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Cultural safety and midwifery care for Aboriginal women – A phenomenological study

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ABSTRACT

Background: Aboriginal and Torres Strait islander[1] women face considerable health disparity in relation to their maternity health outcomes when compared to non-Aboriginal women. Culture and culturally appropriate care can contribute to positive health outcomes for Aboriginal women. How midwives provide culturally appropriate care and how the care is experienced by the women is central to this study.
Aim: To explore the lived experiences of midwives providing care in the standard hospital care system to Aboriginal women at a large tertiary teaching hospital.
Methods: An interpretive Heideggerian phenomenological approach was used. Semi-structured interviews were conducted with thirteen volunteer midwives which were transcribed, analysed and presented informed by van Manen's approach.
Findings: Thematic analysis revealed six main themes: "Finding ways to connect with the women", "building support networks – supporting with and through Aboriginal cultural knowledge", "managing the perceived barriers to effective care", "perceived equity is treating women the same", "understanding culture" and "assessing cultural needs – urban versus rural/remote Aboriginal cultural needs".
Conclusion: The midwives in this study have shared their stories of caring for Aboriginal women. They have identified communication and building support with Aboriginal health workers and families as important. They have identified perceived barriers to the provision of care, and misunderstanding around the interpretation of cultural safety in practice was found. Suggestions are made to support midwives in their practice and improve the experiences for Aboriginal women.
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1. Background

Cultural safety is a term that originated in New Zealand in response to the poor health status of the Maori Indigenous people.[1] The definition of cultural safety is contested with some scholars defining it in terms of small actions which were usually not defined in policy and procedures within the organisation.[2] Other scholars have defined cultural safety as the standard to which nurses and midwives should seek to aspire.[3–6] The Congress of Aboriginal and Torres Strait Islander nurses have outlined the essential features of cultural safety as[7]:

- An understanding of one's own culture;
- An acknowledgement of difference and a requirement that caregivers are actively mindful and respectful of differences;
- Is informed by the theory of power relations;
- Is the experience of the recipient of care;
- Is not defined by the caregiver.

Historically Australian Aboriginal people have experienced a lack of cultural understanding within the delivery of health services which continues to the present day.[6] Culture and culturally appropriate health care is important and can improve the experiences for Aboriginal people accessing mainstream health services. Whilst culturally appropriate services designed and delivered by Aboriginal people to Aboriginal people are a more acceptable and appropriate option,[8] all sectors of health service delivery should be able to respond to the cultural needs of Aboriginal people.

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[1] The term Aboriginal is inclusive of both Aboriginal and Torres Strait Islander peoples in this study.

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Competency ten of the Australian National Competency Standards for the midwife requires that midwives ensure their practice is culturally safe.[9] The standards also require midwives to be able to recognise the specific needs of Aboriginal women and their communities, demonstrate respect for differences in cultural meanings and responses to health and maternity care.[9]

Giving birth is a significant event in a woman's life,[10,11] and negative experiences can contribute to post traumatic stress syndrome, anxiety and depression.[12] It is important for a woman's health and wellbeing that midwives ensure that all Aboriginal women have their spiritual, cultural and physical needs cared for whilst birthing.[13] For many Aboriginal women attending hospital to birth can be a frightening and alienating experience.[14] For some Aboriginal women who believe that their connection to country can be particularly strong during birth, giving birth in a hospital where they do not feel culturally safe is detrimental to their well-being.[14]

Whilst there is significant research surrounding the experiences of women and midwives working in and receiving care in culturally tailored programs, there remains a dearth of literature examining the experiences of midwives as care providers and their understandings of cultural safety in practice within the standard hospital care (SHC) system. Williamson[15] explored how midwives defined culture and how they provided culturally appropriate care to women from culturally and linguistically diverse backgrounds (CALD). She found that midwives applied a generic approach to all women which failed to consider other factors that might impact on an individual woman.[15]

Obstetric led models of care and the institutional systems of care can act as a barrier to midwives achieving the full spectrum of midwifery practice.[16] Relationships and communication with the women can be impacted by these barriers. Quality relationships with caregivers are important to birthing women.[17] Power and racism have also impacted negatively on the experiences of birthing women[18] and the fragmented system that women birth in acts as a barrier to the formation of positive relationships.[17]

Research conducted into the understanding of cultural safety in the Australian health care context discovered that healthcare providers had little or no understanding of the meaning of cultural safety.[19] The findings suggested that when the healthcare providers attempted to define it, they did so in terms of providing safe care.[19]

In order to explore the midwives' lived experiences of the provision of care to Aboriginal women a phenomenological approach was employed. The aim is to present their experiences of cultural care for Aboriginal women and understandings of cultural safety in their practice. Culturally safe care is an outcome that can only be determined by the recipients of care.[7]

2. Participants

Midwifery volunteer participants were sought from a large tertiary teaching hospital in South Australia. A brief entry was made in the birth suite communication book advising them that the research study had commenced and of upcoming information sessions. A mobile number and for the principal researcher was also included. All of the participants contacted the principal researcher prior to the planned sessions and subsequently the information sessions were cancelled.

The midwives were required to be working within the standard hospital care (SHC) system and to have provided intrapartum care to birthing Aboriginal women. Midwives could have any level of experience and they were not required to be permanent staff members in the birthing unit. Thirteen midwives were interviewed by the first author and a data saturation approach was taken. The interviews took place through March and April, 2014. Participants chose to be interviewed at the hospital in which they worked.

The majority of the midwifery participants had been registered midwives for greater than 25 years ($n = 10$). There were two who had 10–20 years' experience and one who fell within the 20–25 years' experience range. All of the midwives were aged thirty-five or greater with the majority aged over 41 years ($n = 10$). All of the participants in the study were female and at the time of the study there were no male midwives working within the birthing unit or rotating through the area. Fifty-four percent ($n = 7$) of participants were hospital trained in nursing and midwifery, 31% ($n = 4$) held Bachelor of Nursing and Bachelor of Midwifery qualifications and 15% ($n = 2$) were hospital trained in nursing and midwifery but also held a Bachelor of Nursing.

3. Ethics

The research study was approved by the hospital human research ethics committee, the South Australian Aboriginal Health Research Ethics Committee and the University of South Australia's human research ethics committee in late 2013 and early 2014.

4. Methods

4.1. Phenomenology

Interpretive Heideggerian phenomenology was chosen as the philosophical foundation guiding the research study. Heidegger questioned the possibility of any knowledge outside an interpretive position and that knowledge was based in the lived world of things, people, relationships and language.[20] Heidegger's interpretive approach is an appropriate foundation when a researcher wants to uncover meanings within a phenomenon and when attempting to understand human experiences.[21] Heidegger[22] used the word *Dasein* to describe *being in this world* and it has been described as the fundamental ontological structure characterising humans and the unity of the world and existence.[23]

Heidegger[22] described how all understanding is connected to fore-structure, and this cannot be set aside. The process of interpretation allows the researcher to look beyond the participants' words and explore the fore-structures and thematic meanings held in the data.[24] Heidegger described a hermeneutic circle as facilitating the circular process of understanding and as essential to the understanding of *Dasein*.[23] The midwives' experiences of *Dasein* in care provision for Aboriginal women were explored using a Heideggerian approach.

4.2. Data collection

Midwives who met the inclusion criteria nominated a time and location for their face-to-face, individual, semi-structured interview which was digitally recorded and transcribed verbatim into de-identified Microsoft word documents.

Prior to the interviews, the participants were required to read the information sheet and sign a consent form. Interviews ranged in time from 30 min to 1 h with an average length of 40 min.

Open ended questions were asked and some prompts used to elicit as much information as possible about the provision of culturally appropriate care for Aboriginal women. The interviews started with asking the midwives to share their experiences in caring for Aboriginal women. Prompts were used which included asking the midwives to share examples. All of the interviews took place at the hospital were the midwives worked.

4.3. Data analysis

van Manen's[25] six step method for hermeneutic phenomenological enquiry was used for data analysis because of its

foundations in Heidegger's work and strong focus on narratives and lived experiences. The transcribed de-identified interview transcripts had van Manen's[25] steps applied individually and although his steps are presented numerically, it was an iterative process. NVivo10 software was also used to manage the large amount of data produced. The analysis included reading and re-reading of the interview transcripts. Sentences and phrases which represented cultural care within the transcripts were grouped together into clusters that shared similar meanings. The sentences and phrases were then considered collectively, which came to form the theme clusters.

The principal researcher, a midwife with many years' experience in labour and birth care, used a reflective journal during the data collection and interpretation stages. This enabled an exploration of the researcher's position and the impact on the interpretations. She was not an Aboriginal woman. The journal enabled a pathway to explore the researcher's position in relation to the participants and the emerging interpretations. It also facilitated engagement with Heidegger's hermeneutic circle. An Aboriginal Cultural Consultant also participated in the project, and the journal facilitated an exploration of her views on the emerging themes.

5. Findings

Six main themes emerged from the data. The experiential themes are presented as a representation of the experience of *cultural care* for the midwives in the study. The themes are: "Finding ways to connect with the women"; "building support networks – supporting with and through Aboriginal cultural knowledge"; "managing the perceived barriers to effective care"; "perceived equity is treating women the same"; "understanding culture" and "assessing cultural needs – urban versus rural/remote Aboriginal cultural needs". The themes are supported with the midwives' actual words. The midwives were all given pseudonyms within the study.

5.1. Finding ways to connect with the women

Establishing rapport and communicating with the women was seen as central to midwifery care. The midwives would seek out ways to facilitate communication in a way that they felt was acceptable to the women. They recognised different communication styles that some women used. They valued the importance of the families and support people to assist them engage with and communicate with the women. They were also able to recognise situations where communication breakdowns had negative impacts on the delivery of care for the women. They talked of frustrations when they were unable to communicate with the women because of language barriers or lack of interpreters or women who appeared to not want to engage with them. They felt able to adapt their communication styles depending on how they perceived the individual woman's needs.

The midwives talked about connecting through non-verbal communication and through language. Language and the ability to establish rapport through discourse was most often associated with positive interactions with the women. Beverley explained:

> "...language is obviously important if you can't speak the language then it is confusing and what not. There is obviously different dialects of Aboriginal culture, of language, so it's not always easy to get, sometimes you can't get interpreters...like you can't change that they don't speak English, and so, we can only do the little things to make them feel safer and that they are somewhere where they can feel culturally safe".

Georgina described how if the woman talked to her freely and seemed comfortable then it provided her with validation that her midwifery care was acceptable for the woman. Georgina explained:

> "But if you are looking after someone in labour and then at the end of the shift they are quite comfortable, like whether they have pain relief or not, whether their labour is progressing or they are able to sit there and chat to you or whatever and feeling quite comfortable around you, I think that's always a reassuring thing for me, I like to think, like you know, if you start the shift and someone is not very chatty but then you leave at the end of the day and you have sort of, over the space of the time, have been able to build that rapport, I think that sort of shows that the level of care you have done has been good because they have been able to relax and become comfortable around you, and then, so have a bit more of a relationship."

The midwives also talked about connecting with the women through support from the Aboriginal staff members and from the women's families and friends. Sophia described caring for a woman who did not speak English so the woman's mother acted as an interpreter for her daughter. Sophia felt that because the woman's mother trusted her, then the woman did too, despite the fact that they were unable to verbally communicate with each other. The woman's mother was vital to providing acceptable care and in connecting with the woman. Sophia explained:

> "...we couldn't have gotten an official interpreter for that language and it really made the situation for that young girl having the baby so much better because, you know, she trusts her mother to look after her and in that respect because the mother trusted us, she trusted us as well."

5.2. Building support networks – supporting through and with Aboriginal cultural knowledge

Building support networks with other Aboriginal health care providers and with the women's families was recognised as important for the midwives in care delivery for Aboriginal women. The midwives talked of partnering with the families, the Aboriginal Maternal Infant Care (AMIC) workers and the hospital Aboriginal Liaison Officers (ALOs). Generally, the partnership with the ALOs was positive but some role confusion around those interactions were also identified. The midwives also talked of building support networks with the family members who came with the birthing Aboriginal women and incorporating their cultural knowledge into care delivery.

Fran described the ALOs as providing a connection which was really important in balancing fear for the woman and providing safe care:

> "Because I do think when they [ALOs] come, I do think that they have provided a very good service and that bridge between both of us...you have got to try and find that link, otherwise she's going to lie in that bed terrified, um, and it doesn't matter how much explaining, she's not listening to me, you know, so I've got to, I've got to find that link to provide her care..."

The availability of support from the ALO team was also identified as limiting for the midwives as they frequently needed their support outside of business hours. There were also some fears identified for some of the midwives when interacting with the ALOs. This tended to be grounded in a fear of being labelled racist, Jean explained:

> "I just feel like no matter what you do, you can't get it right with Aboriginal people because somebody will say it's offensive...I had this fear that someone was always going to say you're a racist and that's, that's happened to me on lots of occasions".

The AMIC workers were not practicing within the SHC system but were still sought out and seen as a resource for Aboriginal cultural knowledge. The midwives also identified the family members and the woman's support people as playing an important role in providing culturally appropriate care as they were able to advocate for women's needs around birth. The families and support people were seen in a partnership, almost bridging role between the midwives and the women.

5.3. Managing the perceived barriers to effective care

Some midwives were able to identify barriers within the standard hospital system that they perceived negatively impacted on their ability to provide care for women. Those barriers included the time restraints placed on the work of midwives within a large organisation, the fragmented systems of care (lack of continuity of care), the lack of 24 h a day support from the Aboriginal workforce and the inflexible policies and procedures of the maternity hospital. They also identified the system whereby women were required to relocate from rural and remote areas to birth as being a barrier to facilitating woman centred care. Lana described how the policies and procedures often led to the midwives having to make compromises with the woman in order to satisfy the institutional requirements and the needs of the woman:

> "...because we're very guided by policies and protocols and guidelines and we have to work within them as well, so if somebody has a specific need in their birth or that I'm not comfortable with then, I would look elsewhere to see what we could do to facilitate that, maybe not that, but something else..."

Sophia judged the overall experience for the woman as positive, if she was able to facilitate her wishes within the organisational constraints. Sophia explained:

> "...most frustrating thing with the, um, Aboriginal people in particular or people that have specific cultural requirements is the inability to actually fulfil those needs when it seems that it's such a simple thing to do, but, for instance there is no facility to, for the Aunty or the mum or the sister to room in with the woman, you know, it's just a fold out bed and it's just, and to me that's what it is, a fold out bed, put the sheets on the bed and the woman or the person can stay, but you know we are governed by rules and regulations...that is her right to do that and you do feel like you are not abandoning them, but you are letting them down because you are not able to provide some really small thing that would actually make a whole world of difference to them..."

5.4. Perceived equity is treating all women the same

The midwives frequently grouped the Aboriginal women with other groups and talked of Asian, Vietnamese, Sudanese, African and Indian women when asked about Aboriginal women. Beverley explained how she treated all women the same:

> "Depending on what their race or ethnicity was I would provide the same care and I am not specifically more culturally sensitive to Aboriginals [sic] than I am to any other person, white, black, yellow or green."

All of the midwives said that they did not do anything different for Aboriginal women, that they treated all women the same regardless. Sophia explained:

> "So I suppose when I look at, or when you ask me specifically about Aboriginal women I suppose I just see women..."

Kate explained in her interview that she did nothing different for Aboriginal women and that she did not even think of Aboriginal women as Aboriginal as she provided the same care to all women:

> "I just treat women pretty much the same, no matter what culture they are from...it's just, I don't think of Aboriginal women as Aborigines [sic]. I actually think of people that I care for and just try and give the same care. That's why I find it really hard to answer these questions because I don't think 'Oh God she's Aboriginal, I've got to do this'. I just introduce myself, work out their situation and go from there, that's all I do for everybody. And to have to actually think about their culture, of which of course I'm always aware of, oh, well deep down you're always aware. It's not foremost in my mind. Don't know if that's a good thing or a bad thing, that's just the way I am, that's the way I do it."

The midwives grouped the women together with other cultures and made comments about how the other cultural groups had needs which they perceived to be just as great as the Aboriginal women. The midwives expressed some resentment as they felt that other cultural groups were missed in favour of the Aboriginal women.

Lana described how she thought that culture was focused on too much. She said that women were all the same and although she recognised Aboriginal people might want to be treated differently she did not because she thought all women were the same. She explained:

> "I think sometimes culture comes into it a bit too much I think, these are women who are in labour, we're all the same and, um, yes, I understand that is important to you and we will do that, but I'm not going to treat you any differently to anybody else and I think sometimes I've heard certain Aboriginal people, that I've heard talk, expect them to be treated differently, well I'm not going to treat you any differently. I'm just gonna [sic] facilitate what you need and that's what I'm going to do, but I'm not going to treat you any differently than anyone else because you're not different. Your culture's different but you're not different. You know, does that make sense?"

The midwives talked at length about individualising the care for all women. This was how they approached any woman in their care. They would meet the woman, attempt to determine her needs (by asking her) and then facilitate her wishes as best they could within the institutional constraints. To the midwives this was the 'same care' for every woman. Equity of care was also important to the midwives. They felt that every woman was entitled to the same care which was individualised.

Discrimination was woven through the interview transcripts. Although the midwives talked of treating all women the same there was an undertone of both overt and covert racist views. It was mostly in relation to stereotyping and in the formation of assumptions about Aboriginal women. The assumptions were negative and were founded in their ability as mothers based on their cultures and on the sorts of lifestyles they assumed the women led.

5.5. Understanding culture

The midwives were required to navigate their own understandings of culture when providing care for Aboriginal women. They seemed to experience difficulty in differentiating between the physical aspects of care provision with determining the woman's cultural needs. Cultural safety for the midwives was also often considered in terms of a physically safe birth. The midwives did consider cultural safety in terms of individualised care but still located the individualised care within physical safety. For some of

the midwives cultural safety was also tied with supporting the family groups in delivering care.

The midwives frequently talked about the ease that they had in providing physical care to the women. However, it became more difficult for the midwives when they attempted to offer support to the women outside of their physical requirements. Maddie felt her role as a midwife was for the physical safety of the mother and baby. She explained:

> "Ok, well I want a healthy outcome for mother and baby and that's my priority, that's what I think a midwife's role is."

When the midwives were asked about what they did differently for Aboriginal women they felt that they did not do anything differently because when they talked of caring for Aboriginal women they talked of physical care. Sophia explained:

> "But I didn't prepare the room any differently than I ordinarily would have because her pressing need was in fact the fact that she had been bleeding so she had lost some blood. She would need some fluid replacement so I suppose you go into midwifery and nursing mode and everybody's body is the same, so if they are hypovolaemic, they are hypovolaemic whether they are Aboriginal or, you know, English."

Cultural safety was often defined in terms of physical safety for the mother and the baby. Lana explained her own interpretation of cultural safety and she saw it being linked with physical safety:

> "I think that it, well to me, means that I am aware of the needs of that specific woman, not necessarily related to whether she's Aboriginal or Sudanese or whatever. I think to me it's what is safe for that woman at that point in time in her labour, her birth or whatever and I would endeavour to assist and provide the care that she, she wants".

5.6. Assessing cultural needs – urban versus rural/remote Aboriginal cultural needs

The midwives in the study made assessments about the women in their care and they tended to link their cultural needs to where they came from. Sometimes this was linked to the familiarity of the hospital environment for the women. At other times it was linked to the perceived notion that a woman who represented the traditional stereotypical image of an Aboriginal woman was somehow more authentic in her ties to her culture.

Twelve of the midwives expressed views that women who were living in rural and remote areas had differing cultural needs from the women living in urban areas. They felt that women who came from rural and remote areas had stronger ties with their cultural heritage, compared to Aboriginal women living in metropolitan areas who four of the midwives said had in fact 'lost their culture'. Kate explained that women from metropolitan areas were far more 'westernised' in their cultural needs:

> "Well, ones from the metropolitan are far more westernised I should say, or 'whitenised', whatever you like to say. . .I think a lot of people from the metropolitan Aboriginals [sic], the expectations are extremely high of what they expect when they come to us whereas I don't think remotely they do, as in the services you need to provide."

The midwives felt that the familiarity of the environment also contributed to the differing cultural needs of women from rural and remote areas. Those women were geographically disconnected from their families, communities, languages and they were faced with unfamiliar environments, schedules, people, communication styles and technology. The midwives felt that those things affected the women's experiences and cultural needs around birth. They also identified fear and loneliness in those women.

6. Discussion

Cultural safety should guide Australian midwifery practice, it is a requirement of midwifery competency[9] and it can only be determined by the recipients of care.[3] The midwives' experiences of *cultural care* have demonstrated that there is some way to go to achieving appropriate care for Aboriginal women birthing in standard care.

When considering the definition provided by the Congress of Aboriginal and Torres Strait Islander nurses[7] for cultural safety, there is an evident clear shortfall in the midwives' understandings. None of the midwives recognised the position of power they were afforded as caregivers, there was no clear respect for difference or even an understanding of their own cultures and the impact that might have on the women they cared for. These factors all impact on the care which is received by the Aboriginal women birthing in the SHC system.

The midwives were able to recognise barriers to the provision of care in the SHC system but were not able to analyse those barriers as potential threats to the cultural safety of the women in their care. Culturally unsafe practices are those which diminish, demean or disempower the cultural identity and well-being of an individual.[26] The hospital regulations which limit or deny family members from staying with the women are a good example of an unsafe cultural practice. For women who are required to travel from rural or remote areas to birth their babies is another example of an unsafe cultural practice whereby these women are isolated from their cultural, social and emotional supports. New Zealand medical practitioners can be de-registered for culturally unsafe practices.[6] Although the midwives were able to recognise them as barriers some further consideration around them from a cultural safety perspective may have demanded the midwives take some action.

Most of the midwives had either not heard of cultural safety or when they did try to define it placed cultural safety within the domain of physical safety. All of the midwives in the study trained when the principles of cultural safety were not embedded within midwifery curricula but they had all completed the mandatory cultural awareness training required by the organisation. Some of the midwives had also participated in an Aboriginal cultural training weekend in the Flinders Ranges exploring the Adnyamathanha people's culture.

The midwives felt comfortable with the physical aspects of care, they were inventive and they found ways to communicate with the women in their care. Communication was important to the midwives and the positive relationships were always tied to the women with whom they were able to establish effective verbal communication. If the women could not verbally communicate with them they still attempted to develop relationships through other means. They were comfortable with the physical side of midwifery practice.

The women's needs outside of the physical were foreign to the midwives; they relied on others for support for this aspect of care. This is where the midwives valued the role of the Aboriginal workforce and of the women's families and support people. The recognition of the importance of Aboriginal cultural knowledge in the role of birth for women shows that the midwives have some knowledge about what might be important for Aboriginal birthing women.

"Treating all women the same" was tied to equity and equal care for the midwives. There was a strong undertone of dissatisfaction within the midwifery data that lay in the sense that equal care for all women was the *same* care. They were unable

to see that equitable care would demand a different approach although some of the midwives did recognise the disparate health outcomes for Aboriginal Australians.

Midwives practicing with a focus on cultural safety need to be able to recognise and respect difference.[27] This is at odds with the midwives' experiences of "treating all women the same". However, the midwives felt strongly that by individualising care for each woman they were providing appropriate care and providing equitable care. Training in the development of reflexivity may help the midwives explore how their understanding of the norm and their assumptions and values might impact on the women in their care.

Houston[28] argued that in order to achieve equity in health care for Aboriginal Australians, health care must be framed with Aboriginal principles and values. The dichotomy occurs as health care in the standard care system is provided with the principles and values of western health care delivery and explains to some extent where the midwives' position of 'same care' originates.

There was recognition of the diversity of Aboriginal Australians with several of the midwives. Those midwives felt that individualised care to each unique woman would ensure her cultural needs were met. Given that so many of the midwives went on to define cultural safety in a physical sense it becomes difficult to reconcile that argument.

Most of the midwives in the study did not consider their own cultures or the culture of midwifery in general when considering the experience of culturally appropriate care. The power over birthing women as healthcare providers and as members of the dominant culture was not considered. The midwives did feel empathy for the women and did seek ways to improve the experiences for the women. Generally they felt powerless to change the situations the women faced. They went out of their way to do little things for the women. One of the midwives paid for television connection, others sought to get things like soaps and shampoos for the women to make the physical aspects easier for the women.

There was a strong sense that they felt unable to enact change for the women due to fear of doing or saying the wrong thing, not knowing what they could do and the barriers exerted from the institutional policies. For example, the hospital policy that limited the capacity of the midwives to allow the woman's family members to stay overnight. When coupled with their westernised understandings of health and healthcare and limited understanding of cultural safety the midwives were not in a position to challenge this policy and enact change. Working on their educational needs and developing their understandings from an Aboriginal perspective would equip them to better manage their requirements as midwives and to help them better support the women.

The notion that women from rural or remote areas had stronger ties to country and culture was a concerning finding. Most of the midwives ($n = 12$) determined that those women had greater cultural needs. Although the needs may have been perceived as greater, they recognised familiarity with the environment as an aspect of that. This shows evidence of confusion around what culture and cultural needs are rather than a true representation of what the cultural differences were. Williamson[15] also found that midwives expected women to follow their traditional birth practices and perceived them to have lost their culture if they did not. Aboriginal people do not become less Aboriginal when they live in cities or towns.[29]

Racism was evident throughout the data. Frequently this involved some level of stereotyping of Aboriginal women. Current cultural respect training should be enhanced to name and address racism to ensure that participants can develop an understanding of Aboriginal people's everyday experiences when accessing healthcare.[30] Moving towards cultural safety training embedded with anti-racism training would be beneficial to address this. Anti-racism frameworks in cultural training would require the health care provider to address their own position in health care delivery and would also contribute to stopping the marginalisation and disempowerment of Aboriginal peoples.[31]

This paper has presented the findings of a qualitative research study where midwifery practices around cultural care for Aboriginal women have been explored. The study also explored the women's experiences of intrapartum care in the standard hospital care system, focusing on their cultural needs as Aboriginal women. The women's data will be reported separately.

7. Study limitations

The use of Heideggerian phenomenology as a philosophical foundation has been criticised because Heidegger never intended it to be used to guide research.[32] Heidegger's personal links to the Nazi socialist party could be seen as a limitation within this study especially given Aboriginal Australian's experiences since colonisation. However, his ontological philosophy does align with the research aims of the project.

The research included a small proportion of midwives, however, other published work has demonstrated similar attitudes from health care providers towards Aboriginal people accessing healthcare.[33–35] These attitudes impact on the health and wellbeing of Aboriginal Australians.[36] Expanding this project to investigate the attitudes, practices and experiences of larger groups of midwives from different institutions would be beneficial for exploring the way forward for cultural safety training for midwives. This would ensure that midwives are aligning their practice to the requirements of the Australian National Competency standards.

The midwives in the study were already qualified when cultural safety was embedded within nursing and midwifery curricula. A study sample with representations from the younger cohorts of midwives would have provided some opportunity to explore their understandings of cultural safety and if these differed from the findings presented here.

8. Conclusion

This study has shown that midwives value effective communication with the women they care for. They attempt to build support networks around Aboriginal women with assistance from the Aboriginal workforce and the women's support people. The midwives identified perceived barriers within mainstream services which included the time constraints in a busy hospital; lack of flexibility in the hospital protocols and polices; the system whereby women were required to relocate to birth; lack of continuity of care; lack of support 24 h a day from the Aboriginal workforce and the speed at which women transitioned through the service.

The midwives had some difficulty differentiating the women's physical needs from their cultural needs. The concept of cultural safety was not well understood. The midwives also determined that women who were living in metropolitan areas had lesser cultural needs than the women who were living in rural and remote areas. Stereotyping and racism was also identified within the study.

Considering the findings from a cultural safety perspective can place the women as central to midwifery practice. It is also able to highlight shortfalls both in midwifery care, in the systems of care delivery and most importantly the threats to the cultural safety of birthing Aboriginal women.

A way forward for standard hospital care could see a strengthening of the partnerships between the Aboriginal workforce, the women and the midwives. Focusing on the development of respectful, positive relationships should be a priority. Consumer feedback would be beneficial to midwifery practice and is required from a cultural safety perspective. Strengthening training with cultural safety as a core concept would align better with the Australian National Competency Standards. Ensuring cultural training was an assessable component of practice and recognition that it is as important as the physical aspects of care for the women would be a positive approach for improving the experiences of the women and supporting midwives in practice.

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