience of being pregnant, but you weren't involved in the program, was this experience different? How? What made it different?**  
**What types of things did you need done for you, or need help with when you were pregnant, that is different to when you are not?**

**When people talk about the birthing program they often say that it works because the AMIC workers work in partnership with the midwives. What do you think about this? Based on your experience, do you think this is something that happens?**  
**Based on your experience can you describe how the partnership worked?**  
**Can you think of a specific example of when they worked together really well?**  
**Do you think this partnership is a good thing?**  
**What do you think the program would be like without it?**  
**Do you think that women are being looked after better because of the partnership?**

**Do you think the AMIC workers are respected in the hospital? Why/why not?**  
**Who do you think respects them and the work they do the most? Other people they work with, community, clients?**  
**Do you think the AMIC workers themselves feel respected (or valued)? By who?**  
**What makes them feel valued by these people?**

**Do you feel that the AMIC workers are respectful of culture?**  
**Do you feel that the midwives are respectful of culture?**

**Do you think the AMIC workers feel supported in their role?**  
**Who do you think supports them the most?**  
**Do you think they would like any more support? If so, what do you suggest**

**Do you think being an AMIC worker would be a hard job to have?**  
**What are some of the things you think they might find hard?**  
**What are some of the things you think they might find easy?**  
**What are the AMIC workers really good at?**  
**What are some of the things you think the AMIC workers need to improve on?**  
**Did you ever need to see your AMIC worker when she wasn't at work?**  
**What type of things would you see her about?**

**Do you think AMIC workers get burnout?**  
**Do you think AMIC workers are able to bounce back from some of the hard things they might have to deal with?**  
**What are the midwives really good at?**

**What are some of the things you think the midwives need to improve on?  
People have told me that there are a lot of different Aboriginal cultures in Port Augusta.  
How do you think the AMIC workers find working with the different groups?  
Do you think they work the same across the different groups?**

**What type of cultural things were the AMIC workers able to do for you?  
Were you happy with these?  
Are there any other things you think you would like done for you when it comes to culture and having a baby?**

**Do you think the AMIC workers would like to do anything else for women to make them more comfortable with the program?**

**Now I'm going to ask some general questions about your pregnancy. You don't have to answer any of these if you don't want to.**

**How did you feel when you found out you were pregnant?  
What did it mean to you to be pregnant?  
Who did you have with you when you were in labour?  
Do you see pregnancy as a medical issue? (OR Some people don't believe that women need doctors and nurses to help them with their pregnancy. What do you think about this?)**

**What are your thoughts on birthing in the bush (on country etc.)?  
Do you think we should be considering alternative ways of allowing women to birth?  
What role do you believe the father has in the birth? Is this changing?  
Who do you think is the most appropriate support person for the woman when she is in labour having her baby?  
Do you think some women avoid going to the hospital or Pika Wiya when they are pregnant?  
How many do you think do this and why?  
The birthing program is often talked about as being 'successful'. Do you agree with this?  
If so, what do you think makes it successful?  
Do you think this program should be offered to everyone (e.g. non-Aboriginal people)?  
If you had another baby, would you like to be involved in the program again?**

Do you mind if I ask you some personal questions?

- Age
- What group/mob do you belong to?

**Thank you so much for sharing your story of being involved in the program. I really appreciate the time you have taken to share this with me. I am just going to take a few minutes to check over the topics I wanted to cover with you. If you want to take this time to think about anything else you may want to talk about...**

## **Interview Schedule for Medical Practitioners**

**Thank** the participant.

Read the **information sheet**? Are there any **questions**?

**Consent forms**- Provide the participant with two consent forms (one for their own reference and one for study records). Explain that the consent forms are a requirement of the University of Adelaide and Aboriginal Health Council Human Ethics Committees. I will be the only person that will see these forms, and once I have signed the witness section on the consent form I will seal the document in an envelope and give the participant a code number. The envelope will be stored in a secure place.

I am really interested in and strongly value your views, opinions and stories, and want you to feel you can be **open to discuss** any of these along the way. Throughout the interview I will ask some **guiding questions**, this will give you the opportunity to talk about what you feel is important. Please feel free to raise any issues that you think are important that I do not cover. I think that the interview will go for about an hour.

I would like to **tape record** the interview... no one will listen to the tape except me. The reason I would like to use the tape recorder so that I can record all of what you say in the right way. I want to make sure that I get your word for word account, this way I shouldn't misinterpret anything you say. Do I have your permission to use the recorder? I will also be taking notes of things you have to say during the interview. If you feel uncomfortable at any time during the interview you can choose to not answer questions, withdraw from the interview or we can stop.

All interview content will remain confidential and you will not be named publicly for anything you say during this interview.

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### **Commence Interview**

As you know, I am really interested in the roles of the AMIC workers in the birthing program. I believe their work is so important and that we need to better understand how they do what they do as AMIC workers to better recognise and support them in their role. I am hoping we can start by you telling me your story of being a Medical Practitioner who has experience of the *Anangu Bibi Birthing Program*. I am really interested in your journey, experiences, thoughts and interactions with the program and its staff.

**How long have you been a \_\_\_\_\_ for?**

**How long have you worked at the Port Augusta Hospital?**

**Can you tell me your thoughts about the program?**

**What are your experiences of working with the AMIC workers?**

**What makes a good AMIC worker?**

**What do you mean by practical welfare?**

**Do you ever disagree with them?**

**What are some of the things the AMIC workers are good at?**

**What are some of the things they need to improve on?**

**How has the program affected your work as a \_\_\_\_\_ when working on the ward?**

Have you ever had any cultural awareness training?

**How do you think you, as a \_\_\_\_\_, are viewed by other healthcare professionals (AMIC workers, program midwives, doctors etc.)?**

### **Definition of the AMIC worker role**

**How would you describe the role of an AMIC worker?**

What are their responsibilities?

What do AMIC workers offer the program that no one else in the program does?

What do you think about the belief that AMIC workers are the cultural brokers of the program?

What do you think the main challenges are for AMIC workers?

What do you think would be the best things about being an AMIC worker?

What do you think would be the worst things about being an AMIC worker?

**What is unique about the role?**

**How would you describe the roles of the midwives involved in the program?**



The program is often described as involving a partnership between the doctors, midwives and AMIC workers. Do you agree with this? Why? How? (could push and say – especially in a hospital where there are clear organisational hierarchies, and doctors have a great deal of responsibility for decisions?)

Do you believe the doctors?? are able to work in partnership with AMIC workers? Why/why not?

I often hear that ‘mutual respect for each role’ is critical to the program. What are your thoughts about this? Do you think it is important? Does it happen?

Through your experiences, do you believe the AMIC workers help to teach other staff members how to be culturally appropriate to clients and families? If so, can you give examples? If not, why do you think this?

What are your thoughts about AMIC workers aligning their work with culture, community and the needs of the health service? Do you think they do this? If so, how and do they do it well?

Do you see this is a challenge for AMIC workers in their daily work?

On the topic of culture, do you believe there are any special cultural needs of Aboriginal women that the AMIC workers need to deal with? What are some of these? Do they manage them well?

Do you know of any cultural practices that the AMIC workers able to adhere to within the hospital setting? (e.g. allowing the woman to take the placenta home, sand to put babies feet in)

What are your thoughts on birthing in the bush (on country etc.)?

What are your thoughts about aboriginal understandings of pregnancy and birth?

Do you think there is scope to integrate these understandings into the program better, and if so would it be of benefit?

*Do you think AMIC workers feel valued in their role?*

*Do you think the AMIC workers feel supported in their roles?*

How could they be better supported in their role?

Do you see burnout as being an issue for the AMIC workers? Why/why not?

If so can you offer any suggestions or strategies around how burnout may be prevented?

*Do you think the AMIC role and the program is sustainable?*

Do you think the roll out of the program will work or is working in other locations?

The birthing program is often talked about as being ‘successful’. Do you agree with this? If so, what do you see as being critical to the success of the model? What do you perceive to be the keys to success? How could it be improved?

Do you mind if I ask you some personal questions?

- Any children
  
- Have you had much experience with Aboriginal women and their families as clients, prior to involvement with the program?

Thank you so much for sharing your story of being involved in the program. I really appreciate the time you have taken to share this with me. I am just going to take a few minutes to check over the topics I wanted to cover with you. If you want to take this time to think about anything else you may want to talk about...

## **Interview Schedule for Program Midwives**

**Thank** the participant.

Read the **information sheet**? Are there any **questions**?

**Consent forms**- Provide the participant with two consent forms (one for their own reference and one for study records). Explain that the consent forms are a requirement of the University of Adelaide and Aboriginal Health Council Human Ethics Committees. I will be the only person that will see these forms, and once I have signed the witness section on the consent form I will seal the document in an envelope and give the participant a code number. The envelope will be stored in a secure place.

I am really interested in and strongly value your views, opinions and stories, and want you to feel you can be **open to discuss** any of these along the way. Throughout the interview I will ask some **guiding questions**, this will give you the opportunity to talk about what you feel is important. Please feel free to raise any issues that you think are important that I do not cover. I think that the interview will go for about an hour.

I would like to **tape record** the interview... no one will listen to the tape except me. The reason I would like to use the tape recorder so that I can record all of what you say in the right way. I want to make sure that I get your word for word account, this way I shouldn't misinterpret anything you say. Do I have your permission to use the recorder? I will also be taking notes of things you have to say during the interview. If you feel uncomfortable at any time during the interview you can choose to not answer questions, withdraw from the interview or we can stop.

All interview content will remain confidential and you will not be named publicly for anything you say during this interview.

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### **Commence Interview**

As you know, I am really interested in the roles of the AMIC workers in the birthing program. I believe their work is so important and that we need to better understand how they do what they do as AMIC workers to better recognise and support them in their role. I hope that this understanding can also benefit you in your role as a midwife.

I am hoping we can start by you telling me your story of being a program midwife who has experience of the *Anangu Bibi Birthing Program*. I am really interested in your journey, experiences, thoughts and interactions with the program and its staff.

### **Individual Journey**

**Why you chose to become a midwife in the birthing program?**

**What were your motivations to becoming a midwife in the program? (contribution to community, community need, individual needs)**

Had you had much experience with the program before you became a midwife? (friends, family members, contact through the hospital etc.)

Have you always been interested in Aboriginal birthing? (or health or children)

Were you approached by someone about becoming a midwife in the program? Or did you find out about becoming one from your own interest?

### **How do you find being midwife in the program? (Experiences)**

Relationships, health service responsibilities, working in a team environment, respect

Do you feel you have been/ or are recognised positively for the work you do?

Do you feel you are recognised enough for your work?

**What are the challenges about being a midwife in the program?**

Family pressures, community pressures, juggling different responsibilities

**How do you juggle these?**

### **How do you find working with the AMIC workers in the program? (Relationships)**

**What are some of your experiences with working with them?**

Strengths/challenges, positives/negatives, how are differences resolved

What do you think makes these relationships work/not work?

**Do you ever disagree with them?**

**How do you think you are viewed by other healthcare professionals (AMIC workers, doctors etc.)?**

**The program is often described as involving a partnership between the doctors, midwives and AMIC workers. Do you agree with this? Why? How?**

**Do you feel you are able to work in partnership with AMIC workers? Why?**

**Can you describe what this partnership often looks like?**

**Do you think this partnership has improved health outcomes of the program?**

**I often hear that ‘mutual respect for each role’ is critical to the program. What are your thoughts about this? Do you think it is important? Does it happen?**

**Do you feel that you, other midwives and healthcare workers in the program are respectful of culture?**

**What are your experiences of AMIC workers teaching you the things you need to know in your work in order to be culturally appropriate to clients and families you work with?**

**Did you undergo any formal cultural awareness training?**

**What are your thoughts about AMIC workers aligning their work with culture, community and the needs of the health service? Do you think they do this? If so, how and do they do it well?**

**Do you see this is a challenge for AMIC workers in their daily work?**

**On the topic of culture, how do you believe the AMIC workers manage the complexities around culture and birthing?**

**In your experience, do you think there are differences in beliefs between Aboriginal people from different generations?**

**How do you think AMIC workers find working with women and families from cultural groups different to their own background?**

**Are there many differences here in Port Augusta? Can the AMIC workers accommodate for everyone? Working across a number of different cultural groups then, do you find the women have similar cultural rules and needs?**

**What type of cultural practices are you and the AMIC workers able to adhere to within the hospital setting? (e.g. allowing the woman to take the placenta home, sand to put babies feet in)**

**Do you think the women you see are happy with these practices? What else could be done to make their experience more culturally appropriate?**

**Do you think the AMIC workers would like to see more done in regards to making the program more culturally appropriate?**

**If you could give a midwife training to be a part of the program a piece of advice on how to deal sensitively about culture in their work, what would you tell them?**

*Definition of the AMIC worker role*

**How would you describe the role of an AMIC worker?**

**What are their responsibilities?**

**What do AMIC workers offer the program that no one else in the program does?**

**What do you think about the belief that AMIC workers are the cultural brokers of the program?**

**What do you think the main challenges are for AMIC workers?**

**What do you think would be the best things about being an AMIC worker?**

**What do you think would be the worst things about being an AMIC worker?**

**What is unique about the role?**

**Tell me about the emotional investment of AMIC workers to the program.**

**How does being emotionally invested impact on the service they provide?**

*Do you think AMIC workers feel valued in their role?*

**Who do you feel values them and their role as an AMIC worker the most? (family, community, colleagues in the program, health service?)**

**What do you think makes them feel valued by these people?**

**Do you think the AMIC workers feel supported in their roles?**

**Who do you think supports them the most in their role as an AMIC worker?**

**Are there are different supports you think they would like to help them in their role as AMIC workers?**

**Do you think they have a mentor or someone they feel comfortable going to when they need support?**

**How could they be better supported in their role?**

**Do you think you are a good support for them in their role?**

Do you think their training prepared them well for what it takes to be an AMIC worker?

Do you think your training and induction to the program prepared you well for what it takes to be a midwife in the program?

**If you were asked to describe to a potential midwife of the program, what is like to be involved, what would you tell them?**

**Do you think the AMIC role is sustainable?**

**What do you think may assist in making the role of AMIC workers sustainable for the future?**

**Perceptions and experiences of burnout**

**We often hear the term ‘burnout’, especially for Aboriginal health workers.**

**Do you think there are issues associated with burnout specific to an AMIC worker?**

**Do you think that burnout affects AMIC workers differently to other roles in the health sector or other roles they might have had in the past?**

**Have you seen AMIC Workers experience ‘burnout’?**

What leads to ‘burnout’?

How do you think this could be prevented?

From your experience how do you think people deal with ‘burnout’?

**Have you seen midwives in the program experience ‘burnout’?**

**I often hear the term ‘resilience’ when talking about Aboriginal health workers in general. Is this something you think AMIC workers are good at (being resilient)?**

If so how do they do this / What makes an AMIC worker resilient?

Is it something you see as important to being a good AMIC worker?

**Has the AMIC worker role changed since your involvement in program?**

If so how?

Has the program changed leading to change in AMIC worker roles?

Have people’s ideas of the role of the AMIC workers changed?

**Has the midwife role changed since your involvement in the program?**

**How do you suggest the AMIC worker role be better acknowledged?**

**How do you suggest the AMIC worker role be better resourced?**

**How do you suggest the AMIC worker role be better developed?**

**I understand the program is being rolled out to other locations. Do you think it will work?**

**How could the rollout be improved?**

**What are the main factors as you see as being critical to the success of the rollout?**

**The birthing program is often talked about as being ‘successful’. Do you agree with this? If so, what do you see as being critical to the success of the model? What do you perceive to be the keys to success? How could it be improved?**

**What are your thoughts on birthing in the bush (on country etc.)?**

Do you think we should be considering alternative ways of allowing women to birth?

What role do you believe the father has in the birth? Is this changing?

Who do you think is the most appropriate support person for the woman?

Do you think some women avoid the hospital system all together to birth? How many do you think do this and why?

**What are the best things about being a midwife in the Program?**

**Where do you see yourself in the future?**

Do you mind if I ask you some personal questions?

- Age
  
- How many years have you been working as a midwife?
  
- Any children

**Thank you so much for sharing your story of being midwife in the program with me. I really appreciate the time you have taken to share this with me. I am just going to take a few minutes to check over the topics I wanted to cover with you. If you want to take this time to think about anything else you may want to talk about...**

## **Interview Schedule for Ward Midwives**

**Thank** the participant.

Read the **information sheet**? Are there any **questions**?

**Consent forms**- Provide the participant with two consent forms (one for their own reference and one for study records). Explain that the consent forms are a requirement of the University of Adelaide and Aboriginal Health Council Human Ethics Committees. I will be the only person that will see these forms, and once I have signed the witness section on the consent form I will seal the document in an envelope and give the participant a code number. The envelope will be stored in a secure place.

I am really interested in and strongly value your views, opinions and stories, and want you to feel you can be **open to discuss** any of these along the way. Throughout the interview I will ask some **guiding questions**, this will give you the opportunity to talk about what you feel is important. Please feel free to raise any issues that you think are important that I do not cover. I think that the interview will go for about an hour.

I would like to **tape record** the interview... no one will listen to the tape except me. The reason I would like to use the tape recorder so that I can record all of what you say in the right way. I want to make sure that I get your word for word account, this way I shouldn't misinterpret anything you say. Do I have your permission to use the recorder? I will also be taking notes of things you have to say during the interview. If you feel uncomfortable at any time during the interview you can choose to not answer questions, withdraw from the interview or we can stop.

All interview content will remain confidential and you will not be named publicly for anything you say during this interview.

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### **Commence Interview**

As you know, I am really interested in the roles of the AMIC workers in the birthing program. I believe their work is so important and that we need to better understand how they do what they do as AMIC workers to better recognise and support them in their role. I hope that this understanding can also benefit you in your role as a ward midwife.

I am hoping we can start by you telling me your story of being a ward midwife who has experience of the *Anangu Bibi Birthing Program*. I am really interested in your journey, experiences, thoughts and interactions with the program and its staff.

**How long have you been a midwife for?**

**How long have you worked on Casuarina ward?**

(If they have worked elsewhere as a midwife/or on a different ward and started work on the ward since the introduction of the program...)

**Did you know about the birthing program before you started work on the ward?**

**Can you tell me a bit about what you know of the program?**

**What are your experiences of working with the AMIC workers?**

Strengths/challenges, positives, negatives, how are differences resolved?

**Do you ever disagree with them?**

**What are some of the things the AMIC workers are good at?**

**What are some of the things they need to improve on?**

**How has the program affected your work as a midwife on the ward?**

What are some of the good things about having the program operating from the ward?

What are some of the bad things about having the program operating from the ward?

Have you ever had any cultural awareness training?

Do you have many Aboriginal clients that aren't in the program?

**How do you think you, as a midwife, are viewed by other healthcare professionals (AMIC workers, program midwives, doctors etc.)?**

**How does the work of the AMIC workers fit in with the everyday working of the ward?**

**If you had an Aboriginal woman on the ward who you thought needed some culturally appropriate advice, is there a formal process you would go through or would you just ask an AMIC worker to approach the woman?**

**Is it easy or difficult to negotiate that type of scenario?**

*Definition of the AMIC worker role*

**How would you describe the role of an AMIC worker?**

What are their responsibilities?

What do AMIC workers offer the program that no one else in the program does?

What do you think about the belief that AMIC workers are the cultural brokers of the program?

What do you think the main challenges are for AMIC workers?

What do you think would be the best things about being an AMIC worker?

What do you think would be the worst things about being an AMIC worker?

**What is unique about the role?**

**How would you describe the roles of the midwives involved in the program?**

**Do their roles differ from yours?**

**The program is often described as involving a partnership between the doctors, midwives and AMIC workers. Do you agree with this? Why? How?**

**Do you believe the program midwives are able to work in partnership with AMIC workers?**

**Why/why not?**

Can you describe what this partnership often looks like?

Do you think this partnership has improved health outcomes for women in the program?

**I often hear that ‘mutual respect for each role’ is critical to the program. What are your thoughts about this? Do you think it is important? Does it happen?**

**Do you feel that you as a midwife, people both on the ward and in the program are respectful of culture?**

**Through your experiences, do you believe the AMIC workers help to teach other staff members how to be culturally appropriate to clients and families? If so, can you give examples? If not, why do you think this?**

**What are your thoughts about AMIC workers aligning their work with culture, community and the needs of the health service? Do you think they do this? If so, how and do they do it well?**

**Do you see this is a challenge for AMIC workers in their daily work?**

**On the topic of culture, do you believe there are any special cultural needs of Aboriginal women that the AMIC workers need to deal with? What are some of these? Do they manage them well?**

Are there many differences here in Port Augusta? Can the AMIC workers accommodate for everyone?

How do you think AMIC workers find working with women and families from cultural groups different to their own background?

**Do you know of any cultural practices that the AMIC workers able to adhere to within the hospital setting? (e.g. allowing the woman to take the placenta home, sand to put babies feet in)**

**What are your thoughts on birthing in the bush (on country etc.)?**

Do you think we should be considering alternative ways of allowing women to birth?

Do you think some women avoid the hospital system all together to birth? How many do you think do this and why?

***Do you think AMIC workers feel valued in their role?***

***Do you think the AMIC workers feel supported in their roles?***

Do you think they have a mentor or someone they feel comfortable going to when they need support?

**How could they be better supported in their role?**

**Do you think you are a good support for them in their role?**

Do you think their training prepared them well for what it takes to be an AMIC worker?

**Do you think the AMIC worker role has changed over the time the program has been running?**

If so how?

Has the program changed leading to change in AMIC worker roles?

Have people's ideas of the role of the AMIC workers changed?

**Do you think the AMIC role and the program is sustainable?**

**What do you think may assist in making the role of AMIC workers sustainable for the future?**

**Reflecting back on the time the program was introduced, what were your views of the program?**

**From what you know of the program, how do you believe it works?**

**Would you ever consider working on the program as a midwife?**

**What did you think of the introduction of the birthing program?**

**Do you think there was a need for it?**

**Do you think the program is a good thing? Why/why not?**

**Do you think we need AMIC workers?**

**Have you heard that the program is being rolled out to other locations?**

**Do you think it will work?**

**How could the rollout be improved?**

**What are the main factors as you see as being critical to the success of the rollout?**

**The birthing program is often talked about as being 'successful'. Do you agree with this? If so, what do you see as being critical to the success of the model? What do you perceive to be the keys to success? How could it be improved?**

Do you mind if I ask you some personal questions?

- Any children
  
- Have you had much experience with Aboriginal women and their families as clients?

**Thank you so much for sharing your story of being midwife who works on the ward where the program is run. I really appreciate the time you have taken to share this with me. I am just going to take a few minutes to check over the topics I wanted to cover with you. If you want to take this time to think about anything else you may want to talk about...**



## APPENDIX D: DISSEMINATION DOCUMENT

### ***Aboriginal Maternal Infant Care workers: better understanding of their role and improving support for them***

#### ***Background***

There are large inequalities in maternal and child health between Australia's Aboriginal and non-Aboriginal populations. Improving the care of Aboriginal women before and during pregnancy has been identified as a key strategy to 'closing the gap' in health.

In 2004 a new model of pregnancy care and birthing was introduced into Port Augusta and Whyalla through the *Anangu Bibi Regional Family Birthing Program* and the *Aboriginal Regional Family Birthing Program*. Central to the model of care are Aboriginal Maternal Infant Care (AMIC) Workers who work in partnership with midwives and other care providers to provide antenatal and postnatal care.

The aim of this study was to increase understanding of the role of the AMIC worker and explore the ways in which they manage the differences between a Western medical approach to maternity care and Aboriginal understandings, knowledge and beliefs about reproductive health and pregnancy.

#### ***Methods***

This was a qualitative study and involved 30 in-depth interviews with AMIC workers (n=6), program midwives (n=6), ward midwives (n=5), clients of the program (n=11) and medical practitioners (n=2). Common themes in interviews were identified and deeper understanding of the issues sought through reflection, discussion and wider reading.

#### ***Summary of key findings***

- Many complexities facing AMIC workers are often invisible to other staff and the systems and institutions they work within.
- The ways AMIC workers negotiate the domain in which they work are influenced by:
  - The strength of their relationships with colleagues and clients
  - Their ability to advocate for both colleagues and clients
  - Their degree of confidence and self-worth arising from the value they place on both clinical and cultural knowledge
- There are noted differences between Western and Aboriginal views about health and care during pregnancy
  - Western views are strongly influenced by medical and biological knowledge of pregnancy, and the purpose of care is monitoring health and reducing risks of adverse health outcomes (mainly physical)
  - Aboriginal views are influenced by Grandmothers Law, whereby pregnancy and birth is sacred, and social and emotional factors are important to health and wellbeing, especially during pregnancy.
- The traditional Westernised work ethic that pervades many institutions, including hospitals, upholds expectations about the 'ideal worker' which are recognised as unhelpful to women workers in general, and are even more inappropriate for AMIC workers, who have a complex caring role as well as many cultural and family obligations.
  - A competent and committed AMIC worker does not conform to the 'ideal worker', which represents a 'white Western male ideal'.
  - An AMIC worker is unable to fulfil the 'ideal worker' expectation as they are unable to detach from their other commitments, obligations and identity – and nor should they be expected to. Instead, AMIC workers are adept at fulfilling multiple roles, and making appropriate compromises.
  - 'Ideal worker' expectations, along with other systemic factors (e.g. inflexible visitation times, experiences of institutionalised racism) and aspects of AMIC worker's private lives (e.g. extent of caring responsibilities) contribute to high levels

of emotional labour and potential burnout.

- The emotional labour required from AMIC workers is large and unavoidable but this is not widely understood by others.
  - Emotional attachment to clients is often strong and clients circumstances and need can be very demanding.
  - AMIC workers have many obligations outside of the workplace, and also continue their AMIC caring role when not technically at work.
  - There are consequences for AMIC workers when something goes wrong (i.e. community backlash).
- A successful program requires:
  - Strong and supportive partnership between AMIC workers and program midwives.
  - Others to show respect and a good understanding of the AMIC Workers' role.
- Negotiating the interface between Western medicine and culturally appropriate care is challenging, but there are successful examples.
  - A strong AMIC-midwife partnership may act as a buffer to the challenges associated with this role, as it provides opportunities for two-way learning and promotes respect for individuals that may have different worldviews.

### ***Preliminary Recommendations***

Strategies that support the development of positive relationships between health professionals will help to ensure the sustainability of this model of care. These include training in cultural safety, and promoting awareness of systemic issues that create challenges for AMIC workers. Additionally, a number of essential resources that may improve the working environment for AMIC workers have been identified.

- Appropriate space conducive of a culturally safe and respectful environment. Somewhere women can feel comfortable and supported (i.e. a space to bring children, have access to appropriate resources, feel safe having private conversations).
- More support given to the program in regards to accessing necessary resources (e.g. transport, car seats, personal items for women).
- Built-in debriefing processes that allow AMIC workers to refresh and gain support.
- Paid on-call roster.
- Better recognition of the program and role of the AMIC workers.
  - On the ward: Possibly team-building exercises and increased awareness around the complexities of client lives and issues that may also affect AMIC workers.
  - In community: More community awareness about program.

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