A cultural and historical exploration of female reproduction in one remote northern-Australian Aboriginal Town

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Abstract

Indigenous women in the Northern Territory of Australia experience significant reproductive and sexual health disadvantage, which widens with increasing geographical remoteness. Attempts to ameliorate this profound inequity, which have been based mostly on Western biomedical models of health care, have had limited efficacy in improving outcomes. Although an abundance of epidemiological data statistically substantiates Australian Indigenous women’s health disadvantage, a paucity of literature describes the contributing cultural contexts of Indigenous women’s health and even less privileges their experiences and perspectives on their reproductive health and gendered bodies. Set in an Australian remote town, this research aimed to historically contextualise women’s reproductive experiences and to document women’s cultural and linguistic constructions of reproduction. An ethnographic approach was used, which included historical and extended fieldwork over a six-year period, participant observations, written fieldwork diaries, reproductive ethnophysiology drawing and language sessions, semi-structured interviews, focus groups, archival document review, training and employment of Aboriginal research assistants, and consultation and advice from a local reference group and a cultural mentor. Women’s current emic perspectives and use of language to describe the female reproductive life cycle, anatomy and physiology are described and documented. The research findings demonstrate how changes to the local care of women during pregnancy and childbirth, which initially colonised ancestral reproductive practices, later nurtured women’s resilience. Planned locations for childbirth have undergone successive changes, with the only available option now being a regional hospital hundreds of kilometres away. Without robust evidence, scientific and clinical logics have been used to deny women their reproductive choices. This thesis suggest that women’s general health outcomes could be improved by a broad range of measures aimed at achieving better sexual and reproductive health rights for women.
Statement of Authorship

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university and that to the best of the candidate’s knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text.

I give consent to this copy of my thesis, when deposited in the University Library, being made available for loan and photocopying, and online via the University’s Open Access repository eSpace. I do not give permission for the digitalised appendices to being available online.

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<tr>
<th>Thesis chapter</th>
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<tr>
<td>5</td>
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<td>Accepted for publication in the journal <em>Women and Birth</em></td>
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<td>Published in the journal <em>Culture, Health and Sexuality</em></td>
<td>First author</td>
<td>Concepta Wulili Narjic, Suzanne Belton, Sherry Saggers, Ann McGrath</td>
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My gratitude and sincere thanks go to the many people (friends, family, professionals and strangers) who have supported me—at different times, in different places and in different ways—through the prolonged gestation and birth of this doctoral thesis. Their support has crossed state and territory borders, forded flooded rivers, traversed slippery mud tracks, transcended cultural divides and survived in both tropical and subalpine climates. Without their support, I could not have been so strong.

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Thank you, Concepta Wulili Narjic, for your generosity and for having the courage and trust to befriend me. As I have already informed you, if I had given birth to a daughter she would have been respectfully named Wulili.

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Thank you to the provincial leader and to the many nuns from the Daughters of Our Lady of the Sacred Heart, who generously shared important memories and opened their archives to me.

Thank you to the many women in the Northern Territory, Victoria and South Australia, and those overseas on secondment, who enthusiastically participated in the research and shared their special stories.

And, finally, thank you Saint Fiacre.
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<tr>
<td>Aboriginal name</td>
<td>A person’s ancestrally inherited traditional name. The name also refers to a physical location in the person’s traditional country. The name is decided by the paternal grandfather or paternal uncle with agreement from the maternal grandparents. Also known as ‘blackfella name’.</td>
</tr>
<tr>
<td>Age-grades</td>
<td>A life-cycle chronology for males and females in Saint Fiacre, which was once common in other Northern Territory Aboriginal communities.</td>
</tr>
<tr>
<td>Bammat</td>
<td>The Murrinh Patha name for birth, also meaning ‘falling down’.</td>
</tr>
<tr>
<td>Billabong</td>
<td>A widely used Aboriginal word from the Wiradjuri people, meaning a fresh watercourse which seasonally runs only after rain.</td>
</tr>
<tr>
<td>Birthing Mother’s</td>
<td>An alternative Aboriginal name in the Northern-Australian Arnhem Land region for ‘Grandmothers’ Law’.</td>
</tr>
<tr>
<td>Black magic</td>
<td>Malevolent Aboriginal sorcery.</td>
</tr>
<tr>
<td>Blackfella name</td>
<td>A person’s ancestrally inherited traditional name. The name also refers to a physical location in the person’s traditional country. It is decided upon by the paternal grandfather or paternal uncle with agreement sought from the maternal grandparents.</td>
</tr>
<tr>
<td>Blackfella way</td>
<td>An act of Aboriginal sorcery directed towards a person or persons to cause illness, harm or death.</td>
</tr>
<tr>
<td>Boomerang</td>
<td>An Aboriginal hunting tool that is carved from wood and thrown by hand.</td>
</tr>
<tr>
<td>Bucket bong</td>
<td>A makeshift device for smoking marijuana, fashioned from a receptacle to hold water, a plastic bottle with a cut-off end and a nonflammable socket for holding the marijuana. In Saint Fiacre, milk tins are often used to hold the water.</td>
</tr>
<tr>
<td>Bush order</td>
<td>A food supply system predominantly used by non-</td>
</tr>
<tr>
<td>Term</td>
<td>Meaning</td>
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<tr>
<td>Aboriginal residents in Saint Fiacre to acquire food and goods from urban supermarkets. For a small charge, the supermarket will pick, pack and freight the order once a fortnight via either boat or truck depending on the season.</td>
<td>Bush Tucker Food that was ancestrally hunted and collected by Aboriginal people in the Saint Fiacre region.</td>
</tr>
<tr>
<td>Centrelink</td>
<td>A division of the Australian Government’s Department of Human Services that delivers social and health-related payments and services.</td>
</tr>
<tr>
<td>Ceremonial group</td>
<td>In Saint Fiacre, this refers to a group composed of multiple clans, mostly from different language groups. The groups, which have obligations to perform singing and dancing at an opposing group’s ceremonial affairs, reflect an ancestral precedent of ceremonial reciprocity.</td>
</tr>
<tr>
<td>Chista thipman</td>
<td>The Murrinh Patha term for the Aboriginal women from Saint Fiacre who undertook their training and vows to become Catholic nuns.</td>
</tr>
<tr>
<td>Clan</td>
<td>In Saint Fiacre, a clan group refers to a landowning group. Clan groups are a basis of governance and leadership structure in the region and have patrilineal inheritance.</td>
</tr>
<tr>
<td>Clap sticks</td>
<td>Wooden musical instruments, often carved, used in ceremonial activities.</td>
</tr>
<tr>
<td>Clinic</td>
<td>The term used by Aboriginal people in Saint Fiacre to refer to the current community health centre.</td>
</tr>
<tr>
<td>Comet hut</td>
<td>The correct name for a type of prefabricated corrugated iron hut, also known as a Sidney Williams hut. Comet huts were used by the thousands in remote northern Australia around the time of the Second World War.</td>
</tr>
<tr>
<td>Cone</td>
<td>The nonflammable socket that holds marijuana in a bucket bong. The term can be used to count the amount of marijuana that has been smoked in the bucket bong.</td>
</tr>
<tr>
<td>Coolamon</td>
<td>A multipurpose Aboriginal carrying vessel often made</td>
</tr>
<tr>
<td>Term</td>
<td>Meaning</td>
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<tr>
<td>from hardwood, with curved sides resembling a canoe. Often used by women for gathering fruits and vegetables, and sometimes as a crib for small babies.</td>
<td></td>
</tr>
<tr>
<td>Country</td>
<td>An Aboriginal person’s paternally inherited ancestral land.</td>
</tr>
<tr>
<td>Da</td>
<td>The Murrinh Patha noun classifier used for camps and living places, localities, time and seasons.</td>
</tr>
<tr>
<td>Da malarnpakpak</td>
<td>The Murrinh Patha name for the season when new leaves appear.</td>
</tr>
<tr>
<td>Da mirrangan</td>
<td>The Murrinh Patha name for the dry and cold season.</td>
</tr>
<tr>
<td>Da ngugumingki</td>
<td>The Murrinh Patha name for a dreaming place/site.</td>
</tr>
<tr>
<td>Da thangka</td>
<td>The Murrinh Patha name for the wet season.</td>
</tr>
<tr>
<td>Daly River language family</td>
<td>One of three major language family groups in the Saint Fiacre region.</td>
</tr>
<tr>
<td>Depo medicine</td>
<td>Aboriginal English name in Saint Fiacre for the contraceptive depot injection that lasts three months. Also known as ‘injection medicine’.</td>
</tr>
<tr>
<td>Dhanba</td>
<td>One of the three dominant ceremonial groups that organise the people of Saint Fiacre.</td>
</tr>
<tr>
<td>Didgeridoo</td>
<td>A trumpet-like wind instrument made from a hollow log and used only by men during ceremonial activities in Saint Fiacre. It has sacred connotations and is often linked with the rainbow serpent.</td>
</tr>
<tr>
<td>Digging stick</td>
<td>A small carved wooden tool used by women to dig for bush tucker, such as yams and tubers.</td>
</tr>
<tr>
<td>Djamindjungan language family</td>
<td>One of the three major language family groups in the Saint Fiacre region.</td>
</tr>
<tr>
<td>Donga</td>
<td>A Northern Territory English term referring to a temporary demountable building.</td>
</tr>
<tr>
<td>Dreaming</td>
<td>A deeply philosophical Aboriginal term with complex nuances and inherent challenges in definition. It is linked to sacred ancestral creation times and can also be used as a type of logic. In Saint Fiacre, it is also used to refer to a</td>
</tr>
<tr>
<td>Term</td>
<td>Meaning</td>
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</tr>
<tr>
<td>Fay go</td>
<td>Aboriginal English term in Saint Fiacre for sexual intercourse without a condom.</td>
</tr>
<tr>
<td>Fighting stick</td>
<td>A long, slender wooden weapon used during physical altercations, once was the preferred weapon for females in Saint Fiacre.</td>
</tr>
<tr>
<td>Fire carrier</td>
<td>A section of plant material with flammable properties that would smoulder, allowing fire to be moved one location to another, hence avoiding the laborious task of making fire from scratch.</td>
</tr>
<tr>
<td>Fire starters</td>
<td>Plant materials known for their highly flammable properties, which are used to kindle fire from small sparks.</td>
</tr>
<tr>
<td>Firestick</td>
<td>A small section of hard wood used to traditionally start fire by means of friction.</td>
</tr>
<tr>
<td>Freshwater people</td>
<td>People who belong to the Twungku (wedge-tailed eagle) moiety group. Their traditional country is generally located inland; hence, they are known as the ‘freshwater people’.</td>
</tr>
<tr>
<td>Garaman language family</td>
<td>One of the three major language family groups in the Saint Fiacre region.</td>
</tr>
<tr>
<td>Grandmothers’ Law</td>
<td>The deeply sacred component of Aboriginal women’s business that involves reproductive and childbirth practices.</td>
</tr>
<tr>
<td>Grog</td>
<td>An Australian colloquial term for alcohol.</td>
</tr>
<tr>
<td>Grog running</td>
<td>The illegal transport of alcohol into legislated no-alcohol or ‘dry’ areas for consumption or further sale for profit.</td>
</tr>
<tr>
<td>Gunja</td>
<td>The English/Sanskrit slang for the illegal herb marijuana.</td>
</tr>
<tr>
<td>Homelands</td>
<td>The ancestral lands owned by a specific clan though they may not permanently reside there. May be interchanged with the term ‘outstation’.</td>
</tr>
<tr>
<td>Humbugging</td>
<td>An Aboriginal English word describing harassing or annoying behaviour. It is often linked to kinship.</td>
</tr>
<tr>
<td>Term</td>
<td>Meaning</td>
</tr>
<tr>
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</tr>
<tr>
<td>obligations</td>
<td>whereby relatives repeatedly ask family members for money, food or drugs.</td>
</tr>
<tr>
<td>Implim</td>
<td>Aboriginal English name in Saint Fiacre for the long-acting reversible contraceptive implant that is inserted under the skin of the inner upper arm. Also known as ‘spaghetti medicine’ or ‘long medicine’.</td>
</tr>
<tr>
<td>Injection medicine</td>
<td>Aboriginal English term in Saint Fiacre for the contraceptive depot injection that lasts three months. Also known as depo medicine.</td>
</tr>
<tr>
<td>Joint</td>
<td>A handmade cigarette containing dried tobacco and marijuana.</td>
</tr>
<tr>
<td>Jumping around</td>
<td>Aboriginal English term in Saint Fiacre for having multiple sexual partners.</td>
</tr>
<tr>
<td>Kale</td>
<td>A Murrinh Patha kinship term for one’s mother and all her sisters.</td>
</tr>
<tr>
<td>Kalekale</td>
<td>A Murrinh Patha kinship term for one’s grandfather and all his brothers.</td>
</tr>
<tr>
<td>Kanamkek-Yile Ngala Museum</td>
<td>The name of the Saint Fiacre museum, which refers to the spiritually significant rainbow serpent and the big father.</td>
</tr>
<tr>
<td>Kandantiga</td>
<td>The name of place near Saint Fiacre where a man named Mollingin had a pre-mission vision of mother Mary and Jesus.</td>
</tr>
<tr>
<td>Kangurl</td>
<td>A Murrinh Patha kinship term for one’s paternal grandfather and all his brothers.</td>
</tr>
<tr>
<td>Kardu</td>
<td>The Murrinh Patha noun classifier used for Aboriginal humans: males and females, human spirits and kinship terminology.</td>
</tr>
<tr>
<td>Kardu (or palngun) keke</td>
<td>The Murrinh Patha female age-grade referring to a middle-aged woman. <em>Kardu keke</em> and the deviation <em>nugarn keke</em> may also be used when referring to a middle-aged male.</td>
</tr>
<tr>
<td>Kardu damlurturt warda</td>
<td>The Murrinh Patha name for childbirth contractions.</td>
</tr>
<tr>
<td>Term</td>
<td>Meaning</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Kardu Diminin</td>
<td>The Murrinh patha name for the traditional clan and landowners of Saint Fiacre township.</td>
</tr>
<tr>
<td>Kardu kunugunu</td>
<td>The Murrinh Patha female age-grade referring to a senior woman.</td>
</tr>
<tr>
<td>Kardu Kura Thipmam</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
<tr>
<td>Kardu mamay</td>
<td>The Murrinh Patha age-grade referring to a prepubescent male or female child.</td>
</tr>
<tr>
<td>Kardu mardinhpuy</td>
<td>The Murrinh Patha female age-grade referring to an adolescent pubescent girl.</td>
</tr>
<tr>
<td>Kardu muthinga</td>
<td>The Murrinh Patha female age-grade referring to an elderly postmenopausal woman.</td>
</tr>
<tr>
<td>Kardu palngun</td>
<td>The Murrinh Patha female age-grade referring to a sexually mature woman. Also used to simply mean woman/female.</td>
</tr>
<tr>
<td>Kardu pana nganaka ngarra wakal thangunu</td>
<td>The Murrinh Patha name for tearing of the genital tissues during vaginal childbirth.</td>
</tr>
<tr>
<td>Kardu Thangkurral</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
<tr>
<td>Kardu Wakal</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
<tr>
<td>Kardu wakal ngala</td>
<td>The Murrinh Patha childhood developmental milestone, referring to a grown-up child before puberty changes commence.</td>
</tr>
<tr>
<td>Kardu wakal ngarrithngarrith</td>
<td>The Murrinh Patha name for spirit children, who have a traditionally important role in human foetal conception.</td>
</tr>
<tr>
<td>Kardu Wakal Thay</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
<tr>
<td>Kardu Wakal Thirnang</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
<tr>
<td>Term</td>
<td>Meaning</td>
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<tr>
<td>-------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>/ Rak Nuthunthu</td>
<td>Fiacre region.</td>
</tr>
<tr>
<td>Kardu Yek</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
<tr>
<td>Dirrangarra/ Kardu Darrinpirr</td>
<td>Fiacre region.</td>
</tr>
<tr>
<td>Kardu Yek Naninh</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
<tr>
<td>Kardu yurrutthururrutharda</td>
<td>The Murrinh Patha name for foetal engagement, measured by the breadth of fingers below the maternal sternum.</td>
</tr>
<tr>
<td>Karrthin</td>
<td>The bird known as the spotted or swamp harrier. Also, one of two moiety groups that socially organise people in the Saint Fiacre region. This type of social organisation is now in decline.</td>
</tr>
<tr>
<td>Kawu</td>
<td>A Murrinh Patha kinship term meaning one’s maternal grandmother mother’s mother and all her sisters and a daughter’s daughter.</td>
</tr>
<tr>
<td>Koonie Koonie</td>
<td>An alternative term used in the Waigit region to refer to Aboriginal Grandmothers’ Law.</td>
</tr>
<tr>
<td>Ku</td>
<td>The Murrinh Patha noun classifier used for animals, birds, insects and marine life; flesh and products from animals; non-Aboriginal humans; spirit-world entities not classified as <em>kardu</em>; Christian god; and female genitalia.</td>
</tr>
<tr>
<td>Ku balli</td>
<td>The Murrinh Patha name for mud crabs.</td>
</tr>
<tr>
<td>Ku ngalmungkurr</td>
<td>The Murrinh Patha name for magpie geese. These are a favourite type of game to hunt.</td>
</tr>
<tr>
<td>Ku tek</td>
<td>The Murrinh Patha name for the beautiful bird known as the red-tailed black cockatoo.</td>
</tr>
<tr>
<td>Ku warnangkarl</td>
<td>The Murrinh Patha word for a witch doctor, singer or wise person.</td>
</tr>
<tr>
<td>Ku warrgi</td>
<td>The Murrinh Patha name for the mangrove worm.</td>
</tr>
<tr>
<td>Kubuyirr</td>
<td>A traditional country placename in the Saint Fiacre region.</td>
</tr>
<tr>
<td>Kungarlburl</td>
<td>A traditional country placename in the Saint Fiacre region.</td>
</tr>
<tr>
<td>Kura</td>
<td>The Murrinh Patha noun classifier used for freshwater, rain</td>
</tr>
<tr>
<td>Term</td>
<td>Meaning</td>
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</tr>
<tr>
<td>Kura Ngaliwe</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
<tr>
<td>Kurlpurru manthay</td>
<td>The Murrinh Patha name for underarm hair.</td>
</tr>
<tr>
<td>Kurlpurruwan</td>
<td>The Murrinh Patha name for genital pubic hair.</td>
</tr>
<tr>
<td>Kutchil</td>
<td>A traditional country placename in the Saint Fiacre region.</td>
</tr>
<tr>
<td>Larrakia</td>
<td>The traditional Aboriginal landowners of the Northern Territory Darwin region.</td>
</tr>
<tr>
<td>Lirrga</td>
<td>One of the three dominant ceremonial groups that divide the people of Saint Fiacre.</td>
</tr>
<tr>
<td>Little people</td>
<td>Miniature human-like dreaming spirits that inhabit one’s traditional country and may bring messages to people.</td>
</tr>
<tr>
<td>Long grassing</td>
<td>A Northern Territory term referring to an itinerant stay in Darwin with the intention of drinking excessive amounts of alcohol and sleeping rough.</td>
</tr>
<tr>
<td>Long medicine</td>
<td>Aboriginal English term in Saint Fiacre for the long-acting reversible contraceptive implant that is inserted under the skin of the inside upper arm. Also known as ‘spaghetti medicine’ or ‘Implim’.</td>
</tr>
<tr>
<td>Magati Ke</td>
<td>An Aboriginal language spoken in the Saint Fiacre region and belonging to the Daly River language family group. It is sometimes considered a dialect of Marri Ngarr.</td>
</tr>
<tr>
<td>Malgarring</td>
<td>A spiritual song cycle used in ceremony.</td>
</tr>
<tr>
<td>Manangkaningi</td>
<td>A Murrinh Patha childhood developmental milestone, referring to a newly born female baby wrapped and carried in paperbark. Can also be called mirringi.</td>
</tr>
<tr>
<td>Mandinhinhinh</td>
<td>The Murrinh Patha name for the pleasure of sexual intercourse.</td>
</tr>
<tr>
<td>Mangka</td>
<td>A Murrinh Patha kinship term for a person’s paternal grandmother and all her sisters.</td>
</tr>
<tr>
<td>Maninh</td>
<td>A traditional country placename in the Saint Fiacre region.</td>
</tr>
<tr>
<td>Marda</td>
<td>The Murrinh Patha name for early pregnancy, also used to...</td>
</tr>
<tr>
<td>Term</td>
<td>Meaning</td>
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<tr>
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</tr>
<tr>
<td>describe feeling full and satisfied from eating sufficient food.</td>
<td></td>
</tr>
<tr>
<td>Mardangu Ngame</td>
<td>A traditional country placename in the Saint Fiacre region.</td>
</tr>
<tr>
<td>Mardawuteth</td>
<td>The Murrinh Patha name for the maternal perception of foetal movements during pregnancy.</td>
</tr>
<tr>
<td>Marri Ngarr</td>
<td>An Aboriginal language spoken in the Saint Fiacre region and belonging to the Daly River language family group.</td>
</tr>
<tr>
<td>Marridjabin</td>
<td>One of the languages from the Saint Fiacre region, belonging to the Daly River language family.</td>
</tr>
<tr>
<td>Mathalinti</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
<tr>
<td>Message stick</td>
<td>A relayed form of communication when a message is sent via word of mouth.</td>
</tr>
<tr>
<td>Mi</td>
<td>The Murrinh Patha noun classifier used for vegetable food items, fruit and faeces.</td>
</tr>
<tr>
<td>Mi kanja</td>
<td>The Murrinh Patha assimilation of the English/Sanskrit term for marijuana, ‘gunja’.</td>
</tr>
<tr>
<td>Mi parnu</td>
<td>The Murrinh Patha name for grass, which is often used around non-Aboriginal people to disguise conversations about marijuana.</td>
</tr>
<tr>
<td>Mi thuwuy</td>
<td>The Murrinh Patha name for tobacco.</td>
</tr>
<tr>
<td>Mob</td>
<td>Aboriginal English term meaning a ‘group of’. It is often qualified as a big or little mob.</td>
</tr>
<tr>
<td>Moiety group</td>
<td>In Saint Fiacre, an ancient form of social organisation that divides the people into two groups. It has a role in ceremonial activity and in the sanctioning of marriage.</td>
</tr>
<tr>
<td>Mollingin</td>
<td>The Saint Fiacre ancestor who is remembered for having a pre-mission vision of Mother Mary and Jesus.</td>
</tr>
<tr>
<td>Muring Nyuwan</td>
<td>One of the languages from the Saint Fiacre region, belonging to the Djamindjungan language family.</td>
</tr>
<tr>
<td>Murrinh</td>
<td>The Murrinh Patha noun classifier used for speech, language, names, places associated with talk or learning,</td>
</tr>
<tr>
<td>Term</td>
<td>Meaning</td>
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</tr>
<tr>
<td>non-Aboriginal songs, stories, legends and news.</td>
<td></td>
</tr>
<tr>
<td>Murrinh Kura</td>
<td>A dialect of Murrinh Patha, also known as ‘heavy talk’.</td>
</tr>
<tr>
<td>Murrinh Patha</td>
<td>The dominant language of the Saint Fiacre region. It belongs to the Garaman language family group.</td>
</tr>
<tr>
<td>Nangu</td>
<td>A traditional country placename in the Saint Fiacre region.</td>
</tr>
<tr>
<td>Nangkun</td>
<td>A Murrinh Patha kinship term for one’s husband and all his brothers.</td>
</tr>
<tr>
<td>Nanhthi</td>
<td>The Murrinh Patha noun classifier used for most natural substances and objects; inedible parts of animals, such as feathers; human body parts; most natural phenomena; urine, menstrual blood and human milk; artefacts and implements; defensive weapons, such as shields; song and dance; and introduced European objects.</td>
</tr>
<tr>
<td>Nanhthi kaminherrkminhyerrk yibimpup</td>
<td>The Murrinh Patha name for a dried-up, shrivelled postmenopausal ovary.</td>
</tr>
<tr>
<td>Nanhthi</td>
<td>The Murrinh Patha name for the female ovary.</td>
</tr>
<tr>
<td>Nanhthi mamurr warda</td>
<td>The Murrinh Patha name for the female ovary.</td>
</tr>
<tr>
<td>Nanhthi ngapurlu</td>
<td>The Murrinh Patha name for breasts. An alternative spelling is ngapulu.</td>
</tr>
<tr>
<td>Nanhthi ngapurlu bammat</td>
<td>The Murrinh Patha name for the fourth and final stage of female breast development, when the breasts are falling down, sagging and pendulous.</td>
</tr>
<tr>
<td>Nanhthi ngapurlu kamarl</td>
<td>The Murrinh Patha name for the nipples of the breast.</td>
</tr>
<tr>
<td>Nanhthi ngapurlu kampuk</td>
<td>The Murrinh Patha name for engorged breasts during lactation. It has also been glossed in one dictionary as breast cancer</td>
</tr>
<tr>
<td>Nanhthi ngapurlu ngala</td>
<td>The Murrinh Patha name for the third stage of female breast development, when the breasts are large, full, firm and well-developed.</td>
</tr>
<tr>
<td>Term</td>
<td>Meaning</td>
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</tr>
<tr>
<td>Nanhthi ngapurlu pirrinurduyi</td>
<td>The Murrinh Patha name for the first stage of female breast development, when the breasts begin to bud.</td>
</tr>
<tr>
<td>Nanhthi ngapurlu thunpith</td>
<td>The Murrinh Patha name for the second stage of female breast development, when the breasts are shaped sharp and pointy. Named after a tree that grows thorns.</td>
</tr>
<tr>
<td>Nanhthi thirrimeme</td>
<td>The Murrinh Patha name for the umbilical cord and navel.</td>
</tr>
<tr>
<td>Nanhthi wanpahwah</td>
<td>The Murrinh Patha name for an ephemeral organ that grows during pregnancy as placental membranes and is expelled during childbirth after the birth of the baby.</td>
</tr>
<tr>
<td>Nardirri</td>
<td>A traditional country placename in the Saint Fiacre region.</td>
</tr>
<tr>
<td>Native sisters</td>
<td>An alternative name, often used by the first missionaries, for the Aboriginal women from Saint Fiacre who undertook their training and vows to become Catholic nuns.</td>
</tr>
<tr>
<td>Ngumink Street</td>
<td>A Murrinh Patha placename in Saint Fiacre, after which the street in the same place is named.</td>
</tr>
<tr>
<td>Out bush</td>
<td>Recreational visits and camping in ancestral homelands outside of the Saint Fiacre town.</td>
</tr>
<tr>
<td>Outstation</td>
<td>A small settlement with dwellings on the traditional land to which an Aboriginal person is ancestrally bound. The settlement generally has poor infrastructure and is isolated from regional services. May be interchanged with the term ‘homeland’.</td>
</tr>
<tr>
<td>Palumpa</td>
<td>One of the many landowning clan groups of the Saint Fiacre region and a placename in the Saint Fiacre region.</td>
</tr>
<tr>
<td>Papa Ngala</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
<tr>
<td>Peppermenarti</td>
<td>A traditional country placename in the Saint Fiacre region.</td>
</tr>
<tr>
<td>Power tickets</td>
<td>In Saint Fiacre, a prepaid ticket that is used to access electricity in a house.</td>
</tr>
<tr>
<td>Purgarli</td>
<td>A Murrinh Patha kinship term for one’s cousin.</td>
</tr>
<tr>
<td>Term</td>
<td>Meaning</td>
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</tr>
<tr>
<td>Purima</td>
<td>A Murrinh Patha kinship term for one’s wife and all her sisters.</td>
</tr>
<tr>
<td>Putput</td>
<td>The Murrinh Patha name for pregnancy when it is visible to others.</td>
</tr>
<tr>
<td>Rak Angileni</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
<tr>
<td>Rak Kirnmu</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
<tr>
<td>Rak Kubiyirr</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
<tr>
<td>Rak Kulingmirr</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
<tr>
<td>Rak Kungarlbarl</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
<tr>
<td>Rak Kuy</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
<tr>
<td>Rak Merrepen</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
<tr>
<td>Rak Nadirri</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
<tr>
<td>Rak Nemarluk</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
<tr>
<td>Rak Nganthawudi</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
<tr>
<td>Rak Nuthunthu</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
<tr>
<td>Rak Perrederr</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
<tr>
<td>Rak Thinti</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
<tr>
<td>Rak Wudipuli</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
<tr>
<td>Term</td>
<td>Meaning</td>
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<td>-----------------------------</td>
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</tr>
<tr>
<td>Right way</td>
<td>A traditionally sanctioned marriage following socially accepted kinship conventions.</td>
</tr>
<tr>
<td>Rollie</td>
<td>A handmade cigarette that is made using commercially procured dried tobacco and paper.</td>
</tr>
<tr>
<td>Saint Fiacre</td>
<td>A pseudonym for the research-site town.</td>
</tr>
<tr>
<td>Saltwater people</td>
<td>People who belong to the Karrthin (spotted or swamp harrier) moiety group. Their traditional country generally has a coastal location and hence they are known as the ‘saltwater people’.</td>
</tr>
<tr>
<td>Sex infection</td>
<td>Aboriginal English term in Saint Fiacre for sexually transmitted infections.</td>
</tr>
<tr>
<td>Sideways talk</td>
<td>A manner of communication that is used to show respect among family members in an avoidance relationship, such as between mother-in-law and son-in-law. It involves two people avoiding direct personal contact by communicating through third persons. It can also be called ‘long-ways talk’.</td>
</tr>
<tr>
<td>Sidney Williams Hut</td>
<td>The common name for a prefabricated corrugated iron hut that was designed by architect Sidney Williams. They were used by the thousands in remote northern-Australian around the Second World War.</td>
</tr>
<tr>
<td>Sista girls</td>
<td>An Aboriginal English name for Aboriginal transgender males on the Tiwi Islands in the Northern Territory.</td>
</tr>
<tr>
<td>Sorry business</td>
<td>An Aboriginal English term referring to bereavement and associated mortuary rites. Grieving often involves self-harm as an expression of the regret and sorrow felt over the death of a loved one.</td>
</tr>
<tr>
<td>Spaghetti medicine</td>
<td>Aboriginal English name in Saint Fiacre for the long-acting reversible contraceptive implant that is inserted under the skin on the inside of the upper arm. Also known as ‘long medicine’ or ‘Implim’.</td>
</tr>
<tr>
<td>Spin dry</td>
<td>A locally used term referring to being arrested for drunk</td>
</tr>
<tr>
<td>Term</td>
<td>Meaning</td>
</tr>
<tr>
<td>------------</td>
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</tr>
<tr>
<td>Term</td>
<td>and disorderly behaviour, being detained in police custody to sober up and then having one’s body and clothes washed and dried in preparation for release.</td>
</tr>
<tr>
<td>Telstra</td>
<td>An Australian telecommunications company.</td>
</tr>
<tr>
<td>Thalamba</td>
<td>A traditional country placename in the Saint Fiacre region.</td>
</tr>
<tr>
<td>Thamul</td>
<td>The Murrinh Patha noun classifier used for all types of spears.</td>
</tr>
<tr>
<td>Thamunh</td>
<td>A Murrinh Patha kinship term for one’s maternal grandfather.</td>
</tr>
<tr>
<td>Thay kampuk</td>
<td>The Murrinh Patha name for a tree that has no common English name but it is known in Latin as <em>Pouteria</em> (or <em>Planchonella</em>) <em>arnhemica</em> from the family Sapotaceae.</td>
</tr>
<tr>
<td>Thay kugalng</td>
<td>The red-flowered kurrajong tree is a seasonal calendar plant. Its blossoms signal that the rains of the early wet season will soon commence.</td>
</tr>
<tr>
<td>Thay thunpith</td>
<td>The Murrinh Patha name for a tree that is known in English as the red-flowered kapok and in Latin as <em>Bombax ceiba</em> from the Bombacaceae family.</td>
</tr>
<tr>
<td>Thay yipi</td>
<td>The Murrinh Patha name for the banyan tree, which is a plant of spiritual/sacred associations to the people of Saint Fiacre. For some people it is a sacred resting place for spirits of deceased ancestors.</td>
</tr>
<tr>
<td>Thu</td>
<td>The Murrinh Patha noun classifier used for striking forces, offensive weapons, thunder and lightning, and playing cards.</td>
</tr>
<tr>
<td>Thungku</td>
<td>The Murrinh Patha noun classifier used for fire, firearms and electricity.</td>
</tr>
<tr>
<td>Totem</td>
<td>Also known in Murrinh Patha as ngakumarl, this is a plant or animal of spiritual significance, which is inherited from a person’s father.</td>
</tr>
<tr>
<td>Troupie</td>
<td>A 4WD Toyota Land Cruiser Troup Carrier. This is a favoured vehicle for transport in remote areas and is most</td>
</tr>
<tr>
<td>Term</td>
<td>Meaning</td>
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<tr>
<td>---------------------------</td>
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</tr>
<tr>
<td>Twungku</td>
<td>A wedge-tailed eagle and one of two moiety groups that socially organise people in the Saint Fiacre region. This type of social organisation is now in decline.</td>
</tr>
<tr>
<td>Waka lumpu-re bammat</td>
<td>The Murrinh Patha name for a frank breech foetal presentation at birth.</td>
</tr>
<tr>
<td>Wakal</td>
<td>The Murrinh Patha word meaning small, usually used to refer to children.</td>
</tr>
<tr>
<td>Wakal demngewerr</td>
<td>The Murrinh Patha name for premature birth.</td>
</tr>
<tr>
<td>Wakal dempinhimardadum</td>
<td>The Murrinh Patha childhood developmental milestone referring to an infant who is able to roll onto the stomach and turn over.</td>
</tr>
<tr>
<td>Wakal dempirnturt</td>
<td>The Murrinh Patha childhood developmental milestone referring to an infant who is able to pull up to a standing position but is still shaky and unable to walk.</td>
</tr>
<tr>
<td>Wakal dimpak</td>
<td>The Murrinh Patha name for childbirth.</td>
</tr>
<tr>
<td>Wakal dimpudeng</td>
<td>The Murrinh Patha childhood developmental milestone referring to an infant who is able to crawl.</td>
</tr>
<tr>
<td>Wakal kanawup dim</td>
<td>The Murrinh Patha childhood developmental milestone referring to an infant who can sit up.</td>
</tr>
<tr>
<td>Wakal mampelip</td>
<td>The Murrinh Patha name for abortion.</td>
</tr>
<tr>
<td>Wakal mampinthap</td>
<td>The Murrinh Patha childhood developmental milestone referring to an infant who starts to practice crawling on hands and knees but who cannot move.</td>
</tr>
<tr>
<td>Wakal manthak</td>
<td>The Murrinh Patha name for miscarriage.</td>
</tr>
<tr>
<td>Wakal me-re bammat</td>
<td>The Murrinh Patha name for a footling breech foetal presentation at birth.</td>
</tr>
<tr>
<td>Wakal mi wulamath</td>
<td>The Murrinh Patha childhood developmental milestone referring to an infant who is able to ask for food and breastmilk.</td>
</tr>
</tbody>
</table>
| Wakal murrinh bangamlele  | The Murrinh Patha childhood developmental milestone referring to an infant who has the strong and correct
<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wakal murrinhdhay</td>
<td>The Murrinh Patha childhood developmental milestone referring to an infant who is able to make baby noises like ‘ooo’, ‘argh’.</td>
</tr>
<tr>
<td>Wakal murrinhdhay</td>
<td>The Murrinh Patha childhood developmental milestone referring to an infant who can make strong baby-talk noises.</td>
</tr>
<tr>
<td>Wakal nungampinhart</td>
<td>The Murrinh Patha childhood developmental milestone referring to an infant who is starting to run around.</td>
</tr>
<tr>
<td>Wakal pirretat pirrim</td>
<td>The Murrinh Patha childhood developmental milestone referring to an infant who is strong enough to stand steady.</td>
</tr>
<tr>
<td>Wakal tharra me ngala</td>
<td>The Murrinh Patha childhood developmental milestone referring to an infant who is walking and running with strength and confidence.</td>
</tr>
<tr>
<td>Wakal thirlminh</td>
<td>The Murrinh Patha name for a deceased premature or stillborn baby, regardless of gestation.</td>
</tr>
<tr>
<td>Wakal tidul</td>
<td>The Murrinh Patha childhood developmental milestone referring to a newly born male baby wrapped and carried in paperbark.</td>
</tr>
<tr>
<td>Wakal wemarda</td>
<td>The Murrinh Patha childhood developmental milestone referring to an infant still wrapped in paperbark but sitting on an adult’s lap (perhaps 3–4 days old).</td>
</tr>
<tr>
<td>Wakal wililime</td>
<td>The Murrinh Patha childhood developmental milestone referring to an infant who is starting to walk.</td>
</tr>
<tr>
<td>Wakal wurdamperdu buybatnu warda</td>
<td>The Murrinh Patha name for foetal inversion in preparation for birth.</td>
</tr>
<tr>
<td>Wakal wurdarduy</td>
<td>The Murrinh Patha childhood developmental milestone referring to an infant who is able to move its body and roll over.</td>
</tr>
<tr>
<td>Wakal wurranpudeng</td>
<td>The Murrinh Patha childhood developmental milestone referring to an infant who is a confident, fast and coordinated crawler.</td>
</tr>
<tr>
<td>Term</td>
<td>Meaning</td>
</tr>
<tr>
<td>------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Weyi denthap</td>
<td>The Murrinh Patha name for a large and open female genital passage after vaginal childbirth. Also known as <em>weyi ngala</em>.</td>
</tr>
<tr>
<td>Weyi mental</td>
<td>The Murrinh Patha name for a small and closed female genital passage.</td>
</tr>
<tr>
<td>Wgintjiti</td>
<td>A traditional country placename in the Saint Fiacre region.</td>
</tr>
<tr>
<td>Whitefella</td>
<td>An Aboriginal English term for a person with white skin. It is not derogatively used in Saint Fiacre. It may be interchanged with the Murrinh Patha words <em>kardu bamam</em> meaning ‘white person’.</td>
</tr>
<tr>
<td>Whitefella name</td>
<td>In Saint Fiacre, this refers to a person’s Western name. Catholic first names are often favoured, with surnames developed from significant ancestors’ Aboriginal names.</td>
</tr>
<tr>
<td>Women’s business</td>
<td>An Aboriginal gendered cultural construct referring to the matters of reproduction, menstruation, contraception, abortion, pregnancy, childbirth, menopause, and female reproductive pathology including urinary tract infections, sexually transmitted infections, cervical and breast cancer. It also refers to women’s ancestral ceremonial and religious rites.</td>
</tr>
<tr>
<td>Wongga</td>
<td>One of the three dominant ceremonial groups that divide the people of Saint Fiacre. An alternative spelling is <em>Wangga</em>.</td>
</tr>
<tr>
<td>Woomera</td>
<td>An Aboriginal wooden spear-throwing device that enhances the speed and force of a thrown spear.</td>
</tr>
<tr>
<td>Wrong way</td>
<td>A traditionally unsanctioned marriage that does not follow socially acceptable kinship conventions.</td>
</tr>
<tr>
<td>Wungwung</td>
<td>The Murrinh Patha term for a feeling of cheerfulness and brightness when seeing one’s homeland after a prolonged absence.</td>
</tr>
<tr>
<td>Yeddar</td>
<td>A traditional country placename in the Saint Fiacre region.</td>
</tr>
<tr>
<td>Yek Diminin</td>
<td>One of the many landowning clan groups of the Saint Fiacre.</td>
</tr>
<tr>
<td>Term</td>
<td>Meaning</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Fiacre region.</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
<tr>
<td>Yek Maninh</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
<tr>
<td>Yek Nangu</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
<tr>
<td>Yek Ngudanimarn</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
<tr>
<td>Yek Wunh</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
<tr>
<td>Yek Yederr</td>
<td>One of the many landowning clan groups of the Saint Fiacre region.</td>
</tr>
</tbody>
</table>
Chapter 1: Introduction

This first chapter introduces the research problem and objectives, including the specific aims and scope of the study. It also explains the common terms and definitions and conceptually links the thesis structure to the four submitted original research papers.

Statement of Research Problem and Objectives

Indigenous women living in the Northern Territory of Australia (see Figure 1.1) experience significant reproductive and sexual health disadvantage. Australian Indigenous women experience higher rates of sexually transmitted infections and bloodborne viruses (Bowden et al., 1999; Kirby Institute, 2014), infertility (Kildea & Bowden, 2000; Silver et al., 2012), cervical cancer mortality (Australian Institute of Health and Welfare [AIHW], 2013a), family violence (Department of the Attorney-General and Justice, 2012), maternal mortality, premature birth and low birthweight babies (Thompson, 2014). As geographical remoteness increases, so too does the disadvantage, to the point where Indigenous women living in remote areas of the Northern Territory are some of Australia’s most socially disadvantaged citizens. Attempts to ameliorate this profound inequity have for the most part been based on Western biomedical models of healthcare provision. To date, this approach has had limited efficacy in improving outcomes in reproductive and sexual health.
Human reproductive physiology is universal, but, globally, the meanings that women attribute to their reproductive experiences are diverse (Inhorn, 2006). This is because reproduction is a culturally constructed and mediated human phenomenon. It is argued that only by listening to and understanding women’s perspectives are health policymakers and practitioners able to define women’s health problems, contextualise these problems with relevance to health interventions and evaluate the delivery of women’s health care in ways that can lead to innovative policies and best care practices (Inhorn, 2006, p. 348). An abundance of epidemiological statistical data substantiates Australian Indigenous women’s health disadvantage, but there is a paucity of literature describing the contributing cultural contexts of women’s health and even less that privileges Indigenous women’s experiences and perspectives on their reproductive health and gendered bodies. If we are to understand the persistence
of women’s health disadvantages despite the greater availability of Western biomedicine, it is vital that Indigenous women’s perspectives on their reproductive and sexual wellbeing are heard and taken into account. This represents an opportunity for medical anthropologists, using qualitative research methods, to illuminate Indigenous women’s cultural constructions of reproduction and challenge the marginalisation of their voices in health literature.

Undertaken during a six-year period (2008–2014) in Saint Fiacre (pseudonym)—a large, remote, disadvantaged Northern Territory Aboriginal town—this doctoral research addresses both this silence and gap in the literature. Conducted with permission from, and in partnership with, Aboriginal women from Saint Fiacre, this research has relied on the ‘deeply qualitative’ tradition of ethnography (Inhorn, 2006, p. 346) to meet the specific objectives of historically contextualising women’s reproductive experiences and documenting women’s cultural and linguistic constructions of reproduction. This has included understanding the changes in how women have been locally cared for during pregnancy and childbirth and exploring women’s emic perspectives and uses of language to describe the female body’s reproductive life cycle, anatomy and physiology.

Four academic papers, of which I am the first author, have been submitted for publication in four peer-reviewed journals; each of the four papers deals with an aspect of the research objectives and each is included as an individual chapter in this thesis. The first paper (see Chapter 5) historically contextualises how women were locally cared for during pregnancy and childbirth in Saint Fiacre and documents the dramatic cultural changes in midwifery care, along with the resulting implications for the community. The second paper (see Chapter 6) builds on this theme, using critical discourse analysis to deconstruct and understand the impact of widely used health
practice manuals on remote Aboriginal women’s choices in planning for place of birth. The third paper (see Chapter 7) documents the language and ethnophysiology used to describe female reproduction in Saint Fiacre. Ethnophysiology being the cultural interpretations and configurations of the human body’s structure and function. The fourth paper (see Chapter 8) examines young women’s current behaviour and knowledge and the associated impacts on sexual health disadvantage.

**Study Aims and Scope**

My aim with this research was to produce an ethnography that moves between historical and contemporary contexts, producing thick and rich descriptions of Aboriginal women’s reproductive experiences and perspectives. The project, based in one remote Aboriginal town in the Northern Territory, was not intended to be representative of other Aboriginal women’s experiences in other towns or communities. The research specifically aimed to:

- develop research partnerships with the women in the community
- increase community capacity through the recruitment and training of Aboriginal researchers
- document the ethnophysiology and language of fertility and reproduction from the emic perspective of women
- produce a historical local account of changes in midwifery care provided to women in the town
- critique health practice manuals that have affected local midwifery care
• return the findings and language recordings back to the town museum and language centre for future safekeeping

• and disseminate the research findings in a timely and influential manner through a series of published articles in peer-reviewed health journals.

**Explanation of Terminology and Definitions**

The name *Saint Fiacre* is a pseudonym used throughout this thesis and in academic papers to describe the research-site town. It is evocative of the town’s Catholic origins and its ongoing religious identity. For the community, the pseudonym provides a measure of identity protection from distant outsiders. However, it is clear to me and to the research participants that people more closely located to the community, or more knowledgeable about the community, may well recognise it. All mention of the research location in the reference list has been omitted.

Compared with other settlements in the Northern Territory, such as Tennant Creek, the population of Saint Fiacre is large. Therefore, when possible, Saint Fiacre is referred to as a town rather than as a community. The term ‘community’, though often used to refer to remote Aboriginal settlements, is only used in this thesis to describe the social cohort of people who live in the town of Saint Fiacre. All research participant names have been replaced with pseudonyms, and all photographs are my own work unless otherwise credited.

Aboriginal English and Aboriginal language words and phrases are presented in italics on their first mention in this thesis and are listed in alphabetical order in the Glossary. There are many spelling variations of Aboriginal words, and unless
otherwise indicated, the spelling generally used is from the source quoted. It is therefore possible for some Aboriginal words to be spelt in multiple ways in this thesis.

For the purpose of describing the ethnicity of Aboriginal and Torres Strait Islander people in Saint Fiacre, the term ‘Aboriginal’ has been exclusively used. The terms ‘Aboriginal and Torres Strait Islander people/women’, ‘Indigenous people/women’, ‘Indigenous Australians’ and ‘Australian Indigenous people/women’ have been variously used throughout this thesis to refer collectively to Australia’s first people. The use of these terms is for practical literary purposes only and does not intend in any way to diminish the cultural diversity among Aboriginal and Torres Strait Islander people. Otherwise, when quoting from a reference, the terminology used in that publication to refer to Aboriginal and Torres Strait Islander people has been replicated.

**Thesis Structure**

This introductory chapter has stated the research problems and objectives and outlined the aims and scope of the project. It has linked the thesis progression, through four separate papers, to the over-arching objectives of the research, and it has described the common definitions and terminology used in the thesis.

Chapter 2 reviews the literature and situates the research objectives. Chapter 3 contextualises the research site by describing the town and presents my reflections on my role as a researcher. Chapter 4 describes the research theory and methodology.

Chapter 5 is the first submitted academic paper, titled, ‘Paperbark and pinard: A historical account of maternity care in one remote Australian Aboriginal town’. Co-authored in descending order by Sarah Ireland, Suzanne Belton, Ann McGrath,
Sherry Saggers and Concepta Wulili Narjic, this paper has been accepted for publication in the journal *Women and Birth*.

Chapter 6 is the second submitted academic paper, titled, ‘The logics of planned birthplace for remote Aboriginal women in the Northern Territory: A discourse and content analysis of clinical health practice manuals’. Co-authored in descending order by Sarah Ireland, Suzanne Belton and Sherry Saggers, this paper has been published in the journal *Midwifery*.

Chapter 7 is the third submitted academic paper, titled, ‘From *wanhpanhs* to wombs: Describing the ethnophysiology and language of female fertility and reproduction in one remote northern-Australian Aboriginal community’. Co-authored in descending order by Sarah Ireland, Suzanne Belton, Sherry Saggers, Ann McGrath, Concepta Wulili Narjic, Michael Walsh and Teresa Ward, this paper has been submitted to the journal *Medical Anthropology*.

Chapter 8 is the fourth and final submitted paper, titled, ““Jumping around”: Exploring young women’s behaviour and knowledge in relation to sexual health in a remote aboriginal community’. Co-authored in descending order by Sarah Ireland, Concepta Wulili Narjic, Suzanne Belton, Sherry Saggers and Ann McGrath, this paper has been published in the journal *Culture, Health and Sexuality* (Ireland, Narjic, Belton, Saggers, & McGrath, 2015).

Chapter 9 discusses the implications of the research, concludes the thesis and makes recommendations arising from the findings.

The Appendices include templates of the letters of invitation, ethics approvals, authorship statements, consent form, a gender-restricted and closed
section and a copy of the booklet that was returned to the women outlining historical and locally significant findings.
Chapter 2: Literature Review

This chapter situates my research project’s aims within the literature pertinent to Australian Indigenous women’s sexual and reproductive health. The literature reviewed in this chapter was sourced via journal databases and library catalogue searches.

The chapter begins with an exploration of what is meant by women’s sexual and reproductive health, followed by an examination of Indigenous women’s current sexual and reproductive health outcomes in Australia and then more specifically in the Northern Territory. Sexual and reproductive health is then situated within a culturally sensitive conceptual framework, and the concepts of *women’s business* and *Grandmothers’ Law* are discussed. Literature that contextualises Aboriginal women’s sexual health outcomes (the theme of the papers in Chapters 3 and 4) and the issue of choice surrounding planned birthplace locations (the theme of the papers in Chapters 2 and 3) is then presented and critically reviewed.

To contextualise the current sexual health outcomes for Aboriginal women, literature published in the last 10 years (2005–2015) and from only the Northern Territory was favoured over older research and over research based outside the Northern Territory. To contextualise Aboriginal women’s planned birthplace locations, it was necessary to draw on formative but older literature of continuing relevance. On topics where Australian literature is lacking, relevant international research was sourced for comparative purposes. The chapter concludes with a review of the literature that is specifically from the research location of Saint Fiacre, literature that informs women’s sexual and reproductive health.
Defining Women’s Sexual and Reproductive Health

For all women, sexual and reproductive function is a fundamental expression of their humanity and an intrinsic part of general wellbeing and health. Reproductive health is defined by the World Health Organization (2006, p. 4) as:

A state of complete physical, mental and social well-being and not merely the absence of disease and infirmity, in all matters relating to the reproductive systems and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how to do so.

This definition embraces a human-rights approach to health, whereby men and women have a universal right to be informed of—and to have access to choose—safe, effective and affordable methods of family planning, along with other methods of fertility regulation, such as legal and safe abortion. For women, these reproductive health rights extend to accessing appropriate health care throughout their experiences of pregnancy and childbirth (World Health Organization, 2006).

Likewise, sexual health is defined by the World Health Organization (2006, p. 5) as:

a state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity. Sexual health needs a positive and respectful approach to sexuality and sexual relationships, and the possibility of having pleasurable and safe sexual experiences that are free of coercion, discrimination, and violence.
For sexual health to be attained and maintained, the sexual rights of all individuals must be respected, protected, and fulfilled.

It is clear from these definitions that the agendas of reproductive health and sexual health are intertwined, aiming not only to support the normal physiological functions of human reproduction, such as conception, pregnancy and childbirth, but also to reduce any adverse impacts of reproduction and sexual activity (Glasier, Gülmezoglu, Schmid, Moreno, & Van Look, 2006). Furthermore, sexual and reproductive health is concerned with ensuring all women, regardless of their reproductive age, are able to have safe and fulfilling sexual relationships, by addressing the impediments of gender-based discrimination and violence, sexual coercion, exploitation and restrictive legislation (Glasier et al., 2006).

The burdens of sexual and reproductive ill health are known to disproportionately affect women and adolescents (Glasier et al., 2006). Women’s reproductive and sexual health outcomes vary across the world and are often closely linked to women’s broader socioeconomic status. In both the poorest and the most-developed countries of the world, unsafe sex is ranked, respectively, as the second and ninth most important risk factor for disease, disability or death (Glasier et al., 2006). It is estimated by Glasier et al. (2006, p. 1595) that every year more than 120 million couples have an unmet need for contraception; 80 million women have unintended pregnancies of which 45 million end by induced abortion; and 340 million people acquire new sexually transmitted infections. The World Health Organization (2015, p.16) estimates that globally in 2015, 303 000 women will die from complications of pregnancy and childbirth. While addressing unmet sexual and reproductive health needs is often about ensuring equitable access to biomedical health services and treatments, it is also about addressing a wide gamut of health-
related human-rights issues. This reorientates the advancement of sexual and reproductive health from a purely biomedical goal towards one that is politically charged and inherently gendered.

**Australian Indigenous Women’s Sexual and Reproductive Health Outcomes**

Although Australia’s sexual and reproductive health outcomes are envied by many of the world’s poorer countries, not all Australians are born equal. The original occupants of Australia, the Aboriginal and Torres Strait Islander people, experience significant disadvantage on all measures of socioeconomic, education and health status. Internationally—and compared with other colonised indigenous populations, such as New Zealand’s Maori—the Australian Aboriginal and Torres Strait Islander population has an alarmingly poorer health status (Kunitz, 2000; Paradies & Cunningham, 2002). This profound inequity is attributed to a complex range of historical, political and social determinants (Carson, Dunbar, Chennall, & Bailie, 2007).

When compared with the lives of non-Indigenous women, the disadvantaged context of many Aboriginal and Torres Strait Islander women’s lives is evidenced in their much poorer sexual and reproductive health outcomes. Their rates of participation in cervical and breast cancer screening are lower, and consequently Aboriginal and Torres Strait Islander women are 2.8 times more likely than non-Indigenous women to develop cervical cancer and 3.9 times more likely to die from it, and they have much poorer breast cancer prognoses (AIHW & Cancer Australia, 2013). Indigenous women diagnosed with breast cancer have a 100% higher chance of dying from any cause, compared with non-Indigenous women (AIHW & Cancer Australia, 2013). The survival rates of both forms of cancer decrease with increasing
geographical remoteness (AIHW & Cancer Australia, 2013). This excessive mortality is also likely linked to poorer participation rates in cancer treatment. As Condon et al. (2014, p.9) noted, Indigenous people with cancer are less likely to be ‘offered, choose and complete curative treatment’.

A higher proportion of Indigenous women also experience polycystic ovary syndrome (Boyle, Cunningham, O’Dea, Dunbar, & Norman, 2011). This endocrine disorder leads to serious health and reproductive complications including irregular menstrual cycles, infertility, hirsutism, acne, obesity, metabolic syndrome (Norman, Dewailly, Legro, & Hickey, 2007) and psychological distress (Teede, Deeks, & Moran, 2010). Women with this disorder appear to be at higher risk for premature morbidity and mortality from diabetes, cerebrovascular disease and endometrial cancer (Wild, 2002). In one small study, Boyle et al. (2011, p.62) found that 15% of Indigenous women had polycystic ovary syndrome, which compares much higher to the reported universal prevalence of around 4-8% of all reproductive aged women, irrespective of ethnicity.

Aboriginal and Torres Strait Islander people continue to be over-represented in the notifications of sexually transmitted infections and viral hepatitis (Kirby Institute, 2014) and experience higher rates of teenage pregnancy¹ (Li, Hilder, & Sullivan, 2012). The notification rates of chlamydia, gonorrhoea and infectious syphilis for the Aboriginal and Torres Strait Islander population in 2013 were, respectively, 3, 14 and 3 times higher than for the non-Indigenous population, with 81% of all chlamydia notifications in the Indigenous population occurring in young

¹ Teenage pregnancy has many different social and cultural implications dependent on context. It may be perceived as a normal sociocultural life event in some Indigenous communities; however, it remains an important reproductive health indicator because of its close association with poorer biomedical health outcomes for both mother and infant (Mangiaterra, Pendse, McClure, & Rosen, 2008).
people aged 15–29 years (Kirby Institute, 2014). If left untreated, these infections can have lasting negative impacts on young people’s health and fertility. For Aboriginal women, these negative consequences manifest in high rates of pelvic inflammatory disease (Silver et al., 2012; Skov, Murray, & Latif, 2008), infertility (Kildea & Bowden, 2000) and premature childbirth (Li et al., 2012). The disparity in these sexual health indicators increases with geographical remoteness, with rates of chlamydia, gonorrhoea and infectious syphilis substantially higher than those encountered in regional or urban areas (Kirby Institute, 2012).

Reproductive health outcomes also demonstrate significant disadvantage for Indigenous women in Australia. Pregnancy and childbirth is more perilous for Aboriginal and Torres Strait Islander women than for non-Indigenous women, with a threefold greater risk of maternal mortality (Johnson, Bonello, Li, Hilder, & Sullivan, 2014). Indigenous mothers are, on average, younger than non-Indigenous mothers (25.2 years vs. 30.3 years), receive less antenatal care during pregnancy and have higher rates of smoking, with 48% of all Aboriginal and Torres Strait Islander women smoking tobacco at some time during their pregnancy. The rate of premature birth for Aboriginal and Torres Strait Islander women is 14.3% compared with 8.3% in the non-Indigenous population, and the rate of low birthweight Indigenous babies is double the rate for non-Indigenous babies (Hilder, Zhichao, Parker, Jahan, & Chambers, 2014). There are also higher rates of foetal deaths (10.8 vs. 7.1) and neonatal deaths (4.1 vs. 2.3) reported in Aboriginal and Torres Strait Islander babies than in non-Indigenous babies per 1,000 births across Australia (Hilder et al., 2014).

**Northern Territory outcomes.**

It is also possible for the disparities in Australian women’s sexual and reproductive health outcomes to be geographically contextualised. The Northern
Territory, a geographically large region (1,346,200 km²), has the smallest population of all Australian states and territories (see Figure 2.1). Of the 229,711 people who live in the Northern Territory, approximately 27% are Aboriginal and Torres Strait Islander people. This is a much larger percentage than in the other states, where only 4% or less of the population is Indigenous. In addition, 80% of the Northern Territory’s Indigenous people live outside the capital city in rural and remote locations (Australian Bureau of Statistics, 2012a), whereas in the other states and territory the majority live in urban areas. Indigenous women account for 36% of all women giving birth in the Northern Territory, and 64% of these women come from remote and rural locations (Thompson, 2014). Compared with Australia’s other states and territory, the Northern Territory demonstrates consistently poorer sexual and reproductive health outcomes. A contributing factor to this may be the higher population of Indigenous people living in remote and rural locations; as the remoteness increases so too does the percentage of the Indigenous population, from only 1% of the Northern Territory’s Indigenous population residing in major cities to 45% residing in very remote areas (AIHW, 2015). It is now well established that the health status and outcomes for Australians living in regional and remote areas, regardless of Indigenous status, decreases as the remoteness of the geographical location increases (AIHW, 1998, 2008).
Maternal deaths are statistically rare events that have been decreasing Australia-wide since reporting began in 1964 (King & Sullivan, 2006). Although the statistical significance of maternal mortality in small population settings is unclear, the Northern Territory in the most recent reporting period (2006–2010) had the highest maternal mortality rate of the Australian states and territories, with 21.3 deaths per 100,000 women who gave birth, while Tasmania had the lowest rate, with 3.2 deaths per 100,000 women (Johnson et al., 2014). The Northern Territory also has the highest proportion of women who smoke during pregnancy (Hilder et al., 2014) and the highest rate of preterm birth in Australia (Laws, Li, & Sullivan, 2010). Rates of common sexually transmitted infections in the Northern Territory are also
disproportionate to other Australian locations and alarmingly high. The Northern Territory notification rates in 2011 for chlamydia, gonorrhoea and infectious syphilis were, respectively, 3, 16 and 13.9 times higher than the national Australian rates (Australian Bureau of Statistics, 2012b).

Northern Territory Indigenous and non-Indigenous pregnancy and birth outcomes also demonstrate marked Indigenous disadvantage. Aboriginal and Torres Strait Islander women in the Northern Territory have higher rates of self-reported smoking during the first 20 weeks (51% vs. 12%) and subsequent weeks (48% vs. 10%) of pregnancy compared with non-Indigenous women. Indigenous women have higher rates of premature birth (16% vs. 7%), low birthweight babies (16% vs. 6%) and perinatal infant mortality (23.4 vs. 8.5 deaths per 1,000 births). Indigenous women are less likely to present during the first trimester of pregnancy when initiation of antenatal care is optimised, compared with non-Indigenous women (50% vs. 80%). Indigenous women, compared with non-Indigenous women, are also more likely to receive insufficient antenatal care (13% vs. 1%), that being no care or less than four antenatal care visits recorded. There is a higher rate of teenage pregnancy, with 20% of Indigenous mothers under 20 years of age compared with 3% of non-Indigenous mothers under 20 years. A more profound divide is evidenced at younger ages, with 9% of Indigenous mothers aged 18 years and under compared with 0.7% of non-Indigenous mothers aged 18 and under (Thompson, 2014). It is likely that these rates of teenage pregnancy are underestimated; pregnancies that end in abortion or spontaneous miscarriage are not included in the figures.

Rates of induced abortion for Northern Territory Indigenous women are lower than for non-Indigenous women but demonstrate a rising trend. The induced abortion rate for Indigenous women in the most recent reporting period (1992–2006)
demonstrates a steady rise from 7 abortions to 12 abortions per 1,000 women aged 15–49. This rising trend suggests a much closer alignment to the non-Indigenous women’s induced abortion rate, which has decreased during the same period from 18.2 to 15.5 (Zhang, Dempsey, Johnstone, & Guthridge, 2010, p. 38). The significance of, and reasons for, the increase in the induced abortion rate for Indigenous women remains unknown but may be influenced by improved service access or women’s increasing knowledge of their options in dealing with unplanned pregnancy. Issues of access are likely to more adversely affect remote-living Indigenous women because only surgical abortions provided in regional hospitals are legally available in the Northern Territory. This requires all remote-living women to travel to one of the two regional centres of Alice Springs or Darwin and, according to legislation, to seek care from a medical specialist.

Viewed in total, the statistics discussed in this chapter are evidence of the profound levels of disadvantage experienced by many Indigenous women in the Northern Territory and particularly by adolescent and reproductive-aged women living in remote locations. It is of equally vital importance that this statistical disadvantage is contextualised by research exploring the social and cultural determinants of Aboriginal women’s sexual and reproductive health. Inhorn (2006, p. 348) argues that only by listening to and understanding women’s perspectives are health policymakers and practitioners able to define women’s health problems, contextualise these problems with relevance to health interventions and then evaluate the delivery of women’s health care in ways that can lead to innovative policies and best care practices. For this to occur in a meaningful and effective manner will require further qualitative research that privileges remote-living Aboriginal women’s own perspectives on their health and lives in the Northern Territory.
Situating Indigenous Women’s Sexual and Reproductive Health

Before examining the current literature that situates my research project, it is crucial to place Indigenous women’s sexual and reproductive health within a cross-cultural and well-informed conceptual framework. It is frequently acknowledged that European colonisation has had disastrous, ongoing effects on the health and wellbeing of Australian Indigenous people (Carson et al., 2007; Mitchell, 2007; Saggers & Gray, 1991), but it is also important to consider how colonisation has differentially affected men’s and women’s health. As Huhndorf and Suzack (2010, p. 1) articulate, colonisation for Indigenous women has resulted in their:

removal from positions of power, the replacement of traditional gender roles with Western patriarchal practices, and the exertion of colonial control over Indigenous communities through the management of women’s bodies, and sexual violence.

A gendered perspective on the history of colonisation has been explored in the context of indigenous women’s experiences in both Australia and Canada (Bourassa, McKay-McNabb, & Hampton, 2004; Grimshaw, Lake, McGrath, & Quartly, 1994; Jasen, 1997; McGrath & Stevenson, 1996). Gendered implications of colonisation that have affected indigenous women include the suppression of childbirth traditions (Jasen, 1997), disruption to girls’ and young women’s sociocultural, sexual and reproductive education (Grimshaw et al., 1994; Healey, 2014), and the introduction of sexually transmitted infections (Mitchell, 2007; Senior, 2005; White & Franklin, 1997) and sexual violence (Grimshaw et al., 1994; Saggers & Gray, 1991). McGrath & Stevenson (1996, p. 39) write that colonisers often used ‘statutory subjugation’ as a strategy to limit indigenous women’s personal agency in many matters concerning reproduction and sexual expression. Such
intrusions included controls over marriage, divorce, sexuality, family composition, motherhood and, in Australia, controls over sexual embodiment, with the colonial enforcement of Western-styled clothing that covered women’s breasts and adversely affected infants’ suckling (McGrath & Stevenson, 1996).

These historical experiences amount to the colonisation of indigenous women’s reproductive embodiment as well as their geographical lands. In Australia, the gendered effects of colonisation on Aboriginal and Torres Strait Islander women’s sexual and reproductive health is, in all likelihood of great significance and is worthy of further sustained research efforts. Certainly, the gendered effects of colonisation have been implicated with ongoing impacts on young indigenous women’s sexual health in Canada (Healey, 2014; Oliver et al., 2015).

As for all women, sexual and reproductive function and health remain an important expression and measure of Aboriginal and Torres Strait Islander women’s general health and wellbeing. The National Aboriginal and Islander Health Organisation stated that from an Aboriginal perspective, health refers not only to physical wellness but also the social, emotional and cultural wellbeing of an individual and the community as a whole and acknowledges a cyclical concept of health that identifies life events such as birth and death as natural occurrences (National Aboriginal and Islander Health Organisation, 1982). This perspective is aligned with the World Health Organization’s definition of the social determinants of health (Morrissey, 2003).

For Indigenous people, women’s health issues are an important aspect of the gendered cultural construct of women’s business (Fredericks, Adams, & Best, 2014). The Aboriginal English term ‘women’s business’ is in vernacular use in Aboriginal communities and in some healthcare facilities and among some non-Indigenous
health professionals. Despite its common and widespread use, the concept generally lacks robust definition in health literature, and its implications on health outcomes or provision is poorly understood and discussed. The exception is Reid’s (1979) informative research paper that examines in detail the cultural definition of, and attitudes towards, the concept of women’s business in one Aboriginal community and their impact on the provision and acceptability of family planning services. The concept of women’s business has been defined in a number of slightly different ways (Bell, 2001; Fredericks et al., 2014; Kosiak, 2014; Maher, 1999; O’Connor, 1993; Reid, 1979). However, common to all definitions is a cultural domain involving gender-restricted information that is shared among and between women, but not with men. It is contextualised as a traditional custom of information organisation, which remains in contemporary practice. It includes intergenerational sharing between women of ‘customs, cultural practices and laws’ (Fredericks et al., 2014, p. 74). The ritualistic and ceremonial content of women’s business has been successively documented in the works of Kaberry (1939), Berndt (1950) and Bell (2001), all of whom explored women’s sacred ceremonial practices. Women’s business also involves all matters concerning reproduction, such as menstruation, pregnancy, childbirth, contraception and abortion (Maher, 1999, p. 232; Reid, 1979). Although the following are not included in these definitions, I suggest women’s business also involves the additional Western medical concerns of female reproductive-system pathology, including urinary tract infections, sexually transmitted infections and bloodborne viruses, and cervical and breast cancer.

Transgressions or breaches in the organisation of gender-restricted knowledge are likely to induce a feeling of shame for many Aboriginal and Torres Strait Islander people (Fredericks et al., 2014; Maher, 1999; Reid, 1979). The
concept of *shame* is complex and difficult to both translate and understand in English (Maher, 1999). It transcends English definitions of ‘guilt’ or ‘disgrace’ and may be felt by or on behalf of a person (Morgan, Slade, & Morgan, 1997). Shame is felt in a variety of contexts: when a person is singled out from the rest of the group for either ‘praise or blame’, is forced to behave in a way that dismisses or rejects larger group obligations or behaves in a culturally unsanctioned manner that conflicts with spiritual or social obligations (Morgan et al., 1997, p. 598). The literature provides many health-related examples of contexts that may cause shame for an Aboriginal patient—for example, a male attendant undertaking a vaginal examination, a female nurse teaching a male self-catheterisation, a female nurse washing an elderly initiated male patient or a male doctor discussing contraception with a woman (Maher, 1999; Reid, 1979). Aboriginal women have also reported feelings of shame as a significant impeding factor in the accessibility and acceptability of women’s health services (Ireland, 2009; Ireland, Narjic, Belton, & Kildea, 2010; Kildea, 1999; Morgan et al., 1997; Simmonds, 2002; Wilson, 2009).

**Grandmothers’ Law.**

Grandmothers’ Law is a significant and deeply sacred component of Aboriginal women’s business, involving reproductive and childbirth practices. Carter et al.’s (1987) ground-breaking report on the proceedings from a large gathering of Northern Territory Aboriginal women in Central Australia was the first written account of Grandmothers’ Law. It explains in detail the sacred ceremonial process of childbirth, referred to by these women as the ‘borning’. The Carter et al.’s (1987) document also describes in heartfelt tones the challenges, disjuncture, disempowerment and fear that many Aboriginal women feel when giving birth in the diametrically opposed Western obstetrical manner. Ramsey (2014, p. 103) defines
Grandmothers’ Law as ‘the traditional knowledge and experience of senior women in a community about attending to women during pregnancy, childbirth and post-partum’. Grandmothers’ Law is known in other regional areas by alternative names, such as Koonie Koonie in the Wagit region and Birthing Mothers in Arnhem Land (Dunbar & Ford, 2010). Although there were, and still are, wide variances in Aboriginal childbirth practices across Australia, common themes of ‘cultural obligation, ritual and taboo’ all feature in the practice of Grandmothers’ Law (Ramsey, 2014). The ancient practices of Grandmothers’ Law are pro-nascent and are credited with the successful survival of countless generations of families of Aboriginal and Torres Strait Islander people over what we now conservatively believe to be at least the last 40,000 years (Grant, Wronski, Murray, & Couzos, 2008; Parbury, 1986; White & Franklin, 1997).

Written historical accounts from early colonisers, combined with more-recent narratives from Aboriginal and Torres Strait Islander women, demonstrate the commonly reported reproductive beliefs and childbirth practices. There appears to be a universal belief in the involvement of a ‘spirit child’ in the physiological conception of foetus. A spirit child is known as a very small spirit-being that resides in the landscape, plants or animals (Spencer, 1914; Stanner, 1936b). In areas of northern Australia, spirit children may come to a woman through her male partner’s dreams, may be caught as an animal or gathered as food, may be disturbed by a woman during the activities of her daily living or may simply find a woman of their own volition (Kaberry, 1939; Kildea & Wardaguga, 2009; Stanner, 1936b). The conception of the spirit child may be marked by a special location in a person’s country or through a significant shared event (Carter et al., 1987; Dunbar & Ford, 2010). A woman considered herself pregnant when she felt foetal movements.
(Ackerman, 1977). In Northern Australia, women observed various dietary and behaviour taboos throughout pregnancy (Carter et al., 1987; Palipuaminni, 1981).

It appears that women often gave birth away from the main clan camp. Senior and knowledgeable female family relatives attended the labouring woman and could use a variety of pain-relief techniques, including therapeutic touch and massage using ash or perspiration, walking, and cold water poured over the abdomen (Carter et al., 1987; Collins, 1798; Palipuaminni, 1981; Roth, 1897). In the Kimberly and in Arnhem Land in northern Australia, women were encouraged to stay upright and active during labour (Kildea & Wardaguga, 2009; Stewart, 1999). Sometimes, active labour was recounted as involving hanging, swinging or squatting while holding onto low branches (Callaghan, 2001; Roth, 1897). A birth pit was prepared in the ground, and the woman kneeled or squatted as the baby was born (Collins, 1798; Ramsey, 2014; Roth, 1897). After birth, the baby’s umbilical cord was managed with various techniques. These included cutting the cord with a sharp finger nail, stone or oyster shell; tying the cord with hair or string; pounding the cord with a rock; or tying off the cord with a true knot after pulsating had finished (Callaghan, 2001; Palipuaminni, 1981). The placenta was perceived as sacred, and care was taken in its disposal (Carter et al., 1987; Dunbar & Ford, 2010; Kildea & Wardaguga, 2009; Ramsey, 2014). In many parts of northern Australia, ceremonial smoking to spiritually cleanse and strengthen the woman and newborn was common (Carter et al., 1987; Dunbar & Ford, 2010; Kildea & Wardaguga, 2009; Ramsey, 2014).

Although Aboriginal reproductive and childbirth practices such as those described have been severely disrupted and marginalised by a colonising process involving the introduction of Western biomedicine, some regional strongholds remain—mostly in remote areas, where women continue to pass on their ancestral
knowledge (Kosiak, 2014). Despite such strongholds, much of the knowledge and many practices involved in Grandmothers’ Law have now been lost. It is timely to remember that the transmission of culturally bound knowledge is often linked to the survival and strength of the custodian’s first spoken language. Colonisation has destroyed many Indigenous languages. Of the more than 250 Indigenous languages once spoken in Australia, current surveys suggest that only 120 are still spoken and, of these, only 13 are in a strong condition—that is, in use by people of all ages and, in this process, being passed onto children. Around 100 Australian Indigenous languages are classified as critically or severely endangered (Marmion, Obata, & Troy, 2014, p. xii). This suggests that many Aboriginal women’s surviving ancestral reproductive knowledge is threatened and endangered. With Aboriginal women’s consent and support, this knowledge is worthy of preservation. Indeed, the work of Aboriginal women of Maningrida and Kildea (2008) and the work of Stewart (1999) with the women of Warmun provide two good examples of how researchers working alongside and with the support of Aboriginal women have been able to document important reproductive knowledge in a culturally sensitive and acceptable manner.

**Contextualising Aboriginal Women’s Sexual Health in the Northern Territory**

As the promotion of sexual health involves reducing the adverse impacts of sexual activity, most notably the transmission of sexually transmitted infections, it is essential that health interventions are based on an understanding of how Aboriginal women’s life context affects their sexual behaviour. It is not possible to understand this from statistical profiles alone. There is limited literature from the past 10 years contextualising Aboriginal women’s current sexual disadvantage from a Northern Territory perspective. A collection of original research papers set in regional and
remote locations in the Northern Territory and involving young Aboriginal female participants aged 16–35 years provides some useful findings (Chenhall, Davison, Fitz, Pearse, & Senior, 2013; Senior & Chenhall, 2008b, 2012; Senior, Helmer, Chenhall, & Burbank, 2014; Stark & Hope, 2007). Epidemiological statistics support the use of this sampled cohort, because younger people aged 15–29 years account for the majority of notifications for sexually transmitted infections (Kirby Institute, 2014). In this instance, data rigour is enhanced through the use of multiple qualitative methods: ethnography, semi-structured questionnaires, and group body-mapping scenarios. Findings synthesised from this collection of research emphasise the situational vulnerability of young Aboriginal women who have poor agency in negotiating sexual encounters. Limited health literacy regarding sexually transmitted infections, alcohol use, low condom use and normalised intimate partner violence are all implicated as important factors exacerbating risky sexual behaviours that perpetuate poor sexual health outcomes. Fagan & McDonnell (2010) and Mooney-Somers et al. (2012), working with Indigenous youth in Queensland, reported similar findings to the Northern Territory findings.

**Fertility management.**

Aboriginal women’s condom usage and negotiation is explored in this body of literature, and findings can be complemented by an Aboriginal male perspective through the notable work of Willis (2003), who explored cultural obstacles affecting Pitjantjatjara men’s attitudes to, and use of, condoms. Despite a record of high Aboriginal teenage pregnancy in the Northern Territory (Thompson, 2014), surprisingly little research has explored young women’s knowledge and use of contraception and fertility management techniques beyond condoms. The role of long-acting reversible contraceptive implants (LARCs) and access to emergency
contraception, along with the provision of abortion services, are all important adjuncts to addressing unplanned pregnancies. Nevertheless, there is no sustained research eliciting the beliefs, knowledge or experiences of young Aboriginal women regarding access to these pharmaceuticals and services in the Northern Territory.

**Sexual education.**

It would seem plausible to consider sexual education as another important intervention for addressing Aboriginal women’s sexual health disadvantage due to the concomitant increase in personal agency and enhancement of health literacy. Although limited research has examined the effectiveness of sexual health education programs in Australian Indigenous settings (Willis et al., 2005), recent evaluations in the Northern Territory suggest that approaches combining clinical best practice with a coordinated sexual health program can reduce the incidence of sexually transmitted infections (Guy et al., 2012; Su & Skov, 2007). International evidence also suggests that when young people’s sexual knowledge is increased, sexual health outcomes can be improved without any adverse effects (UNESCO, 2009). Willis et al. (2005, p. 6) caution that although education programs often employ social, clinical and behavioural interventions, they need to be based on the ‘sound knowledge of the behaviours, knowledge, beliefs or practices that they are trying to influence’.

Although the qualitative research currently available from a Northern Territory setting contributes valuable insights into the context of young Aboriginal women’s lives, more research is needed in order to enhance both the social generalisability of the findings and their representativeness of the diversity in Aboriginal women’s experiences. Qualitative research into the cultural and social contexts influencing young women’s sexual behaviour remains a key research priority.
Health literacy.

Low health literacy is identified in all the literature as a significant obstacle to better sexual health. Low health literacy is known to be exacerbated by poor socioeconomic status and has a significant impact on health-seeking behaviours, including a person’s willingness to access preventative health campaigns and adhere to treatment (Boyle, Fredericks, & Teede, 2013). Although cultural beliefs (Shaw, Huebner, Armin, Orzech, & Vivian, 2008) and language (Vass, Mitchell, & Dhurrkay, 2011) are important contributors to health literacy, a scarcity of literature explores the impacts of Aboriginal women’s cultural body-concepts and linguistic constructions of their body. Some international research certainly highlights diversity in women’s beliefs about their bodies and reproduction (Brewis, 1994; Cornwall, 1992; MacCormack & Draper, 1987; Shedlin, 1979; Sobo, 1993). In much of this international research, culturally constructed beliefs are deemed to affect not only health literacy (e.g. as in how the body is believed to function) but also, notably, women’s sexual behaviours, such as the acceptance or rejection of condoms and other contraceptive methods (Sobo, 1993).

Communication.

Although effective communication in sexual health contexts in the setting of the Northern Territory has received scant attention in the literature, rudimentary investigations into cross-cultural health communication between Indigenous people and non-Indigenous health practitioners in the Northern Territory have been conducted (Cass et al., 2002; Lowell, 2001; Mobbs, 1991; Trudgen, 2000; Vass et al., 2011; Watson, Hodson, Johnson, & Kemp, 2002; Watson, 1987). Although only a small collection of literature, it confirms profound communication barriers when Aboriginal people attempt to access Western health-related scientific knowledge.
Communication problems are compounded by language differences and by opposing Aboriginal and non-Aboriginal worldviews. Vass et al. (2011, p. 33) suggest that the term ‘worldview’ refers to the way in which a group of people ‘categorise and conceptualise their reality’, forming a ‘foundation philosophy that informs each group’s perception of their respective worlds’. A person’s worldview is highly informed and contextualised by their first spoken language. These issues are particularly pertinent in the context of the Northern Territory, considering it has an Indigenous population with poor health status and represents one of the most linguistically diverse areas in the world, with more than 100 Aboriginal languages and dialects spoken (see Figure 2.2) (Department of Community Services, 2015). The role of cross-cultural health communication in Aboriginal health disadvantage is a reprehensibly under-prioritised research area. It is logical to assume that Aboriginal women’s poor sexual health outcomes may be perpetuated by poor cross-cultural communication. This remains an urgent and worthy area for further investigation.

In other parts of the world, the impact of language as a barrier for indigenous people accessing sexual health services and information is recognised. Of note is the organisation Pauktuutit Inuit Women of Canada, which collaborated with linguistic professionals to produce a sexual and reproductive health resource in English and five of the region’s major language dialects (Pauktuutit Inuit Women of Canada, 2012). The resource records and explains in plain language common sexual health terms and clinical procedures and is intended to be used by health professionals and Inuit patients and caregivers to enhance cross-language communication. This method of cross-expertise collaboration between health and linguistic professionals could also be used to improve sexual health communication in linguistically diverse areas of northern Australia.
Figure 2.2. Major Aboriginal languages of the Northern Territory. Source: Aboriginal Interpreter Service, 2015.
Contextualising Choice for Indigenous Women’s Birthplace Location in the Northern Territory

Reproductive health aims to support women’s access to appropriate care during pregnancy and childbirth. For more than 30 years, Aboriginal and Torres Strait Islander women in Australia have been consulted about what they deem appropriate reproductive health care, and their ongoing dissatisfaction with the cultural responsiveness of maternity care has been recorded. Despite women’s many suggestions, little change has been made to the provision of maternity services, reflecting the profound loss of agency many Aboriginal and Torres Strait Islander women feel during their childbirth experiences (Kildea & Wardaguga, 2009). Although Indigenous perspectives remain muted and marginalised in Australian maternity care reform (J. P. Wilson, 2014), issues pertinent to Aboriginal and Torres Strait Islander people continue to be debated among Indigenous communities and among women, families, elders and non-Indigenous health professionals alike (Kosiak, 2014). Kosiak (2014, p. 121) suggests several issues related to maternity are of more importance to Aboriginal and Torres Strait Islander women, one of which is ‘where women choose to give birth and whether they are able to choose the location’.

Due to the medicalisation of childbirth, the physical location for the planned place of birth remains a contested and debated issue in Australian reproductive healthcare settings and discourse (Australian College of Midwives, 2011; MacColl, 2009; Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2014). Planned non-hospital birth locations are often marginalised in health policy and planning, receive little government funding and, when desired by women, often prove difficult to access (Commonwealth of Australia, 2009; Dahlen, Jackson, Schmied, Tracy, & Priddis, 2011; Dahlen, Schmied, et al., 2011). For
Indigenous women, place of birth has additional cultural complexities and impacts because giving birth on ancestral country is frequently believed to endow the newborn baby with cultural identity, custodial land rights and kinship connections (Carter et al., 1987; Felton-Busch, 2009; Kildea, 2006). The setting of the Northern Territory is uniquely placed for an examination of the birthplace debate and provides revealing insights into how socioeconomic and health disadvantage denies many Aboriginal women their cultural and reproductive health choices.

**Regional birthplaces.**

Within the regional limits of Darwin and Alice Springs, Northern Territorian women can access a range of sanctioned planned birthplace locations, which include a hospital-based ward, a birth centre and home. All of these planned birthplaces are embedded within publicly funded models of maternity care involving a range of health practitioners, including obstetricians, registrars, general practitioners and midwives. Women’s eligibility to access these models varies and is often linked to a perceived biomedical risk during pregnancy or childbirth. Despite the range of birthplaces on offer in the Northern Territory, only 1% of births occur at home. The great majority of births (97%) occur in hospital (Thompson, 2014), of which a small minority (3.2%) occur in a birth centre (Hilder et al., 2014). Of the 1% of homebirths in the Northern Territory in 2011, none were Indigenous women (Thompson, 2014). The percentage of Indigenous women using birth centres is unknown because publicly available perinatal data do not report birth-centre births by Indigenous and non-Indigenous status. This makes it difficult to draw conclusions regarding equity in Indigenous women’s access to different models of maternity care. It is likely that because more Indigenous women than non-Indigenous women present later for antenatal care, many of the more popular care models may already be booked out.
There appears to be no service provisions in place to enable better access for Indigenous women, such as reserving a number of places for disadvantaged women presenting late in their pregnancy. Higher levels of maternal morbidity experienced by Indigenous women may also prevent access to care models that are only available for pregnancies deemed low risk.

Remote birthplaces.

Outside the regional limits of Darwin, Gove and Alice Springs, remote maternity services stipulate routine evacuation of all pregnant women into regional areas in order to give birth in a hospital, with only antenatal and postnatal care offered in a woman’s home town (Congress Alukura, 2014b). Although only 39% of all women who give birth in the Northern Territory are Indigenous, these women live predominantly in very remote and rural locations (Thompson, 2013). This means that compared with their non-Indigenous and regional counterparts, these women are disproportionally affected by limited birthplace choice. Hancock (2007, p. 79) tellingly states that remote Aboriginal women are the least likely of all Australian women to have choice and control over their pregnancy care, their care provider and their planned place of birth.

When Northern Territory birthplace locations are more closely examined according to Indigenous status, an unusual pattern emerges. Despite Indigenous women having no participation in the regional homebirth services, around 4% of all Indigenous mothers give birth outside of hospital settings in what are deemed ‘unplanned locations’, such as in remote health centres, in transit or at home. The most common location is a remote health centre. This contrasts with less than 1% of all non-Indigenous Northern Territory women giving birth in unplanned locations outside of hospital settings (Thompson, Zhang, & Dempsey, 2012, pp. 6–7).
Of Aboriginal births recorded as occurring in unplanned locations, some may be intentional. It is likely that these births include a combination of intentional, unintentional, premature and term pregnancies. My research in one remote Northern Territory Aboriginal community demonstrates that up to 10% of women give birth outside of a hospital facility in their community and that many of these women intend to do so by quietly resisting transfer to urban centres (Ireland, 2009; Ireland et al., 2010). In addition to demonstrating that Aboriginal women continue to have planned births outside of the offered system, my research highlights the paradox of a health system that discourages women from seeking care during the most vulnerable transitions of childbirth. It is common practice in remote areas of the Northern Territory for a labouring woman, regardless of health status or pregnancy duration, to be administered tocolytic drugs to stall the contractions of labour and to be evacuated by plane. Participants in my research were knowledgeable about this practice and chose instead to stay at home for birth or opted to seek professional health care only when birth was imminent, thus avoiding evacuation during labour.

There have been attempts to improve remote Aboriginal women’s experiences of regional maternity services in the Northern Territory. The most notable has been the Midwifery Group Practice which commenced in 2009 (Kildea et al., 2016). This service redesign provides regional-based maternity care to Aboriginal women from remote areas that are accessing antenatal and childbirth services in Darwin. It has been favourably evaluated for increasing women’s access to continuity of midwifery care, decreasing the number of women receiving less than four antenatal care visits and improving communication between regional and remote care providers (Josif, Barclay, Kruske, & Kildea, 2014; Kildea et al., 2016). Importantly, for the first time, the service was able to increase remote women’s
birthplace options to include the Darwin birth centre. Yet the evaluation also demonstrated that some maternal and infant health indicators did not improve after the introduction of the service and some worsened over time, for example the treatment of urinary tract infections and anaemia (Kildea et al., 2016). Whilst the service redesign certainly improved women’s positivity towards regional maternity care (Josif, Barclay, Kruske, & Kildea, 2014), the rate of babies born outside of hospital remained unchanged and was nearly 20 times higher than for women across the rest of Australia (Kildea et al., 2016).

Historical health statistics (NT Department of Health, 1980), narrative accounts (Holleley & Preston, 1984; Palipuaminni, 1981) and anecdotal conversations demonstrate that prior to the regional centralisation of maternity childbirth services, Aboriginal women in some communities could elect to give birth in their community-based health clinic. In these clinics, which were closely aligned to contemporary definitions of a primary maternity unit (Monk, Tracy, Foureur, & Barclay, 2013), maternity care was provided by midwives and Aboriginal health workers without on-site obstetrical, anaesthetic, laboratory or paediatric support. Primary maternity units in other parts of the world have been demonstrated to assist with providing equitable and accessible maternity care to women with low-risk pregnancies (Monk et al., 2013) and culturally safe and empowering maternity care to women from an all-risk Indigenous population, without compromising safety (Houd, Qinuajuak, & Epoo, 2004; Van Wagner, Osepchook, Harney, Crosbie, & Tulugak, 2012).

Lacking clear evidence of an improvement in perinatal outcomes from the centralisation of maternity services (Hancock, 2007; Kildea, Kruske, Barclay, & Tracy, 2010), the re-introduction of primary maternity health services that support
childbirth in select remote Aboriginal communities has been suggested as one way of addressing Aboriginal maternal and infant health inequity (Kildea et al., 2010). Importantly, it has also been proposed as a way of satisfying the long-standing requests by Aboriginal women to give birth on their ancestral home country, with some women also believing that ‘birthing on country’ is a means of improving reproductive health outcomes (Carter et al., 1987; Danila Dilba Medical Service, 1998; Kildea, 1999; Kildea et al., 2010; Kildea, Magick Dennis, & Stapleton, 2013). Despite the proposed re-introduction of remote childbirth services, a dearth of literature historically contextualises changes to remote maternity services in the Northern Territory. Historical perspectives on maternity care are of vital importance because, through a deeper understanding of the past, clinicians, researchers and policymakers can better manage and respond to the challenges that occur when developing and maintaining midwifery-led maternity services (Monk et al., 2013, p. 213). This is especially important in the context of developing remote primary midwifery services with the inherent challenges of providing physically and culturally safe care for Aboriginal and Torres Strait Islander women and their families.

The literature providing historical perspectives on remote midwifery in the Northern Territory is very limited. There is a small compilation in booklet format of women’s accounts of childbirth in Darwin and its surrounds, spanning the years 1888–1938 (Moran & Hanckel, 1988). The booklet uses the narration of women from ethnically diverse backgrounds to provide revealing insights into the gendered isolation and hardships of childbirth in the Northern Territory. In addition, there is a dense two-volume work by Kettle (1971), spanning the years 1824–1970, which documents the evolution of health services in the Northern Territory. Although
Kettle’s primary objective was to contextualise the broader history of health services, it is possible through the details of her work to plot the quiet development of hospital-based maternity services in the Northern Territory. Aboriginal health worker Palipuaminni (1981) also shares her experiences of working on Bathurst Island with pregnant women who, in the early 1980s, were supported to give birth in the health centre if their pregnancy was uncomplicated and not their first. Her account records important cultural details on the taboos of pregnancy practiced by the island community. In addition, Goodale (1971) provides a brief but insightful account of midwifery care during a bush camp birth with Tiwi women in the late 1950s. This childbirth account formed part of Goodale’s ethnographic monograph about the Tiwi women on Melville Island. Despite these worthwhile contributions to the historical record of Northern Territory midwifery, very little is known about how remote childbirth services were actually provided and whether the experience of giving birth in a remote location was culturally and/or physically safe for Aboriginal women. Although the complexities of the gendered interface of Australia’s colonisation has certainly been explored, as in the work of Grimshaw et al. (1994) and of Summers (1980), the colonising implications of Western midwifery’s introduction into remote Aboriginal communities remains all but unaddressed in the literature.

**Birthplace location and Inuit women.**

While little research has explored birthplace location for Indigenous women in the Northern Territory, considerable international attention has focused on understanding the changes to birthplace location for the remote indigenous Inuit women of Canada and Greenland (Daviss, 1997; Douglas, 2006; Gherardi, 2002; Kaufert & O’Neil, 1990; Montgomery-Andersen, Douglas, & Borup, 2013). The Inuit women of Canada and Greenland, and the Aboriginal women of the Northern
Territory share a legacy of recent colonisation and removal of childbirth from their remote communities; as such, the literature on Inuit women provides both compelling policy implications and theoretical models applicable to the Northern Territory setting. The work of Montgomery-Anderson et al. (2013) is a useful example of how birthplace location can be explored and better understood by the novel application of a theoretical model. In their research, they use Daviss’s (1997) theoretical model of logics to review literature on birthplace location in Greenland from 1953–2001. Their findings demonstrate that birthplace location has changed in Greenland and that childbirth has shifted from a personal and community act to one that is now private and political.

Daviss (1997) designed a theoretical model of logics after her decades of global midwifery practice during which she witnessed ‘firsthand the contradictions and tensions between traditional and medical definitions or reproductive risk and normalcy’ (p. 443). Her clinical experiences led her to identify several principles she perceived as being used to inform decision-making during pregnancy, childbirth and the postpartum period. These principles provide a helpful framework for understanding the competing knowledge systems that may lie beneath otherwise authoritative discourse, such as that encountered in clinical practice manuals. Daviss’s work builds on Jordan’s (1992) seminal theoretical concept of obstetrical authoritative knowledge. Jordan proposes that, in any given situation, several knowledge systems exist at once; however, one of those knowledge systems will gain ascendance, due either to its association with a structural power base or to its efficacy. The knowledge system that gains ascendance will dominate and become the authoritative way of viewing and managing the situation. Daviss (1997) deconstructed these knowledge systems into types of ‘logic’ that govern decision-
making. Seven potential types of logic that underpin maternal care practices and their definitions are presented in Table 2.1.

### Table 2.1

**Daviss’s Logics**

<table>
<thead>
<tr>
<th>Logic type</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>Scientific</td>
<td>Logic based on evidence from science, including biology, physics and epidemiology, which statistically analyses health and disease patterns during reproduction.</td>
</tr>
<tr>
<td>Clinical</td>
<td>Logic based on health practitioners’ physical assessments and examinations of mothers and babies and varies according to training, experience, knowledge, philosophy, and peer pressure. It is often presented as scientific logic but frequently has no scientific basis.</td>
</tr>
<tr>
<td>Personal</td>
<td>Logic based on the knowledge used by families and individuals to assess what they may lose and/or gain from the decisions they make during pregnancy and birth. Personal logic also refers to the knowledge health practitioners use to evaluate the positive and/or negative effects that a clinical decision might have on their future careers.</td>
</tr>
<tr>
<td>Cultural</td>
<td>Logic based on information concerned with the fundamental beliefs a cultural group society holds in relation to management of birth, including traditional community knowledge and spiritual knowledge.</td>
</tr>
<tr>
<td>Intuitive</td>
<td>Logic based on knowledge held by a person who has become so familiar with a particular situation that he or she can make decisions about it without relying on any other particular category of logic.</td>
</tr>
<tr>
<td>Political</td>
<td>Logic based on knowledge of the consequences of what will be thought, done and viewed about birth by family, community, the general public, and government policymakers. It is concerned with issues of who has the power of control over the birth process and which cultural institutions and values will be reinforced and perpetuated through this control.</td>
</tr>
<tr>
<td>Legal</td>
<td>Logic based on knowledge of liability and litigation that can result from decisions made during childbirth.</td>
</tr>
<tr>
<td>Economic</td>
<td>Logic based on assessments of the costs and savings associated with the different ways of caring for pregnant and birthing women, often concerned with the goals of saving, making or not losing money.</td>
</tr>
</tbody>
</table>

*Note: Adapted from Daviss, 1997, pp. 443–444.*

Daviss (1997) notes that the different types of logic are rarely equally privileged, and she cautions us to not make presumptions about who operates from
which logic. In her experiences working with indigenous Inuit women and medical practitioners in Canada regarding childbirth, she found that:

A physician rarely uses only clinical logic, or an Inuit elder only cultural knowledge. Many physicians attracted to the North have more hope and faith in restoring Inuit traditions than the Inuit themselves, and some Inuit leaders have more respect for the medical model than physicians. Such apparent incongruities remind us of the ability of all participants to adjust and change. (Daviss, 1997, p. 445)

Montgomery et al. (2013) used Daviss’s model to inform changes to birthplace location in Greenland, and it has similar potential to deconstruct changes to Indigenous women’s birthplace location in remote areas of the Northern Territory. Understanding these changes remains an intellectually important, though unacknowledged, factor for addressing the re-introduction of remote childbirth services for Aboriginal women. The rationales behind past changes to maternal and perinatal health policy need to be more transparently articulated so that proposed alterations to future health interventions can be better judged and informed.

**Saint Fiacre Literature**

To this point, the literature review has focused on positioning my research in relation to the broader literature concerning Indigenous women’s sexual and reproductive health in the Northern Territory. Now, it will situate my research within the literature specific to the research site community. My doctorate research sits alongside, and contributes to, a small but growing body of knowledge generated from the Saint Fiacre community in the Northern Territory. Since colonisation, the Saint Fiacre community has had longstanding engagement with anthropologists and
other applied researchers, such as linguists and ethnomusicologists, who have lived and worked for extended periods in and among the community (Australian Institute of Aboriginal and Torres Strait Islander Studies [AIATSIS], 2015; Falkenberg, 1962; Falkenberg & Falkenberg, 1981; Gordon, 2004; Ivory, 2009; Marett, 2005; Marett, Barwick, & Ford, 2013; Nambatu et al., 2009; Reynolds, 1999; Stanner, 1936b, 1979, 1989; Street, 1987; Street & Mollingin, 1983; University of Melbourne, 2015; Walsh, 1994; Walsh, 1996; Ward, 1983). This collection of work substantiates the strength and richness of the Saint Fiacre people’s cultural expressions.

The most notable of these researchers is Australian anthropologist William Edward Henley Stanner. After years of fieldwork visits spanning the period 1935–1978 (AIATSIS, 2015), Stanner wrote and published profusely about his experiences with the Saint Fiacre people (AIATSIS, 2015; Stanner, 1936a, 1936b, 1953, 1979, 1989). Stanner is now deceased but remains warmly and well regarded by the people in Saint Fiacre. Against a background of critical condemnation from Indigenous people over the conduct of anthropological researchers (Nakata, 2008; Smith, 1999), the ongoing and heartfelt respect for Stanner adds much rigour and validity to his work. Stanner’s research was shaped by his personal interests and his gender; his key informants were appropriately male, and his research preoccupations were often men’s sacred life and religious practices. Despite these limitations of interest and gender, his seminal work provides lasting insights into the region’s demography and social organisation. Stanner shared brief but important insights into female-related realms, including an account of early conception beliefs (Stanner, 1936b), female age-grades and childhood milestones (Stanner, 1932a). Photographs taken during his fieldwork visits provide visual contributions; some depict women’s bodies—their clothing and ornamental scarring practices visible. Some demonstrate childcare
practices, such as the transportation of infants in paperbark bassinettes, and others show hospital facilities and health workers.

Stanner’s work is complemented by the exceptionally detailed work of two Norwegian social anthropologists, married couple Aslaug and Johannes Falkenberg. For six months in 1950 while living at the Saint Fiacre mission, the Falkenbergs undertook fieldwork and produced a meticulous account of the Saint Fiacre people’s social organisation and relations (Falkenberg, 1962; Falkenberg & Falkenberg, 1981). Their work provides a compelling account of the likely nature of people’s social and cultural organisation prior to the mission’s commencement. Although their work was undertaken in 1950, some 15 years after the mission commenced in 1935, the Falkenbergs explain that the mission was able to assert real influence only from 1940 onwards. They also explain that their adult informants had grown up in an ancestrally structured society and were able to articulate the changes that had occurred since the mission commenced. The cultural reality depicted in the Falkenbergs’ account establishes an important point from which to situate change and continuity in women’s reproductive lives. In their findings, the Falkenbergs devote attention to understanding gendered obligations and behaviours, including marriage rights, taboo and punishment, female kinship terms, age-grades and breast development, and sanctioned sexual acts. Some of these themes are revisited and revalidated in my own research, especially those concerning female age-grades and breast development.

Although not a trained linguist, my research includes an interest in the implications of language use in the contexts of women’s reproductive and sexual health. The dominant Aboriginal language of the Saint Fiacre community is fortunate to be in a strong cultural position (Kelly, Nordlinger, & Wigglesworth, 2010), and
this is evidenced in its universal uptake as the first spoken language in a large and growing population of babies and small children. The language of *Murrinh Patha* has been an ongoing focal point for outsider interest. This interest began in 1946, when mission staff member Father WH Flynn learnt to speak fluent Murrinh Patha and, in doing so, enhanced his evangelising by giving all sermons in the local language (Falkenberg, 1962, p. 19). Significantly, for my research agenda, Flynn documented the first (unpublished) dictionary of Murrinh Patha, which is held in the private collection of the local museum. It included two private books, titled ‘Moralia’, and although dealing with morally circumspect topics, it documented the vocabulary of sexuality and reproduction. This has been an important resource for the triangulation and validation of my language data.

More recently, linguist Chester Street compiled a Murrinh Patha dictionary (Street & Mollingin, 1983) and a language learning resource (Street, 1987). Ward (1983) also provides an insightful account into the cultural organisation of the Saint Fiacre people through the medium of language. Walsh (1994, 1996) and other academic linguists have pursued specialised topics regarding the construction and acquisition of Murrinh Patha language (Blythe, 2012; Kelly et al., 2010; University of Melbourne, 2015). Walsh’s (1996) work on human-body concepts and typology provides the only published commentary on language protocols concerning speech about genitals. His work situates women’s current speech practices concerning the naming of female genitals. The other formative language-based work is that of Nambatu et al. (2009), in which the authors record the *Marri Ngarr* and *Magati Ke* people’s ancestral language and knowledge about the region’s plants and animals. Its extensive listing of the common English, scientific Latin, Marri Ngarr, Magati Ke
and Murrinh Patha names for all the plants and animals proves an invaluable resource for locally based research endeavours.

While none of the literature discussed so far has a female-focused topic, two doctoral dissertations based in Saint Fiacre do. The work of Reynolds (1999) on Aboriginal ritual engaging with Catholic sacrament in Saint Fiacre provides a recent account of women’s interfaith spiritual practices. Of some significance to my research is a section dealing with women’s first menstruation ceremony, a ceremony no longer in practice. It addresses the recent history of the ceremony and includes an explanation of its practice. The data discussed in the section was generated from discussions with now deceased and irreplaceable culturally senior-ranking female informants. As such, this information is invaluable. The second work of importance is that of Gordon (2004), who examines the role of the Catholic Church and women in Saint Fiacre during the years 1935–1958. She advances the proposition that the church did much to advance the social status of the women, who, she argues, were being oppressed by internal and external influences in Aboriginal and settler cultures. Although it raises complex issues in need of further critique, her work contributes context to the role of Aboriginal women in the mission around the time of significant gendered social changes. It also provides brief commentary on the role that the founding mission priest played in women’s health care. Notwithstanding these commendable contributions, there remains no Saint Fiacre research dealing specifically with ancestral midwifery and childbirth practices or with the history of the introduction of Western midwifery.

Conclusion

This chapter has situated my research in relation to a selected range of literature pertinent to Aboriginal women’s sexual and reproductive health in the
Northern Territory of Australia. Using a range of statistical sexual and reproductive health measures, the review of the literature has established the vulnerability and disadvantage of many remote-living Aboriginal women in the Northern Territory. While a body of literature has assisted in contextualising Aboriginal women’s current sexual health disadvantage, the collection is small, and several gaps remain regarding the topics of fertility management, health literacy, sexual education, and cross-language communication.

This chapter has also explored literature contextualising women’s choice in planned birthplace locations. Although it is clear that many Aboriginal women wish to be supported in giving birth in their remote communities but do not have this option, the rationale behind this maternity care decision is not clear in the literature, nor has it been historically situated. International research offers theoretical models that could be used in an Australian setting to better understand changes to Aboriginal women’s planned birthplace locations. The next chapter will explore the research site of Saint Fiacre.
Chapter 3: Research Site

This chapter describes the town of Saint Fiacre—the setting for the research. It explains my relationship with the community; describes the region’s demography, location and resources; and reflects on everyday life within the community.

My Relationship with Saint Fiacre

My relationship with the Saint Fiacre community formally began in 2006, when I accepted a job as a remote-area nurse and midwife. After years of global nomadism, my partner and I committed to a two-year contract to live in the Saint Fiacre town and work full-time in the community health centre. We were hungry to break away from hospital-based practice and intrigued by the prospect of an adventure in Australia that was more akin to going overseas—that is, experiencing a place where the people speak a different language, where our skin colour makes us the minority and where differences in culture might provoke us to question our own. In all of these regards we were correct, but we were certainly not prepared for the influence that these two years would have on our future.

We moved into a government-provided nurse’s house on Ngumink Street and began working long hours at the community health centre, as well as being regularly on-call and responsible for attending to any after-hours emergencies. Working at the health centre amplified our sense of intimacy and rapport with people. Nursing and midwifery are unusual occupations in that they allow repeated access to multiple strangers’ lives, where one openly participates in private events (e.g. birth, death, serious illness) that would otherwise usually only be shared between close friends and family. Through the simple act of being with many different Saint Fiacre people during important lifetime events and transitions, I began to acquire localised
knowledge. Some of it was significant knowledge, such as who belonged to which family or clan group, but mostly it was more mundane, such as where to buy rosary beads or how to make a good cup of tea according to the local palate. As I became more familiar with and confident in my understanding of these more mundane aspects, I also became aware of how little I actually understood about the practice of Western midwifery care in the context of Aboriginal women and their families.

Inspired to search for a better understanding of the clinical experiences I was encountering, I undertook my honours degree (Ireland, 2009; Ireland et al., 2010). During the course of my honours research, I developed two particularly strong and inspiring relationships: one with senior elder and Yek Yedder midwife Mrs Concepta Wulili Narjic and the other with medical anthropologist and midwife Dr Suzanne Belton. As we worked together on the honours project, many women began to share information about unrelated matters of women’s business: birth stories from the old hospital, experiences of working as a midwife with the nuns, bush birth stories from the old times, and their renewed interest in supporting young pregnant women. With Concepta and Suzanne’s encouragement and support, the end of one research project became the starting point for another, and thus this doctorate research project was born.

Location, Geography and Access

Saint Fiacre is a remote town, most often referred to as ‘remote Aboriginal community’. In this context, the term ‘community’ when coupled with ‘Aboriginal’ or ‘Indigenous’ has become racialised in Australia, used in literature and by the media as a euphemism for the extreme social and economic disadvantage encountered in towns with a dominant Aboriginal population that are located vast distances from urban infrastructure and resources. Unlike remote non-Aboriginal
settlements, the locations of these towns often have no economic basis. Rather, their location is the result of historical government racial policy at the time they were established or of their heritage as Aboriginal ancestral **homelands**.

Saint Fiacre fits into the second category, being the ancestral homelands since time immemorial for the **Kardu Diminin** people. After the arrival of Roman Catholic missionaries in 1935, another 21 landowning clan groups joined the Kardu Diminin people (Thamarrurr Region Council, 2007) and, over time, settled permanently in this place identified by and locally named after a small freshwater-creek crossing (Costigan & Crocombe, 2010; Northern Territory of Australia, 2008). The town is located on declared Aboriginal land under the Aboriginal Land Rights (Northern Territory) Act 1976 and is held in trust by the government ‘for the benefit of Aboriginals entitled by Aboriginal tradition to the use or occupation’ of it (s. 4 (1)). The greater land lease of isolated wilderness is approximately 13,467 square kilometres (Thamarrurr Region Council, 2007, p. 13 ref).

From my own explorations (by foot, boat, plane, car and motor/mountain bike), the landscape and physiography of the lease is both rich and varied. Along the coastline are pristine beaches of white sand and arid dunes (see Figure 3.1). Also common to the coast are the dark mangrove forests on fecund estuaries and wetlands, which give way to open tidal mudflats. On the nearby floodplains, parched grasses grow between tall-standing magnetic termite mounds (see Figure 3.2). In the open eucalyptus woodlands, the understorey is interspersed with the splaying leaves of cycad. Deep **billabongs** are punctuated with pink and purple waterlilies (see Figure 3.3), and nearby swamps are dotted with thick paperbark trees. Borrowing from Bird Rose’s (1996) terminology, this land is ‘nourishing terrain’ and continues to be the source of spiritual and physical sustenance for the people of Saint Fiacre.
Figure 3.1. Red cliffs along the coastline near Saint Fiacre.

Figure 3.2. Magnetic termite mound near the Saint Fiacre town.
Aboriginal people in the region possess specialised knowledge of the local flora and fauna, which once allowed them to subsist on the land exclusively through hunting and gathering. Plants were used for a variety of purposes, including for sources of food, plant – animal associations used in hunting and gathering, material culture, medicine and making weapons and implements (Nambatu et al., 2009) (see Table 3.1). A variety of animals (birds, reptiles, mammals, frogs, freshwater and saltwater fish, shellfish and cephalopods, prawns, crabs and insects) were used as sources of food, and many animal by-products (bones, sinews, fat, feathers, fur) were used for medicinal, cosmetic and construction purposes. Some animals and plants were used as seasonal calendars, such as the *thay kugalng* (red-flowered kurrajong tree), whose blossoming signals that the rains of the early wet season will soon commence (Nambatu et al., 2009, p. 24), while others had cultural and spiritual significance for the people, such as the *thay yipi* (banyan tree), the sacred resting place for spirits of old deceased people (Nambatu et al., 2009, p. 44). The hunting of
animals involved the use of many techniques and tools, such as camouflage, fishing line or stronger handlines, poisoning, night hunting, nets or traps, clubbing or spearing with wooden implements and, after the mission commenced, firearms (Nambatu et al., 2009).

Table 3.1

Examples of Ancestral Uses of Plants Found in the Saint Fiacre Region

<table>
<thead>
<tr>
<th>Plant use categories</th>
<th>Plant use examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plant-based food sources</td>
<td>Cabbage/pith, fruit flesh, fruit seeds, gum, preparation/flavouring, tubers/yams and water sources</td>
</tr>
<tr>
<td>Plant – animal associations</td>
<td>Edible plants found in animals, calendar plants, plants for animal food</td>
</tr>
<tr>
<td>Material culture</td>
<td>Artefacts, carving, firewood, glues/resins, insect repellant, shade/shelter, soap, tobacco, toys, honey brush, poisons</td>
</tr>
<tr>
<td>Medicine</td>
<td>Treatment for respiratory, skin and other aliments</td>
</tr>
<tr>
<td>Weapons and implements</td>
<td>Boomerangs, clap sticks, coolamons, didgeridoos, digging sticks, fighting sticks, firesticks, fire carriers, fire starters, fish poison and traps, shields, smoking pipes, spears, watercraft, woomeras</td>
</tr>
</tbody>
</table>

Source: (Nambatu et al., 2009, pp. 177–179).

The area has recently gained significance for its biodiversity and is now identified as an important international seasonal breeding ground for many bird colonies (Bird Life International, 2012; Chatto, 2000). For hundreds of generations, Aboriginal families have feasted on seasonal bounties, such as the *ku ngalmungkIRR* (magpie geese) of which 500,000 are estimated by Bird Life International (2012) to breed on the coastal floodplains surrounding Saint Fiacre.

The Saint Fiacre town has complex borders of human relationship with the land, demonstrated by the approximate 16 *outstations* scattered through the immediate surrounding countryside. These small land estates mostly belong to the
other 21 landowning groups who are now settled permanently on the Kardu Diminin land. Periodically inhabited, these small camps have human visitation according to seasonal change, access to motorised transport and the cultural practice of closing homelands out of respect for a recently deceased community member.

The town’s climate is meteorologically categorised as tropical monsoonal, with a pronounced dry season from May to September, followed by a wet season that lasts until around April (Haig & Matsuyama, 2003). It is not surprising that the people who have lived in this climate for thousands of years know the seasonal changes so intimately that they are able to identify three major seasons rather than two—da thangku, da mirrangan, da malarnpakpak—and nine subseasonal weather patterns (Bowden McCormack Lawyers & Advisors, 2010, p. ref 16; Street & Mollingin, 1983, p. 32).

Due to the monsoonal climate, road access to the town is reliable during the dry season only (see Figure 3.4). The road is unsealed for the last 190 kilometres and crosses several significant river systems, which until recently made it impassable during heavy rain. However, seasonal isolation is now being challenged by upgrades to all water crossings and the construction of a large all-season road bridge across the widest of the rivers. The condition of the road varies considerably; the drive from Darwin can take between four to eight hours depending on driver skill and vehicle capacity. The road has undergone considerable improvement since 2007 when offshore development began on gas plant, which now mines natural gas and liquid hydrocarbons from the seabed in the Timor Sea (Woodside Energy Ltd, 2004).

Access to the town by air is achievable in all seasons by means of a one-hour direct flight from Darwin in a small light plane. In a larger plane with a more powerful engine, the flight takes 40 minutes. A community-owned freight and
transport service provides a regular service, with two flights per day Monday to Saturday and one flight on Sunday. The all-weather tarmac airstrip has permanent runway lights and an illuminated windsock, enabling night landings.

Figure 3.4. Rendering assistance to a bogged ‘troupie’ on the main road to Saint Fiacre.

Language

Saint Fiacre is one of the few places in Australia with a strong, growing population of people who speak an Aboriginal language as their first language. At the expense of making the other regional languages of the area near extinct, and of superseding English, Murrinh Patha\(^2\) has become the lingua franca of the community (Street, 1987; Walsh, 1994). Three language boundaries divide the greater region of Saint Fiacre into the Garaman, Daly River and Djamindjungan language families.

\(^2\) The Murrinh Patha language has been documented over time and spelled with many variations, including Murin Bata, Murinhy Patha, Murrinh-Patha and Murrinpa. For consistency, I have chosen to use the spelling ‘Murrinh Patha’.
Each of these language families consists of several languages united by similarities in vocabulary and grammatical structure (Street, 1987, p. 1).

**Garaman language family.**

The main language of this language family group is Murrinh Patha, which has one dialect known as *Murrinh Kura*. Street (1987) and some of the participants in this research described Murrinh Patha as ‘light talk’ and Murrinh Kura as ‘heavy talk’. Street (1987) suggests that this dialect was only spoken north of the Fitzmaurice River, and in my language work sessions, there was one woman able to speak it. The name ‘Murrinh Patha’ means simply ‘language-good’ (Walsh, 1994, p. 299), but it was described to me, somewhat poetically by a Kardu Diminin woman, as meaning the ‘sweet, flowing, nectar-like language’. Murrinh Patha vocabulary is proportionally unique: it shares, respectively, only 4% and 11% of its words with the Djamindjungan and Daly River language families. However, its grammatical structure is very similar to all Djamindjungan family languages (Street, 1987).

The town of Saint Fiacre is located well within the Garaman language family area, which explains why Murrinh Patha has gained dominance and is now the first language spoken by children, despite it not necessarily being their parent’s first language. Along with the rapid increase in population that occurred during the 1960s (Taylor, 2008), this weakening of first languages was dramatic, with several generations now unable to speak or understand their ancestral first language.

**Daly River language family.**

This family group has 24 languages and dialects, which were, and sometimes still are, spoken north of the Garaman family border (Street, 1987). Languages known by people in Saint Fiacre, such as Marri Ngarr, *Marridjabin* and *Magati ke* all
belong to this group. According to the Thamarrurr Region Council (2007), linguists predict that by 2010–2020, Magati Ke Magitige will not be actively spoken, and by 2050+, Marri Ngarr and Marridjabin will cease to be actively spoken. Despite this loss of languages, many people still use their language name to identify who they are, for example, ‘I am a Marri Ngarr woman.’

**Djamindjungan language family.**

The Djamindjungan language family also includes multiple languages and dialects spoken southwest of the Garaman family. This language family has a much smaller presence in Saint Fiacre, but the most well known language from this family is the Murinh Nyuwan or the Djamindjungan language (Street, 1987).

**English literacy and numeracy.**

Despite the strength of the growing population of first-language Murrinh Patha speakers, young people’s levels of English literacy and numeracy are, in general, astoundingly low. Taylor (2010) reports that longstanding disengagement with formal schooling has resulted in many young adults aged 35 years and under not possessing the necessary literacy and numeracy skills to participate in the current labour market. From my own observations, children of primary-school age are often unfamiliar with the fine motor skills required to grasp a pen and are unable to write their names or perform simple numeracy tasks, such as grouping silver coins into dollar stacks. This is in stark contrast to middle-aged and senior people, who are well skilled in literacy and numeracy—a direct legacy of the earlier mission-style education, which saw them separated from their families and living in dormitories. Catholic Education NT runs an accredited bilingual English and Murrinh Patha school (Catholic Education Office, 2012). This bilingual program, which was
introduced between 1974 and 1978 (Nganbe & McCormack, 2009; Northern Territory Archives Services NTRS 226, 1993), has resulted in some children growing up with the ability to not only speak but also read and write in both Murrinh Patha and English.

**Demographics**

**Population.**

Saint Fiacre’s current and burgeoning population is well documented by Taylor and colleagues (Taylor, 2004, 2008, 2010; Taylor & Stanley, 2005), whose recent attention on the region has resulted in robust documentation of the demographic profile and future projections for the Saint Fiacre population. Historically, taking a count of the Saint Fiacre population has been hampered by certain nuances. The greatest difficulty has been in differentiating and accounting for those people in regular, lasting settlement in the town and those in frequent transit to the town but who reside *out bush* in outstations on surrounding clan estates. This has resulted in what Taylor (2008) describes as a blurring between what constitutes the size and composition of the town and what constitutes the total regional population.

By referring to mission administration records and to the fieldwork diaries of anthropologist William Edward Hanley Stanner, it is possible to assemble a historical record of Saint Fiacre population counts, which were conducted sporadically between 1935 and 1947 and then annually during the years of mission administration from 1950 to 1973 (Taylor, 2008, p. 221). Taylor (2008) asserts that the totality of these records indicate substantial population growth, with a particularly rapid increase in the Saint Fiacre population in the 1960s. The Australian Bureau of Statistics (ABS) collected population data from 1976 to 1996, presumably to assist
with the government’s regional development and planning priorities. However, Taylor (2004) discovered that the ABS data, when compared with other available Saint Fiacre data sets (such as client lists at the health clinic or housing profiles from the council office), suggested a different trend: one of population stagnation, followed by rapid growth and then marked population decline. Although there remained slight differences, both in defining these alternative data sets and in the counting methodology used, this finding was of great concern and led to a pressing social need to document more rigorously the demography of Saint Fiacre and the region in order to leverage appropriate, equitable government investment in the town.³

Taylor and the Thamarrurr Region Council sought permission for and organised a community-wide census to count the population in a culturally congruent manner, nominating senior family group members to assist with the collection of population data. After several methods of data cleansing were applied, Taylor (2004) reported a resident Aboriginal population of 2,034 in the year 2003 (p. 25), compared with the 2001 ABS statistic of 1,700 (statistically adjusted to accommodate for natural increases between censuses) and a total service population of 2,373 (p. 27). This is projected to grow to 3,833 by the year 2023 (p. 35).

**Age and sex composition.**

The age and sex composition of the population has many implications for the provision, design and targeting of community health services and infrastructure. Of particular importance is the largely youthful population in Saint Fiacre. Taylor’s

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³ In 2012, the Saint Fiacre community was awarded $7.7 million in settlement of a longstanding dispute with the Australian Government before the Australian Human Rights Commission over the discriminatory funding of the Saint Fiacre school. This was only possible after the Taylor reports demonstrated significant underfunding of Aboriginal children’s education in Saint Fiacre compared with funding to other Northern Territory schools (Carney, 2012; Christie, 2012; Robinson, 2012).
(2004, p. 30) work showed almost half (45.7%) of the Saint Fiacre population to be under 15 years of age, with a slightly higher proportion of males (47.7%) to females (43.9%) and a distinct trend of females dominating in the age groups 29 and above. In fact, young children aged 0–9 years old were shown to account for 30.8% of the total population (Taylor, 2004, p. 30).

This abundance of children is a reflection of the importance of women’s social, biological and physical roles as mothers in Saint Fiacre (see Figure 3.6). Just over 66% of the female population \((n = 482)\) are of childbearing ages (15–44 years) (see Figure 3.5). In addition, the large \((n = 471)\) female cohort of young prepubescent girls (0–14 years), representing 43.9% of the female population, suggests the potential for sustained population growth over time, even if current fertility rates were to decline (Taylor, 2004, pp. 29–30).

*Figure 3.5. Saint Fiacre females in age groupings, 2003. Source: Taylor, 2004, p. 30.*
The current average birth rate is somewhere between 69 (Ireland, 2009, p. 66) and 79 births per year (Taylor, 2010, p. 12). It is projected that this will increase to an average of 157 births per year between the years 2020 and 2027 (Warchivker, 2007, p. 20). The rate of low birthweight babies in the region is around 11.5%, which, although it compares favourably with the overall Northern Territory rate for Indigenous babies of 13.6% (Taylor, 2004, p. 88), is nearly double the national rate for non-Indigenous babies (6.1%) (Laws, Abeywardana, Walker, & Sulivan, 2007, p. 53).

Discrepancies in data sets make it difficult to calculate with certainty the total fertility rate for women in Saint Fiacre. Taylor proposes that when relying on locally sourced data from the Saint Fiacre Catholic Church baptismal records, a total fertility rate can be calculated as somewhere between 4.4 (Taylor, 2004, p. 34) and 3.4 (Taylor, 2010, p. 13), an average of 3.9. These ‘educated guesses’ remain substantially higher than the total fertility rate for Indigenous women across the Northern Territory, which at the time of these calculations was 2.9 and 2.4.
respectively. In 2005, the total fertility rate for non-Indigenous women in the Northern Territory was 2.0 and for the whole of Australia 1.8 (Zhang & Johnstone, 2009).

**Health status.**

Publicly available datasets on the health of people in Saint Fiacre are difficult to obtain. A blunt indicator of general health status is the mortality rate. Taylor (2004, p. 78) identified the median age of death as 46 years in the Saint Fiacre region, which at the time was four times higher than the disproportionately high median age of death for Indigenous people across the Northern Territory. Male mortality is high in the Saint Fiacre region, with a standardised rate of 38.2 males compared with 12.2 females per 1,000 deaths (Taylor, 2004, p. 78).

My experience working in the Saint Fiacre health clinic personally validated the profound health inequalities experienced by people in the region. Disease resulting from poverty and overcrowding are starkly and physically manifest. Never in my years of nursing in southern states of Australia did I encounter on a daily basis multiple presentations of crusted scabies and skin sores, rheumatic heart disease or ear canals pouring with green pus. My skills required quick adjustment. I soon became an expert in the curious debris regularly encountered in the ears of remote Aboriginal children: stones, sticks, toilet paper, beads, lollies, cockroaches, crickets and centipedes.

An accelerated trajectory of complex chronic disease also plays out in remote Aboriginal communities. In very short periods, I witnessed the demise of many of Saint Fiacre’s ‘youthful’ elderly—those aged 35 years and above—from diabetes or related renal disease attrition. In southern Australian climates, my experience had
been that these sorts of patients were always at least 60 years of age. Although most of the data was of limited quality, Taylor (2004, p. 86) proposed that around one quarter of all people in Saint Fiacre had a diagnosed chronic disease and that this translated to around two-thirds of those aged 35–54 years of age. The two leading chronic diseases were hypertension and renal disease. For unknown reasons, women were over-represented in those diagnosed with chronic diseases (Taylor, 2004), despite constituting less than 50% of the population. This may be because women attended the community health centre more frequently than did men, with females accounting for 58.1% of all presentations (Warchivker, 2007, p. 38). Increased woman’s attendance, perhaps for reproductive related healthcare, may provide more opportunities for the screening and diagnosis of chronic diseases. Certainly, across the Northern Territory, Indigenous people die at higher rates than non-Indigenous people from chronic diseases. In 2009, Indigenous people were twice as likely as non-indigenous people to die from circulatory diseases and seven times more likely to die from endocrine and related disorders (NT Department of Health, 2012, p. 10).

Regrettably, no discrete data on measures of key reproductive and sexual health for women in Saint Fiacre is publicly available—such as average age at onset of puberty, the rates of sexually transmitted infections, contraception use, terminations and infertility—nor data on screening rates for breast and cervical cancer.

**Town Services, Communications and Infrastructure**

The Saint Fiacre town is the hub for the region and nearby outstations. Services available in Saint Fiacre include a supermarket, fruit and vegetable shop, furniture and hardware store, community health centre, post office, police station, takeaways, council chambers, Centrelink office, museum, knowledge centre,
swimming pool, credit union, butcher, aged-care facility, primary and secondary schools, school boarding house, crèche, women’s centre, Correctional Services, land and sea ranger office, mechanic’s workshop, petrol bowsers and a women’s safe house (see Figure 3.7 and Figure 3.8). There is also a church, presbytery and convent, with Catholic pastoral services provided by a resident priest, nuns and brothers. This includes an alcohol-awareness and family recovery centre.

*Figure 3.7. The Saint Fiacre shopping mall, where a takeaway, post office, butcher and knowledge centre are located.*

*Figure 3.8. The Saint Fiacre swimming pool.*
Standard landline telephone communications are available in Saint Fiacre, and Telstra NextG mobile phone reception has been available since 2008. In a remarkably short time, mobile phone ownership and usage has been passionately incorporated into the community’s kinship and communication networks. UHF radio has adequate coverage in the region and is often in use by council workers and others involved in remote bush trips. As with all remote locations, the long distance from technicians when problems arise and the infrastructure vulnerability in extreme weather events, such as tropical cyclones, hamper the quality and consistency of these communication services. There is a sealed airstrip.

The Northern Territory Power and Water Corporation supplies electricity through a very large and noisy generator that consumes approximately two million litres of diesel per annum; however, there are plans to convert this to natural gas (PowerWater, 2011). The supply of drinking water is maintained through designated bore fields and reticulated for domestic use in homes and gardens (Haig & Matsuyama, 2003). The scaffolded water storage towers in the middle of town are a significant landmark.

Most Aboriginal community members access food and grocery items from the local supermarket. Taylor (2004) reported the prices of basic food items to be almost 40% higher than in an average Darwin supermarket. Despite marked improvements with the supermarket in recent years, there remains a very limited variety of food items, and most are tinned or highly processed with poor nutritional value. Living with restricted purchase choices appears to enhance brand loyalty through fear of, or lack of confidence in, a new or unknown item. Many times I have observed people being overwhelmed by their choices when visiting Darwin and resorting to a familiar brand, such as Sunshine milk powder or Bushells tea bags.
With poor numeracy, some people struggle to calculate which items offer the best value. Recently, one young mother was complaining to me about the high price of tinned powdered milk ($11), stating that she could buy two bottles of fresh milk for $8. She was not able to understand that the tin of powdered milk offered better value for money, making almost triple the volume of milk for a third of the price of the bottled fresh milk.

*Bush tucker*, including meat, seafood, fruits and vegetables, sourced by hunting and gathering when available, complements supermarket supplies. Staple daily dietary items include damper made from flour and water at home (see Figure 3.12), white bread, processed tinned meat, and brewed tea with sugar and powdered milk. There is still a preference for cooking on the coals (see Figure 3.10) or for stewing in a recycled flour drum or saucepan over a wood fire outside (see Figure 3.9). Indoor kitchens are often underused for food preparation and cooking and do not contain the kitchen utensils common in Western kitchens, such as pots, pans, cutlery and crockery. Rather, kitchens are a place to access running water. However, in some better-appointed facilities, there may be an electric stove, kettle, frypan (see Figure 3.11) and refrigerator—all misused or in various stages of disrepair. Communal drinking tins are often preferred, and a large brew of tea is sipped and passed between people seated in a group. If a mug is needed and not available, the cut-off bottom of a plastic soft-drink bottle or an empty powered-milk tin is often used. The hygiene standards in all of the kitchens I have visited are poor and must affect household health.
Figure 3.9. Making damper using a shopping bag as the mixing tray.

Figure 3.10. Cooking bush tucker—freshly gathered mud crabs on an open fire.
Figure 3.11. A common cooking scene—stewing kangaroo in an old flour drum over the fire.

Figure 3.12. Stewing kangaroo in an electric frypan in a kitchen.
Across the Northern Territory, 66% of Indigenous people live in overcrowded households (see Figure 3.13), which is 11 times higher than the Australia-wide rate (NT Department of Health, 2012, p. 12). In the Saint Fiacre town during 2003, there was one household bedroom for every 5.6 people (Taylor, 2004, p. 72); this has recently improved with the addition of more houses. Security and storage of food is difficult—if not impossible—to maintain in these overcrowded households and hence many families shop for only one meal at a time. This dictates daily regular cycles of shopping, and the attendance of different family groups at the shop can be predicted according to the time of the day. Problems with the security and supply of food commonly results in people, including children, going without food or a substantial meal for 24 to 48 hours. Patients attending the community health centre often reported this pattern of sustenance.

Non-Aboriginal residents with credit cards may use bush order services in Darwin, whereby supermarkets provide distance shopping to patrons living in remote areas, packing and transporting items to a remote location for a small handling fee and additional transport costs (see Figure 3.14). In comparison with local options, bush order offers significantly subsidised prices and a greater variety of food options. Some government employees are eligible for rebates on the cost of transporting food to their remote place of residence. Without common access to credit cards or loan schemes and with poor literacy and numeracy, Aboriginal residents are unable to access this service.
Figure 3.13. In Saint Fiacre, housing conditions are poor and often overcrowded.


Figure 3.14. The barge that delivers bush order food and supplies to Saint Fiacre during the wet season when the roads are closed.
Recreational Drug Use

Tobacco.

Australia has several species of indigenous plants that contain nicotine. Drawing on the information collated by Scollo and Winstanley (2012, p. 8.2), these plants have been traditionally ‘harvested, prepared, traded and chewed’ by Indigenous people across the continent. The nicotine plants have mood-enhancing effects and were therefore highly sought after by Indigenous people, who considered their use significant in friendships, trading relationships, ceremonies and the practice of medicine. Two species of native tobacco plants known as *mi muth* grow in Saint Fiacre. The foreign substance of tobacco and the new practice of smoking were introduced in the early eighteenth century to the Aboriginal people in northern Australia by Macassan traders and readily became incorporated into ceremonial life. Tobacco was often smoked with crab-claw pipes, a practice that from my observations is still evident among some of the elderly residents of Saint Fiacre.

There is evidence to suggest that ongoing supplies of tobacco were a powerful motivator for some remote Aboriginal people in the Northern Territory to gather and settle at European outposts. Stanner (1953) and Read and Japaljarri (1978) recount instances of Aboriginal migration to acquire tobacco. During the commencement of the mission in Saint Fiacre, tobacco was in ready supply. The mission’s founding-party supply ship had ‘50lb’ of tobacco on-board as ‘a gift to establish friendly relations with the wild Aborigines’ (*Sydney Morning Herald*, 1935).

Today, regardless of Indigenous status, the prevalence of cigarette smoking is very high in the Northern Territory. During the 2007–2008 reporting period in the Northern Territory, 54.6% of Aboriginal people and 28.4% of non-Aboriginal people smoked tobacco compared with the overall national rate of 21% (NT Department of
Health, 2012, p. 15). Since the introduction of tobacco into Saint Fiacre, its use appears to have been omnipresent. There are no official usage statistics, but heavy dependency appears common. A certain ‘crankiness’ or ‘wildness’ is well recognised by women as a symptom of tobacco withdrawal, and non-Aboriginal smokers are often targeted with strategic *humbugging* to replenish the supply. On several occasions, I have observed the incredible dexterity of Saint Fiacre women, who, when walking along a paved urban footpath in Darwin, are able to dexterously pick up cigarette stubs from the ground using only their toes. In one seamless action of blurred motion, barely observable to a bystander, the stub is transferred in a flash from toe to hand to skirt pocket. This collection of discarded stubs is later harvested and combined to make enough tobacco for a smoke or chew. As a nonsmoker and a health practitioner, it has always been my personal preference to never supply tobacco or lend money to buy tobacco. I am well aware that this stance alienates me from an otherwise very efficient, fast rapport-building and coercive local economy. When asked to supply, I always reply, ‘I cannot do that because I do not want to gift you sicknesses.

Tobacco is sometimes smoked as a *rollie* (a hand-rolled cigarette), but many middle-aged women prefer to chew it seasoned with fire ash. There is a flurry of activity before the wet season as women search out specific tree species and harvest great quantities of bark (see Figure 3.15), resulting in death of the trees from ringbarking. Over several days, the bark is dried in the sun and then laid on corrugated iron sheeting, where it is carefully set alight. The iron base allows easy collection of the resulting ash. The powdery fine white ash is stored in plastic bags and tins for use over the prevailing damper months. The women tell me the ash makes the *mi thuwuy* (tobacco) ‘taste better’, but it is thought that the alkali in the
ash releases the active alkaloid nicotine in the tobacco, enhancing its stimulant effect for the chewer. This effect has been noted in other countries where similar combinations of stimulants, such as areca nut and coca are chewed with lime alkali substances, such as burnt crushed oyster shells (Miner, 1939).

There is a ritualistic quality and precision to the preparation of chewing tobacco: a large pinch is moistened with saliva and rolled in the palm of the hand to form a dense ball three centimetres in diameter. The ball is then delicately dusted in fine ash and adeptly flicked into the inner cheek or lip pocket of the mouth. If tobacco supplies are running short, the ‘balls’ are kept in use for a long time. Sometimes they are conveniently stored behind the ear or on the laminated dashboard of the *troupie* or in the pockets of cotton skirts. Resembling dried animal faeces, they are always rather unpleasant ‘finds’ for an unseasoned chewer such as me. After fieldwork sessions in my accommodation, I would often sweep up multiple tobacco balls from under the sofa.

*Figure 3.15.* The Ute tray filled with bark collected by women during a fieldwork outing to be later prepared for use with chewing tobacco.
Alcohol.

As Brady (2005) comments, alcohol has been Australia’s favourite drug since the arrival of Europeans. It is believed that before colonisation, Indigenous Australians prepared fermented drinks from plant substances, such as nectar, honey, gum and roots. Macassan traders in northern Australia also introduced spirits, palm wine and gin, but it was not until European colonisation that Indigenous people had access to voluminous alcohol supplies and adopted riskier European drinking habits (Brady, 2005). Today, alcohol consumption in the Northern Territory remains higher than elsewhere in Australia. From 2002 to 2011, the amount of pure alcohol consumed per capita in the Northern Territory showed a small declining trend, from 15.27 to 13.6 litres, compared with the static national rate of 10.3 litres (NT Department of Health, 2012, p. 13). Although there are more Indigenous, than non-Indigenous people who abstain from alcohol use in the Northern Territory, those who consume alcohol do so at a higher rate than in the non-Indigenous population (Northern Territory Government, 2010). Indigenous people living in remote Northern Territory communities appear to consume much less alcohol than do Indigenous people living in non-remote areas (Northern Territory Government, 2010), and this may in part be due to legislated alcohol-free zones.

Saint Fiacre once had a social club serving alcohol, but after community action in 1994, alcohol was banned and the town declared ‘dry’ (Territory Health Services, 1998). Only those non-Aboriginal residents with a liquor licence can now legally drink grog in their town-based homes. In other parts of the Northern Territory, alcohol restrictions as part of a broader public health campaign to reduce alcohol harm have had favourable outcomes, including reductions in alcohol consumption, alcohol-related harm and antisocial behaviour, and the restrictions have
generally been implemented with widespread community support (Gray, Saggers, Atkinson, Sputore, & Bourbon, 2000). Despite the past devastating problems with alcohol-related antisocial behaviour in Saint Fiacre, the social club is tenderly recalled as a place where people gathered to share music, song and dance. Videos of the local bands performing in the club are now enthusiastically listened to and watched by people in the library.

In response to the prohibition of alcohol, the people of Saint Fiacre have coped in a variety of ways. Grog running is an intermittent solution, whereby takeaway alcohol legally purchased at distant towns is smuggled back into the community, sometimes by back bush roads, and illegally consumed in the alcohol-free area. The smugglers are often grog running as a familial obligation, and there are significant whitefella penalties, including fines and forceful police seizure of the vehicle used. These penalties were recently increased and now include an $11,000 fine or six months in prison (Jones, 2012).

Other people choose the legal option of visiting the ‘wet’ canteen approximately 90 kilometres away. Regular parties of people venture down the road for a social drinking session, where strict alcohol serving laws allow only light beer to be served and prohibit takeaway purchases. After many drink-driving fatalities on the dirt road, the council now provides a bus shuttle service for people to visit the canteen and drink safely.

A more extreme solution, used mainly by middle-aged people is that of leaving the community for long periods to go long grassing, a term referring to an extended itinerant stay in Darwin, the specific purpose being to drink excessive amounts of alcohol. It is so named as most people make temporary camps among the grass in the parklands or coastal reserves around Darwin’s central business district,
where they live rough and focus their existence solely on the supply and consumption of alcohol.

Although destructive to the physical body, long grassing is a complex social phenomenon, offering a form of emotional stress release and a sense of friendly camaraderie. Many of the articulate and intelligent middle-aged men look forward to going long grassing, as one would a holiday. There appears to be no social stigma associated with long grassing, and in Saint Fiacre the practice is openly discussed, almost as one would discuss a hobby. However, it is a risky pastime; violence and beatings are common, and some drinkers cannot escape the lure of grog, with weeks of long grassing turning into endless months. There are frequent hospital admissions due to the alcohol-induced downward spiral of chronic disease, injuries and immune-system compromise. Others tragically succumb to accidental death, such as being fatally hit by vehicles when drunkenly crossing the street.

The phenomenon of long grassing can be contextualised by statistics that demonstrate the disproportionately high rates of alcohol-related hospitalisations and deaths in the Northern Territory. For Indigenous people, both direct and indirect hospitalisations for alcohol-attributable conditions remain much higher than for non-Indigenous people (399 vs. 146 per 10,000 hospitalisations) (NT Department of Health, 2012, p. 14). Skov, Chikritzhs, Li, Pircher and Whetton (2010) state that the rate of alcohol-attributable deaths in the Northern Territory is 3.5 times the rate found elsewhere in Australia. The rate of alcohol-attributable deaths in the Northern Territory for the non-Indigenous population is about double the national rate, while for the Indigenous population the rate is 9 to 10 times the national rate (Skov et al., 2010, p. 269).
For the luckier people, long grassing ends with what is affectionately known as a *spin dry*. This involves being arrested for drunk and disorderly behaviour and then being detained in police custody to abruptly sober up while one’s physical body and clothes are washed and dried in preparation for release. A spin dry, followed by a free flight home financed by a family member or an Aboriginal organisation, such as *Larrakia* Nation, has saved many people from a premature alcohol-related death in Darwin. Yet, often—with time—the cycle begins again.

**Gunja.**

Cannabis use is more common among Indigenous Australians (22%) than among non-Indigenous Australians (11%) (Gray & Wilkes, 2010, p. 5). Marijuana in Saint Fiacre is called *mi kanja*, coined from the English/Sanskrit slang *gunja*. Smoking gunja is one of the favoured recreational pursuits of young people of both sexes. Often it is a shared household experience, with nocturnal groups of young people gathering in unfurnished bedrooms to share a milk-tin *bucket bong*. Discarded smoking paraphernalia and cleverly constructed bottle-lid *cones* are found in roadside rubbish and frequently tripped over when visiting particular gunja houses. Compared with a handmade rolled *joint* made from smoking papers, a bucket bong offers an efficient way to get stoned using smaller amounts of gunja.

Although males and females pursue gunja smoking, some suggest that young men disproportionately suffer from the practice. For a significant number of young men, gunja smoking cascades into mental psychosis and the lifelong burden of painful fortnightly antipsychotic depot injections (Ireland, 2009). According to McCormack (2006), young men fund their gunja habit by targeting female family members who care for children and receive welfare payments. The young men use a well-rehearsed cycle of intimidating women, be they aunties, mothers or
grandmothers, to forfeit money that was intended to be used in the care of children, for the next gunja deal. Similar tactics are described in other remote Aboriginal communities, and as Senior and Chenhall (2008a) describe, various strategies are employed by regular users to acquire funds for their next purchase, including constant humbugging of family members or, much to the annoyance of regular gamblers, playing cards just long enough to win their gunja money.

Gunja is a relatively recent addition to the local economy, and the informal ‘rules’ of gunja dealing are still in establishment. Some gunja deals can be perilous, with some young men being physically assaulted, and reports of young women using transactional sex to broker deals. Since the advent of welfare quarantining and consequent lack of surplus cash, alternative economies have responded, with items such as power tickets and mobile phone credit being exchanged for gunja. Methamphetamines are yet to be experimented with in Saint Fiacre, but the health services in a distant Aboriginal town are reporting its use, and there is anecdotal evidence of it gaining traction.

**Community Health Services**

The Northern Territory Department of Health and Families provides primary healthcare services to the community. Those who live in Saint Fiacre know the community health centre simply as the clinic. A model for remote practice is in use, whereby registered nurses have an extended clinical role and scope of practice. This extended practice is dictated by three manuals: the *CARPA standard treatment manual* (Central Australian Rural Practitioners Association, 2014), the *Women’s business manual* (Congress Alukura, 2014a) and the *Clinical procedures manual for rural and remote practice* (CRANAplus, 2014).
Remote-area nurses in remote workplaces are able to diagnosis and treat patients and to prescribe drugs for a range of medical conditions outlined in these manuals. In the same circumstances in regional areas, their practice would currently be illegal. The manuals describe treatment plans, which may include consulting a doctor; this can be achieved face-to-face or, most commonly, with a district medical officer at the end of a phone line.

Saint Fiacre has one of the largest staffed community health centres in remote northern Australia, with 10 positions for remote-area nurses, a registrar position and a notoriously difficult-to-fill position for a permanent resident general practitioner. The permanency of on-site medical assistance makes Saint Fiacre somewhat unusual; in the smaller settlements, doctors make only short-term day visits. In addition to this staffing complement, there are four funded positions for Aboriginal health workers in Saint Fiacre (Warchivker, 2007), which are currently vacant despite trained and skilled resident health workers living in the town. There remain a few employed Aboriginal clinic drivers and receptionists, but otherwise whitefellas fill the support positions—even those of the unskilled cleaners.

The current community health centre opened in 2010, a large facility costing $7.6 million (Northern Territory Government, 2011). It involved extensive renovations and a large addition to an existing older clinic building. The building has an emergency treatment bay, a baby treatment room, multiple consultation rooms, an X-ray room and equipment, a women’s procedure room (see Figure 3.16), a secure drug storage room and dispensary, a soundproof audiology booth and staff meeting and education rooms.
Attempts were made to localise and indigenise the new clinic, with Murrinh Patha signage and separate entries for men and women. As the government’s health e-newsletter announced:

The bright colours of the clinic’s interior, denoting areas for men, women and children, were chosen by community members (Northern Territory Government, 2011, p. 1)

However, cultural sensitivity failed in the process of translation. The separate male and female entrances defeat the purpose of a private gendered space by leading into the same unscreened universal waiting room, and the incorrectly spelt Murrinh Patha signage has persisted for years despite complaints from literate older locals to correct the mistakes (see Figure 3.17).

Figure 3.16. Women’s procedure room in the Saint Fiacre community health centre.
Figure 3.17. Signage in the Saint Fiacre community health centre with the misspelt Murrinh Patha word, ‘palngun’.

Women’s Health Services

Despite Saint Fiacre’s large population and socioeconomic disadvantage, there are no separate health service models to target its vulnerable subpopulations. All health care provided at the clinic accords with the dominant biomedical model of care. The demographic profile clearly suggests that women in Saint Fiacre would greatly benefit from targeted sexual health services for the large numbers of younger women and from community-based primary maternity services to support the sustained rates of pregnancy. Links between maternal and child health outcomes suggest that targeted investment in women’s health can have major positive effects on the overall population health, and there is no reason to think this would not be the case in Saint Fiacre.
Sexual health.

Sexually transmitted infections and bloodborne viruses.

Screening and treatment of women in Saint Fiacre for sexually transmitted infections and bloodborne viruses occur through opportunistic, planned and targeted testing. According to the *Women’s business manual* (Congress Alukura, 2014a, p. 250), common pathways for testing include:

- a woman presenting with a sexual health problem as her chief complaint
- screening performed as part of regular antenatal pregnancy care
- screening as part of a routine yearly adult health check
- opportunistic screening targeting those under 35 years of age, if offered by the healthcare provider
- a community-wide screening, depending on the resources and motivation of current clinic staff
- a personal request from a woman.

Women who present with a specific sexual health problem have little choice in the gender of the health practitioner they see, unless they are pregnant and seeking midwifery care from the known female midwife. At presentation, the patient’s name is entered onto a generic computerised waiting list, and the next available practitioner calls her into a consultation. For most women, especially young Aboriginal women in Saint Fiacre, sexual health problems are a sensitive topic and best dealt with by another female. Some of the remote-area nurses do not convey sensitivity in dealing with gender issues, and one male nurse described to me how he was accused by
colleagues of ‘being lazy’ when referring female clients on to another female nurse for the assessment of sensitive problems like genital sores.

**Contraception.**

The *Women's business manual* (2014a, p. 331) currently suggests a range of contraception options for women, ranging from condoms, diaphragm, intrauterine device, contraceptive pill, depot contraceptive injection, Implanon, emergency contraception pill and tubal ligation. This may seem a reasonable range of options to meet the lifestyle and health needs of the majority of women, but only a very small selection of these options are used by women in Saint Fiacre.

**Cervical screening and breast health.**

According to national guidelines, cervical cancer screening is offered to women with an uncomplicated history every two years. Screening is accessed at the clinic either through the doctor or through nurses who have undergone appropriate training. Availability of female practitioners is not assured. There is no on-site mammography machine, and it is not common practice for breast screening services to visit the community. During my time working at the clinic, colleagues and I won a small grant that enabled women to travel and stay overnight in Darwin in order to have a mammogram. There are no publicly available recorded rates of cervical and breast screening in Saint Fiacre.

**Maternity care.**

**Antenatal care.**

Antenatal care is offered at the clinic by a remote-area nurse, an Aboriginal health worker or a registered midwife, all of whom follow the clinical protocols in the *Women's business manual* (Congress Alukura, 2014b). The manual recommends
pregnant women attend a minimum of 7–10 antenatal visits. An obstetric team visits
the community intermittently and collaborates on the care of women who have
complicated pregnancies. The resident midwife operates out of a clinic room,
respected as a ‘women’s only’ space. Common pregnancy problems during my
midwifery practice in the community included anaemia, family violence, urinary
tract infections, sexually transmitted infections, and a lack of choice around place of
birth.

**Childbirth.**

Birthing services are currently not endorsed by the government—the provider
of health services in Saint Fiacre—and are therefore not on offer at the local clinic.
The content of the *Women’s business manual* (Congress Alukura, 2014b) reflects this
position. Despite this, around 10% of all births do occur in the community every year
(Ireland, 2009). In Saint Fiacre, childbirth in most circumstances is treated as a
medical emergency, with the preference being to administer tocolytics to stop labour,
followed by emergency aeromedical evacuation to Darwin Hospital. This care
preference persists even when a low-risk healthy woman presents at term in
established labour. The *Women’s business manual* (Congress Alukura & Nganampa
Health Centre Inc., 2008) qualifies that the decision to treat childbirth as a medical
emergency should be based on medical and obstetrical problems and staff expertise
and that tocolysis should be considered in term labour after 37 weeks only when
‘transfer to a hospital will give better outcomes’ (p. 29). The often-indiscriminate
practice of tocolysis indirectly encourages women who would prefer to have their
babies in the community to not seek care during the first stage of labour. These
women then sometimes opt to give birth at home in their camp or to only present to
the clinic for care when the birth of the baby is imminent (Ireland, 2009).
Despite the fact that most care providers prefer evacuation, women do have a combination of planned, unplanned, term and premature births in Saint Fiacre every year. In the event of a childbirth emergency occurring, basic medical equipment is available. This includes an electricity generator, a foetal Doppler, an incubator, an I-MED observational machine, an appropriate obstetrical bed with stirrups, adult and neonatal intubation equipment, stirrups, an ultrasound machine, a pulse oximeter, oxygen, an ECG machine, a defibrillator, and intravenous fluids. Obstetrical and resuscitation drugs available include adrenaline, betamethasone, calcium gluconate, ergometrine, hydralazine, magnesium sulphate, nifedipine, salbutamol, syntocinon, naloxone and pethidine (Remote Health, 2005). However, no blood transfusion products are on hand. Aeromedical help summoned from Darwin is theoretically a one-hour flight away; however, in practice, there are often lengthy retrieval delays.

The architect of the new clinic apparently had a vision for Saint Fiacre health services that included the provision of community-based birth services. This was, in part, directed from a consultancy that demonstrated community support for the re-introduction of birthing services (Warchivker, 2007). On the original clinic plans, it is possible to see that the new women’s procedure room is so named to disguise the original intent of the room as a safe place for women to give birth (see Figure 3.18). It is a spacious room with a private outdoor courtyard and an ensuite bathroom complete with a deep birthing bath (see Figure 3.19).
Figure 3.18. The women’s procedure room in the Saint Fiacre clinic.

Figure 3.19. The ensuite bathroom with birthing bath in the women’s procedure room in the Saint Fiacre clinic.
Health and Supernatural Intervention

Elkin (1979) and Berndt and Berndt (1999) document Aboriginal people’s early beliefs regarding the practice of sorcery and black magic and their effects on creating and curing illness. These authors suggest that supernatural practices, such as sorcery, were in common use in Indigenous Australian societies before colonisation. Spencer (1914, pp. 257–262) provides a Northern Territory account of the various magical and medicinal techniques that members of the ‘Kakadu tribe’ used to treat illness and to cause illness or death in another person. These techniques often involved the ritualised use of an object related to the intended recipient of the magic, such as a portion of their food or their excrement. People in Saint Fiacre retain strong beliefs about the role of supernatural forces and spiritual powers in health, illness and physical accidents. Although not openly discussed with outsiders, many unusual coincidences, near misses, car accidents, injuries, suicides or illnesses are attributed to supernatural interventions. This usually involves a practitioner of black magic and is referred to in hushed tones as the blackfella way.

Maher (1999) explains that ‘traditional’ Aboriginal models of illness causation emphasise spiritual and social dysfunction, with supernatural intervention as the main cause of serious illness. These beliefs are evident in Saint Fiacre today and form a causation logic that challenges both scientific rationalism and most practitioners of Western health care. For example, terminal lung cancer or a serious car accident may be the result of sorcery targeting a specific individual or family. Tobacco smoking or not wearing a seatbelt would not be considered as factors in such misfortune. Explanations of such events are complicated and often involve visible ‘evidence’ such as the appearance of a totem animal, or witnessing of a supernatural event such as the presence of a spirit or an unnatural action such as the
‘trees walking’. The explanations are sometimes so foreign to my Western, lineal perception that, no matter how hard I try, I cannot understand and I am only able to politely acknowledge the explanation. People’s belief in this logic is shared only reluctantly, not only because of its obvious whitefella incompatibility but also because of the church’s historical prohibition on the practice of sorcery.

Social Identity

Elkin (1979) suggests that, pre-colonisation, there were around five distinct, regionally varied types of social Aboriginal organisation: the Kariera, Karadjeri, Nyul-Nyul or Aranda, Aluridja and Ungarinyin styles, named after prominent tribes who used them (p. 90). These organisation styles contributed to the geographical diversity encountered among Aboriginal groups’ marriage rules and social behaviours. At the time the mission started in Saint Fiacre, Stanner stated that the Kareira type of social organisation was in use except that marriage between cross cousins was prohibited (Stanner, 1936b). Despite colonisation, people’s social identity in Saint Fiacre remains remarkably embedded in this ancestral Aboriginal concept of social organisation. The order of ancestral organisation is now augmented by introduced Western social affiliations, such as a person’s football team, Catholicism and, for some people, paid employment.

It would appear that cultural dynamism has been a feature in the lives of Saint Fiacre people for some time. During the 1930s, Stanner noted an ongoing process of what he described as ‘acculturation’, whereby the Saint Fiacre people were borrowing, adopting and abandoning social organisation structures from nearby Aboriginal tribes, most likely those from the Kimberley region in Western Australia.
(Stanner, 1932b). These included structures such as the subsection system\(^4\) believed to have been introduced into the area around 1915 (Falkenberg & Falkenberg, 1981, p. 196). Today, these remain in memory for a small number of older people, but many younger generations are unable to state how they fit with or relate to these once-common social orders.

**Moiety group.**

Elkin (1979, pp. 121–124) states that the term *moiety* means ‘half’ and that pre-colonisation the division of Aboriginal tribes into two halves was a widespread organisational practice across Australia. People in Saint Fiacre are broadly organised into societal halves, represented by the moiety groups of the *Twungku* (wedge-tailed eagle) and the *Karrthin* (spotted or swamp harrier) (Thamarrurr Region Council, 2007, p. 7). Early in his research, Stanner (1936b, p. 192) noted this to be an ancient custom and a theme in local mythology. He stated that the moieties regulated marriage, with partnerships formed by opposing or exogamous groups. Generally, the moiety groups have geographical borders: Karrthin are *saltwater people* and Twungku are *freshwater people*. This dichotomy of the social organisation is now in decline, but belonging to either freshwater people or saltwater people is still a common reference point used by people today. Within these broad geographical divides, a more intimate concept of ancestral country dictates the intricate patterns of social organisation and identity that shape life in Saint Fiacre.

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\(^4\) According to Elkin (1979, pp. 125–134), a section is a kinship system that uses four named ‘sections’ or ‘groups’ to universally identify all members of an Aboriginal group. Sometimes these section names include feminine and masculine variant forms. A subsection system further divides these groups into eight sections on the basis of distinguishing between cross cousins and the children of cross cousins. The section and subsection systems delineate rules for marriage and an order of indirect matrilineal descent.
Country.

Country is a central tenet of social organisation in Saint Fiacre. Country is inherited through the patriarchal line—that is, your country is your father’s land, and his country is his father’s land, and so on. An individual is also knowledgeable about, and has an ongoing relationship with, their mother’s land and their husband’s or partner’s country. In ancestral times, an Aboriginal wife would leave her country upon marriage and live the remainder of her life on her husband’s country, which would in turn become her children’s country (Falkenberg, 1962).

All of these relationships dictate land visitation access and rights, land care obligations and the responsibility to teach and learn the stories of spiritual and moral significance that are represented in the physical geography of the land. Unrelated people without these kin-based connections are prohibited from accessing the land. Special permission of the landowner is always needed before arrival. Although these visitation rights and responsibilities are not enforceable under Australian law, they are standard practice in local etiquette and customs.

Aboriginal people often personify the concept of country. They talk with warmth of feeling towards their land, as they would of a close friend or loved relative. Country in turn is able to feel emotions, and people themselves feel sentiments towards the country. As Burgess et al. (2009, p. 567) note, Aboriginal people reference situations such as speaking to country, singing to country, visiting country, worrying for country, feeling sorry for country and longing to return back to country. Sometimes, even a specific place in the country can be gendered (Bird Rose, 1996, p. 36). There are terms in Murrinh Patha that are used to personalise the effect of country, such as wungwung, meaning to feel cheerfulness and brightness after seeing one’s homeland after a long period of absence (Street, 2012, p. 41). People in
Saint Fiacre feel that the land is a special part of their lives, providing beautiful places to camp, fish and harvest bush food (Thamarrurr Region Council, 2007).

In addition, other important identity markers, such as an *Aboriginal name*, *totem* and *dreaming*, are all inherited through country. Bestowed to every baby born, an Aboriginal name is decided upon by the paternal grandfather or uncle, with agreement sought from the maternal grandparents. The name signifies an actual place in that family’s land and therefore ties the child forever with their country (Ward, 1983). Because everyone now has an additional English name used on government records and for whitefella paperwork purposes, people are known by their Aboriginal or *blackfella name* and their *whitefella name*. Most people use their whitefella name in dominant culture situations, such as when at work or when visiting the Centrelink office.

Every person also has a *ngakumarl* (totem) and *da ngugumingki* (dreaming place) to affirm connections back to their land (Ward, 1983, p. 2). These are often animals, plants or geographical features found in one’s country, such as a billabong, and they may involve healing powers from the land, such as ‘diarrhoea dreaming’. An individual with diarrhoea dreaming, for example, can cure people of diarrhoea by cutting his or her own hair and burning it. The burnt hair placed in the navel of the sick person will release a scent, healing the person with the diarrhoea (Saint Fiacre community members, personal communication, April, 16, 2008). Likewise, a stranger trespassing on a person’s distantly located dreaming site may be signalled by an unexplainable physical ailment, such as a headache. The land in a dreaming place is sacred and cannot be disturbed, such as by the removal or rearrangement of rocks, and often the hunting, killing or collection of a personal totem is prohibited (Ward, 1983).
Sometimes, people talk about their totem protecting them from harm and bringing messages or signs when they are out bush. Sudden appearances of someone’s totem may also bring warning of imminent death of a family member who shares the same totem. It is common for some people to share totems between clan groups, but a dreaming site location remains unique. Networks of relationships develop between people who share the same totem, and this commonality socially positions them as if they were brothers and sisters (Ward, 1983). People will often name their car or family pets affectionately after their totems, such as a friend who called a red four-wheel drive *ku balli* (mud crab) and another who called his dog *ku warrgi* (mangrove worm).

Patriarchal land inheritance also dictates a person’s landowning clan and language affiliations. There are reported to be between 20 (Ivory, 2009) and 22 (Thamarrurr Region Council, 2007) clan landowning groups currently in the Saint Fiacre region, each consisting of subfamily groupings. However, when collating evidence from available references (Ivory, 2009; Thamarrurr Region Council, 2007; Ward, 1983), 32 separate clan groups were identified (see Table 3.2). This may reflect smaller populated clans merging over time with larger clans, errors in the reference materials or the use of different regional borders when listing the clans. As Stanner (1936b), when writing on the exact borders of a given country, so wisely commented:

The difficulty of giving each term an exact local range may be only a difficulty of ethnographic logic. To attempt to do so may be to seek a precision of which only the ethnographer sees the need. Many other Aboriginal concepts have vague applications. (p. 189)
Each clan name has an individual meaning and usually refers to a physical characteristic of the land, such as ‘people of the small stone land’ or ‘people of the black water’ (Thamarrurr Region Council, 2007, pp. 9–12). Clan groups are used as a basis of governance and leadership structure in the region, with senior representatives elected to advocate the wishes and needs of the clan via the local council (Ivory, 2009). A clan group is not only united by land ownership and belonging but also by the same language (although many now are unable to speak it) and by ceremonial group affiliation.

Table 3.2
Saint Fiacre Region Clan Names, Language and Ceremonial Group Affiliations

<table>
<thead>
<tr>
<th>Clan Name</th>
<th>Language</th>
<th>Ceremonial Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Yek Diminin</td>
<td>Murrinh Patha</td>
<td>Dhanba/Malkarrin</td>
</tr>
<tr>
<td>2 Yek Yederr</td>
<td>Magati-ge</td>
<td>Wongga</td>
</tr>
<tr>
<td>3 Yek Wunh</td>
<td>Murrinh Patha</td>
<td>Lirrga</td>
</tr>
<tr>
<td>4 Yek Ngudanimarn</td>
<td>Murrinh Patha</td>
<td>Dhanba/Malkarrin</td>
</tr>
<tr>
<td>5 Yek Nangu</td>
<td>Murrinh Patha</td>
<td>Dhanba/ Wurlthirri/ Malkarrin</td>
</tr>
<tr>
<td>6 Yek Maninh</td>
<td>Murrinh Patha</td>
<td>Dhanba/Malkarrin</td>
</tr>
<tr>
<td>7 Rak Wudipuli</td>
<td>Marri Ngarr</td>
<td>Lirrga</td>
</tr>
<tr>
<td>8 Rak Thinti</td>
<td>Marri Ammu</td>
<td>Wongga</td>
</tr>
<tr>
<td>9 Rak Perrederr</td>
<td>Marritjevin</td>
<td>Wongga</td>
</tr>
<tr>
<td>10 Rak Nuthunthu</td>
<td>Murrinh Patha</td>
<td>Dhanba/Malkarrin</td>
</tr>
<tr>
<td>11 Rak Nganthawudi</td>
<td>Menhthe</td>
<td>Wongga</td>
</tr>
<tr>
<td>12 Rak Nemarluwudi</td>
<td>Ngan.gi-tjemmerri</td>
<td>Lirrga</td>
</tr>
<tr>
<td>13 Rak Nadirri</td>
<td>Marritjevin</td>
<td>Wongga</td>
</tr>
<tr>
<td>14 Rak Merrepen</td>
<td>Ngan.gi-tjemmerri</td>
<td>Lirrga</td>
</tr>
<tr>
<td>15 Rak Kuy</td>
<td>Magati-ge</td>
<td>Wongga</td>
</tr>
<tr>
<td>16 Rak Kungarlarl</td>
<td>Marri Ngarr</td>
<td>Lirrga/Wongga</td>
</tr>
<tr>
<td>Clan Name</td>
<td>Language</td>
<td>Ceremonial Group</td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------</td>
<td>------------------</td>
</tr>
<tr>
<td>17 Rak Kulingmirr</td>
<td>Marri Ngarr</td>
<td>Lirrga</td>
</tr>
<tr>
<td>18 Rak Kubiyirr</td>
<td>Marri Ngarr</td>
<td>Lirrga</td>
</tr>
<tr>
<td>19 Rak Kirnmu</td>
<td>Murrinh Patha</td>
<td>Dhanba/Malkarrin</td>
</tr>
<tr>
<td>20 Rak Angileni</td>
<td>Marri Ammu</td>
<td>Wongga</td>
</tr>
<tr>
<td>21 Mathalint</td>
<td>Murrinh Patha</td>
<td>Dhanba</td>
</tr>
<tr>
<td>22 Rak Kirnmu</td>
<td>Murrinh Patha</td>
<td><em>Unlisted</em></td>
</tr>
<tr>
<td>23 Kardu Kura Thipmam</td>
<td>Murrinh Patha</td>
<td>Dhanba</td>
</tr>
<tr>
<td>24 Papa Ngala</td>
<td>Ngankitjemmerri</td>
<td>Lirrga</td>
</tr>
<tr>
<td>25 Palumpa</td>
<td>Ngankitjemmerri</td>
<td>Lirrga</td>
</tr>
<tr>
<td>26 Kura Ngaliwe</td>
<td>Ngankitjemmerri</td>
<td>Lirrga</td>
</tr>
<tr>
<td>27 Kardu Wakal Thirnang</td>
<td>Murrinh Nyuwan</td>
<td><em>Unlisted</em></td>
</tr>
<tr>
<td>/ Rak Nuthunthhu</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28 Kardu Yek Naninh</td>
<td>Magati-ge</td>
<td>Wongga</td>
</tr>
<tr>
<td>29 Kardu Thangkurral</td>
<td>Marritjevin</td>
<td>Wongga</td>
</tr>
<tr>
<td>30 Kardu Wakal Thay</td>
<td>Marri Ngarr</td>
<td>Lirrga</td>
</tr>
<tr>
<td>31 Kardu Yek Dirrangarra</td>
<td>Marri Ngarr</td>
<td>Lirrga</td>
</tr>
<tr>
<td>/ Kardu Darrinpirr</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32 Kardu Wakal Bengkunh</td>
<td>Marri Ngarr</td>
<td>Lirrga</td>
</tr>
</tbody>
</table>


**Ceremonial group.**

Ceremonial groups are composed of multiple clans, mostly from different language groups (Ward, 1983). These collectives have obligations to perform singing and dancing at an opposing group’s ceremonial affairs, reflecting from time immemorial the ancestral precedent of ceremonial reciprocity (Marett, 2005). During common ceremonial occasions, such as mortuary rites (see Figure 3.23) or male circumcision, the practice serves as a socially unifying and affirming mechanism.
For each group, a corpus of exclusive songs is performed with unique male and female dancing styles and body-paint designs. Married women are expected to not only know their own ceremonial group’s dance style but also to learn that of their husband’s (Ward, 1983). Although multiple clans constitute the ceremonial group, only one clan’s mythical dreaming sites and land features will be invoked and celebrated in the company repertoire (see Table 3.3). Song composing is a deeply spiritual and psychic undertaking, whereby supernatural forces—sometimes deceased ancestors or spirit beings—communicate to the songmaker through dreams (Marett, 2005).

According to Marrett’s (2005) detailed ethnomusicology work with senior men in the community, the current tripartite ceremonial group system was formed in the 1950s and 1960s as a response to the increasing numbers of people being permanently settled on the mission, many of whom had been tribal nemeses. Designed to bring social cohesion and belonging to all people living in Saint Fiacre, three specific ceremonial genres were created: Lirrga, Dhanba and Wongga.5

The Lirrga (see Figure 3.20) was designed to give legitimacy to the Marri Ngarr immigrants from the north, who were some of the later people to settle on the mission and who had a history of inter-clan conflict due to southern land incursions. The Lirrga song lyrics, spiritually conceived from the mermaid dreaming spirits who live in homeland billabongs, are sung by the males of the group, accompanied by didgeridoos and supported by women dancing (Marett, 2005, p. 59).

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5 The ceremonial groups have many other spelling variants, including Tjarnpa and Wangka.
Table 3.3

Saint Fiacre Ceremonial Groups and their Associated Language, Clan and Ceremonial Obligations

<table>
<thead>
<tr>
<th>Ceremonial group</th>
<th>Affiliated language groups</th>
<th>Clan focus in company corpus</th>
<th>Ceremonial obligations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lirrga</td>
<td>Marri Ngarr</td>
<td>Rak Wudapuli</td>
<td>Wongga and Dhanba people</td>
</tr>
<tr>
<td>Wongga</td>
<td>Marr Tjevin, Marri Ammu, Magati</td>
<td>Rak Perrederr and Nadirri</td>
<td>Dhanba and Lirrga people</td>
</tr>
<tr>
<td>Dhanba</td>
<td>Murrinh Patha</td>
<td>Kardu Diminin</td>
<td>Lirrga and Wongga people</td>
</tr>
</tbody>
</table>

The Dhanba group (see Figure 3.21) sing localised versions of public song cycles from neighbouring Aboriginal nations in the Kimberly, Western Australia. Lyrics are also psychically conceived but through dreams involving little people, very small human-like dreaming spirits who inhabit ones country and whose existence is known and accepted by all. Unlike the other song genres, there is no didgeridoo accompaniment; however, the men and women dance and sing in echo formation, accompanied by clap sticks with complex isorhythmic patterns (Marett, 2005, p. 59).

Lastly, the Wongga group (see Figure 3.22) is unique in that their musical genre is said to have always been practiced in the region. However, with the establishment of the new tripartite system, a fresh and purposeful repertoire of songs was established. As with the other genres, song lyrics are psychically conceived through dream and have common themes of death and regeneration. As with the Lirrga style, these are sung by men accompanied by the didgeridoo, hand clapping and clap sticks and supported by women dancing (Marett, 2005, p. 59).
During fieldwork in Saint Fiacre during 2011, I was an audience member for five days of a circumcision ceremony performance (which had last been conducted in 1996). That same year, I also attended a mortuary rite ceremony held for an old friend at an outstation (See Figure 3.23). In 2012, I attended the opening ceremony of the senior boarding school. During these three performances, I was able to identify the distinct style of each of the three ceremonial groups. There are some references in other literature to the smaller ceremonial groups: *Parlga, Wurlthirri* (Thamarrurr Region Council, 2007, p. 26; Ward, 1983, p. 44) and *Malkarrin* (Ivory, 2009, pp. 80–81). To the best of my knowledge, in the most recent whole-of-community ceremonial events, there was no presence or mention of the Parlga or Malkarrin group, and all members of the Wurlthirri group were incorporated into the Dhanba.

*This figure has been removed for electronic dissemination but is available in a hard copy of the thesis held in the Charles Darwin University library.*

*Figure 3.20.* Lirrga Ceremony Group dancing during a public circumcision ceremony in Saint Fiacre in October 2011.
This figure has been removed for electronic dissemination but is available in a hard copy of the thesis held in the Charles Darwin University library.

Figure 3.21. Dhanba Ceremony Group dancing during a public circumcision ceremony in Saint Fiacre in October 2011.

This figure has been removed for electronic dissemination but is available in a hard copy of the thesis held in the Charles Darwin University library.

Figure 3.22. Wongga Ceremony Group dancing during a public circumcision ceremony in Saint Fiacre in October 2011.
Figure 3.23. Mortuary rite ceremony with Dhanba performers at Nama Outstation in 2011.

**Kinship.**

Elkin (1979) explains the importance of social relationships for Aboriginal people, describing them as ‘the basis of behaviour’ and ‘indeed the anatomy and physiology of Aboriginal society’ (p. 85). Relationships and associated behavioural expectations are codified within the Aboriginal kinship system, which reckons relationships both through and beyond the immediate community, essentially meaning that, from an emic perspective, all Aboriginal people are related. Elkin (1979) explains that this is in contrast to the Western family system of kinship, which is a limited system in that it can describe only the immediate members of a family unit and then those most closely related to it. The kinship terminology of the Western family system can only describe the ‘generation level, collateral position (indefinitely), sex (mostly) and marriage ties’ (p. 84). This differs from the Aboriginal kinship system, which essentially enlarges the family unit to universally
include the community. Elkin (1979) explains that this is achieved by classifying parts of the community with normal kinship terminology (e.g. mother, father, uncle, aunt) in a model that is restricted generationally (vertically) by grandparent and grandchild and collateral (horizontally) by second cousin. The key principle that distinguishes this model from Western family kinship is that brothers and sisters in the Aboriginal kinship system are equivalently regarded, and terms are applied accordingly (Elkin, 1979). As an illustration of this equivalence, my mother and all my mother’s sisters would equivalently be called ‘mother’ (rather than the Western term ‘aunt’), and my father and all my father’s brothers would equivalently be called ‘father’ (rather than the Western term ‘uncle’).

Elkin’s (1979) theoretical reckoning of the Aboriginal kinship system is clearly practiced in Saint Fiacre today. People appear to gain a deep spiritual and emotional satisfaction from simply spending time with extended family and relations. It is a resonance deeply expressed in the kinship system, which allows people to belong and refer to an extended circle of family linked by a common biological ancestor and/or through marriage affiliations. Language is the instrument of kinship and involves logical sequences of intergenerational naming. These ‘names’ or kinship terms continue to codify familial roles, behavioural expectations and social obligations. Its complexity continues to mystify most non-Aboriginal people in Saint Fiacre because it is so unlike the dominant Western family kinship structure.

The aforementioned distinguishing principle of sister and brother equivalence in the Aboriginal kinship system (Elkin, 1979) explains many features of Murrinh Patha kinship terminology. Where, in English, a generic term such as ‘grandparent’ accounts for both our paternal and maternal grandparents, Murrinh Patha has multiple terms. Many English kinship terms can only be given to one individual (e.g.
mother, father), but the Murrinh Patha kinship convention is to name all sisters of the biological mother as mother and likewise all brothers of the biological father as father. Another distinct feature of the kinship structure in Saint Fiacre involves a reciprocal intergenerational cycle of kinship terms. For example, if a person calls her paternal grandmother *mangka*, she would also call her son’s daughter *mangka*. This way of making kinship ‘circles’ was explained to me by a woman as a way of families metaphorically being embraced and ‘holding onto the land’. Other reciprocal kinship terms are *kangurl*, meaning one’s paternal grandfather and all his brothers and a son’s son; *thamunh* meaning one’s maternal grandfather and all his brothers and a daughter’s son; and *kawu* meaning one’s maternal grandmother mother’s mother and all her sisters and a daughter’s daughter. See Figure 3.24, which shows the common immediate and reciprocal kinship terms for five generations, centred on a female identity, highlighted in red.

The encouragement of children’s social orientation in the Aboriginal kinship system is evident from very early ages, and because of this many small infants are able to point out and name their immediate kinship circle. Child’s play can be observed as an opportunity to practice kinship. For example, one of my research assistants was playing with her three-year-old grandchild, her daughter’s daughter. The child was playing *kale* (‘mothers’) with a plastic pale-skinned doll in a pink pram. On passing her doll *wakal* (small child) to her grandmother, she would say ‘Here, take kawu’. In doing, so the little girl was role-playing the kinship name of her doll, identifying its sex and relating it back to her own grandmother. This gave her practice in locating her kinship network and, if needed, gave adults the opportunity to correct any errors in kinship reasoning.
There are also gendered social implications of the Aboriginal kinship system. This kinship structure means that special social roles, such as that of a mother, are shared by more than one woman at a time, and unlike dominant culture are not at all age specific. For example, the younger of biological sisters may assume a mother-like role should her older sister have a baby. Despite being prepubescent and unable to bear children herself, she will call all her sister’s children wakal as if they were her own sons and daughters, and they too will call her kale—the same as their biological mother. As she grows into an adult, she will afford her sister’s children—the equivalent of nieces and nephews in Western kinship—similar attention, love and resources to those she would give her own children. This is not to say that babies do not receive the majority of early care from, and form a strong attachment bond with, their biological mother, but there certainly is a very special relationship developed between children and their mother’s sisters. Thus, the personal capacity and skills needed to care for children are fostered very early in life through the Murrinh Patha Aboriginal kinship structure. The same kinship rules apply between fathers and brothers, and perhaps this makes the reproductive task of having their own biological children a small developmental step for many of the teenage parents in Saint Fiacre.

Certain behavioural expectations are also institutionalised within the kinship structure (Elkin, 1979; Street, 1987). Deep respect is communicated to certain family members through ‘avoidance’. Avoidance behaviour includes not looking at each other, not talking to each other, not sitting in the same place as each other and not even saying aloud the person’s name. Although it is possible later in life to circumnavigate some of these rules through ceremony, most of the relationship rules are applied throughout the life cycle (Thamarrurr Region Council, 2007). These

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6 Biological mother is differentiated as ‘kalekale’.
avoidance rules are commonly applied to the relationship between mother-in-law and son-in-law and between postpubescent brothers and sisters (Street, 1987). In their work, Falkenberg and Falkenberg (1981, pp. 48–49) referred to these avoidance relationships, using the term ‘restrictive’ relationships. They, too, documented many of the conventions of restricted behaviour that were commonly expected between certain family members, such as between a man and his mother-in-law. People in these avoidance or restrictive relationships use a third person to communicate, often referred to as *sideways talk*, and they are very careful to maintain a large personal space and avoid all eye contact. Many of the middle-aged women in Saint Fiacre spell out the letters of their brother’s name and, in doing so, avoid the offence associated with mentioning his name (Saint Fiacre community members, personal communication, April, 16, 2008)

**Kinship and marriage conventions.**

Kinship rules continue to influence socially sanctioned partnerships and Christian marriage in Saint Fiacre. Kinship rules make it possible to refer to a couple’s union as either a *right way* or *wrong way* marriage. This terminology is in use in Saint Fiacre today, but people readily admit that many marriages no longer follow such formal conventions. Street (1987) comments that polygyny was once common before the mission started with some men having two or more wives, who were often biological sisters. According to Falkenberg and Falkenberg (1981, pp. 34–35), a ‘right way’ union would constitute partners with the following characteristics: being from different individual and mother clan groups; being from opposing moiety groups; not being close genealogical relatives (regardless of clan); and fitting into a prescribed kinship classification. Using the terminology of Western kinship, this would dictate that a girl is best suited to marry her *nangkun*- maternal
great-uncle's daughter's son (her mother’s mother’s brother’s daughter’s son), and that a boy is best suited to marry his puririma- maternal great-uncle’s daughter’s daughter (mother’s mother’s brother’s daughter’s daughter). However, Falkenberg and Falkenberg (1981, p. 35) readily admit that when trying to establish general rules governing marriage, a variety of responses may be given, and they listed at least 11 possible conventions that could be applied.

Additionally, the documentation of ‘marriage rules’ in Saint Fiacre has historically been confounded by the adoption of the skin subsection system, which, in Stanner’s (1936b, p. 188) opinion, was ‘radically’ changing marriage conventions in the 1930s. Today, it seems that the relevance of the subsection system has waned, almost into non-existence. This is supported by Street (1987, p. 40), who even in the 1980s noted that the subsections, while still known and sometimes used by the older generations at the time, were a concept unknown among the younger people. However, many of the older research participants (50 years and above) were married in sanctioned subsection unions. Marriage conventions remain just a small part of this extensive kinship system, intimidating and confounding in its relational complexity and sophistication.

**Age-grade.**

In dominant Western society, our chronological age earns us certain rights, responsibilities and expectations. Our age determines many legal and developmental milestones, such as when we are able to start school, to legally have consensual sex, to drive a car, to undertake paid employment and to make independent decisions about our wellbeing. A similar process occurs in Saint Fiacre through a concept known interchangeably in the literature as ‘age stages’ (Stanner, 1936a), ‘age divisions’ (Stanner, 1932a) ‘life stage progressions’ (Thamarrurr Region Council,
2007) and *age-grades* (Falkenberg & Falkenberg, 1981). These are marked not so much by chronological age but by the physical development and appearance of the human body. Age-grades were once thought a common Aboriginal cultural practice (Elkin, 1979), with Stanner (1936a) explaining how the lifespan of men and women were divided into age stages, with anthropologists documenting a similar concept and unique terminology used by Tiwi Islanders. Goodale (1971, p. 22) also recognised and recorded the use of age-grades by participants in her monograph about Tiwi women, based on fieldwork in the late 1950s.

For women in Saint Fiacre, age-grades centre on the physical development of sexual maturity, signalled by changing breast shape. Accordingly, Falkenberg and Falkenberg (1981) listed six stages for females, progressing from a sexually undeveloped female prior to puberty to an elderly woman with sagging breasts (see Table 3.4). Additionally, Stanner (1932a) differentiated 15 age divisions for infants, based on physical developmental milestones, such as rolling, sitting up, looking, crawling, walking and running. Although current fieldwork suggests that these age-grades may have changed (and this is discussed later in Chapter 7), they remain important social classifications.
Figure 3.24. Murrinh Patha kinship terms for a person connected by a common family member with reciprocal intergenerational names in colour.
In Saint Fiacre, the physical body is scrutinised as a marker of social change. Physical changes or anomalies are quickly noted. A slight change in my own bodyweight was always met with smirking enquiries whispered into my ear, ‘Are you putput (pregnant)’? At another time, a very tall and slender friend from Sydney visited me in Saint Fiacre. She had small narrow hips, tiny breasts and strikingly grey hair. Many of my Aboriginal female friends were mystified by her physical appearance: the body of a young undeveloped mardinboi (a girl whose breasts are beginning to develop) but the grey hair of an old woman. Matters became even more confused when, in conversation, she revealed she had no children of her own. In Saint Fiacre, her physical appearance defied the accepted social norms of age divisions. On her next visit, people jokingly called her mutchinga (an old woman with pendulous breasts) to account for the grey hair.

Table 3.4

*Murrinh Patha Age-Grades and Descriptions*

<table>
<thead>
<tr>
<th>Age-grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Konunganga</td>
<td>A girl before puberty.</td>
</tr>
<tr>
<td>Mardinboi</td>
<td>A girl whose breasts are beginning to develop: ‘a little bit milk’.</td>
</tr>
<tr>
<td>Nalaru</td>
<td>A girl from the time her breasts start developing until breast development is complete: ‘big milk’.</td>
</tr>
<tr>
<td>Palnun</td>
<td>A young woman whose breasts are slightly sloping.</td>
</tr>
<tr>
<td>Kake</td>
<td>A middle-aged woman with sloping breasts.</td>
</tr>
<tr>
<td>Mutinga</td>
<td>An old woman with pendulous breasts.</td>
</tr>
</tbody>
</table>

*Source:* Falkenberg and Falkenberg (1981, p. 80). *Note:* Author’s own spellings of age-grades have been used in Table 3.4.
Catholicism.

Catholicism in Saint Fiacre is a unique fusion of Catholic faith and Indigenous spirituality (see Figure 3.25). The weaving of faiths is immortalised in the pre-mission story of the once infamous bad man Mollingin who, while sitting on the healing black sands of Kandantiga, had a vision of the Mother Mary and Jesus (Stockton, 1985; Toohey, 2001). His vision brought him redemption from his previously bad ways, gave him the special and mysterious malgarrin song cycles (Stockton, 1985) and no doubt added credibility to the Christian messages and mythology being introduced at the mission.

Figure 3.25. A church mural in Saint Fiacre, combining Aboriginal and Western Catholic mythology and symbols.
Today, Saint Fiacre is known as a Catholic community and remains staffed by religious workers from the Missionaries of the Sacred Heart, the Daughters of Our Lady of the Sacred Heart and the Christian Brothers of Queensland (Catholic Diocese of Darwin, 2011). As in most parts of the Western world, the religious staff members are aged, and their longstanding devotion stands as an artefact of an era when young people gave lifelong commitments to pursuing their religious faith. Saint Fiacre parish is part of the Diocese of Darwin, and this faith-based relationship is a legacy of the Catholic mission that started in 1935.

Catholicism and its sacramental pathways are now entrenched in the community’s ceremonial and spiritual economy. Its acceptance and dominance in the community is evidenced in Saint Fiacre having Australia’s first married Aboriginal deacon, Boniface Perdjert, in the 1970s (Australian Catholic Church, n.d.), and, in the past, the Aboriginal religious nuns, known at the time as native sisters (Pye, 1973) (see Figure 3.26). Catholic rites remain important elements of funerals and associated sorry business, of school attendance, of community celebrations and as an antidote to community disharmony, such as inter-clan fighting or harmful sorcery.

A visible expression of unifying religious faith in both young and old, regardless of gender, is the widespread community fashion of wearing large crucifixes or brightly coloured plastic rosary beads. Broken strings of such beads are found discarded in bush camps or beside the street (see Figure 3.27). Children’s whitefella names are flavoured with religious entailments, such as ‘John the Evangelist’, ‘John the Baptist’ and ‘Mary Magdalene’. Among the middle-aged women, church attendance is still strong, but the younger people appear less enthusiastic.
Figure 3.26. A shrine in the Saint Fiacre church commemorating the Aboriginal sisters.

Figure 3.27. Discarded no-longer-worn crucifixes and rosary beads collected off the ground in Saint Fiacre in 2012.
Employment.

There are many people in Saint Fiacre without paid employment, and this is particularly so for the younger people in the town. Many of these young unemployed have poor pre-vocational skills due to their disengagement with school education. Taylor (2010, p. 35) reported that in 2009 the unemployment rate, calculated as a proportion of the labour force, was 43.8%. At the time, the national unemployment rate was 5.7%. If people engaged in a work-for-welfare payment scheme in Saint Fiacre had been included in the figures, the rate would have been 74%. With such widespread economic welfare support—many say dependency—those with the motivation and ability to maintain paid employment often require more than financial returns. Due to kinship obligatory behaviours, a worker may be expected to share a large portion of their wages among extended family members. Employment at the council, school, rangers or clinic appears to be valued and offers a certain social status and respect from the community. In many cases, such employment also enables the worker to access resources; for example, clinic drivers can offer to transport family members around the town, or a council worker can freely use the phone and fax machines.

Football.

Football is very popular in Saint Fiacre, and it intermingles with classical concepts, such as totems, dreaming places and even funerals. For example, it is widely known that one prominent leader in the community is usually dressed in black jeans and a red T-shirt. The symbolism is lost to a casual passer-by, but those who know him realise that he is displaying the colours of his dreaming totem \textit{ku tek} (red-tailed black cockatoo) as well as the colours of his favourite football team, the Essendon
Bombers. Similar symbolism is also observed at funerals, when guests are requested to wear the colours of the deceased’s football team and totem.

Local football popularity manifests in both passive and active recreation. Weekend television broadcasts of football games are followed seriously in the town. Neighbours shouting, yelling and banging on upturned flour drums to celebrate goals scored by their team often disturb sleepy Sundays. The town boasts many all-male teams, which battle throughout the season for the honour to compete in the grand final. Athleticism and competition is rewarded with adoring and energetic crowds who gather at the oval and barrack enthusiastically. The stakes at the grand final recently increased; the best players from the competition are now invited to join the Saint Fiacre Magic team and given the chance of inter-Territory competition. Although young women are yet to venture onto the football playing field in organised teams, they are very much part of the players’ support networks and see football talent as a highly attractive quality in their young men. Women often wear their team’s jersey and delight in dressing their children in league merchandise (see Figure 3.28).

*Figure 3.28. Saint Fiacre Magic football jersey. Source: Morris, 2011.*
Female gang membership.

Gang-related rioting and violence in Saint Fiacre has been widely publicised in the media and has received infamous attention (Ivory, 2003; McMahon, 2007; Whittaker, 2007). Gang membership is loosely based on clan group affiliation, with gang names inspired by 1980s heavy-metal music bands. Some research addressing this recent phenomenon suggests that male membership is predominant and appears to be associated with higher levels of illegal substance use, violent behaviour and involvement in the criminal justice system (Cunningham, Ivory, Chenhall, McMahon, & Senior, 2013). In a countertrend, young females are now also choosing to organise themselves into separate gang groups. In 2012, researchers identified three female gangs (Cunningham et al., 2013). In my recent fieldwork, young female research participants were able to name 12 current female gangs: Kim Wild, Samantha Fox, Blonde, Sexy Girls, Cher, Tina Turner Mob, Britney Spears, Ice-Fucking-Head, Shakira, Gill Smith, Night Watch and Bad Girls. Links between the trend in female gang membership and illicit substance use, violence or criminal activity is yet to be established, and research participants tended to describe these groupings as being peaceful in nature and not a source of tension, unlike the male gangs.

Conclusion

This chapter has described in detail the research-site town of Saint Fiacre. It has considered the region’s demography, location and resources and has reflected on life within the community, particularly from a woman’s point of view. The next chapter will describe the methods used in the research.
Chapter 4: Research Theory and Methods

This chapter outlines the research theory and methods used to explore women’s reproductive and sexual health experiences and perspectives in Saint Fiacre. It includes a discussion of the research orientation and the theoretical framework and provides a detailed explanation of how the research was undertaken.

Research Orientation

My research focus—sexual and reproductive experiences—requires orientation within a field of inquiry that seeks to understand the social meanings and significance of women’s experiences. Qualitative research offers this emphasis on meaning. Hughes (2001) suggests that qualitative research seeks to ‘show something’s meaning or significance to particular people or groups of people’s (p. 53), and it does so through its concern with the words and stories that people tell (Liamputtong, 2010). It focuses on ‘interpretation and meaning’ (Atkinson & Pugsley, 2005, p. 229), and importantly—in the context of this research—it is also considered a ‘legitimate and appropriate tool’ for studying people’s subjective experiences and for comprehending ‘the meaning and interpretations individuals have within the context of their lives’ (Liamputtong & Ezzy, 2006, p. 19). Ulin, Robinson and Tolley (2004, p. 4) confirm that this type of research has a ‘theoretical and methodological focus on complex relationships between 1) personal and social meanings, 2) individual and cultural practices, 3) the material environment or context’.

Theoretical Framework

I have used feminism and decolonising theories to frame my work and to shape the research design. These theories also directly affected the methods used and how the data has been analysed. Although not always consciously identified, all
researchers work within a certain paradigm or theoretical standpoint. Often a researcher’s personal perspective of the world influences their choice of paradigm (Hughes, 2001). Ulin et al. (2004, p. 12) explain that ‘your view of the world—your basic philosophical grounding—influences the problems you study, the sources of data you consider appropriate, the methods you choose to gather your data, and the way you carry out your studies’.

**Feminism and Indigenous feminism.**

Feminism is a theoretical influence in my work. Although feminist theoretical perspectives commonly ‘view women as oppressed within patriarchal structures’ (Grbich, 2004), Kralick (2005) advocates a need to ‘unpack’ the assumptions and experiences that lead researchers to consider a feminist approach in their work. I identify with a feminist approach that recognises the centrality of women’s experiences and views them as legitimate sources of knowledge (Jackson, Clare, & Mannix, 2004). In feminist research, ‘women and their concerns are the focus of the investigation’ (Liamputtong & Ezzy, 2006, p. 9), but there is also a focus on the concept of power. Ulin et al. (2004) suggest that a feminist health perspective is not only about women but also about how unequal access to power can have ‘profound’ impacts on the health of a population. A feminist theory gives authority to the centrality of Aboriginal women’s experiences in my work, justifies the female-only research team and participants, illuminates past gender biases in the recording of cultural knowledge and gives permission to analyse data from a gendered and power-based perspective.

However, the validity of feminist theory has been questioned and its rhetoric attacked by indigenous women and women of colour as not being representative of their own lived experiences (Green, 2007; Huhndorf & Suzack, 2010) and as being an
agent of ‘Othering’ (Cannella & Manuelito, 2008, p. 45). St Denis (2007) suggests that many indigenous women reject feminism ‘not only as irrelevant but also racist and colonial’ (p. 34). Hooks (2000, p. 19) elaborates, stating that poor, lower class or non-Caucasian women do not define feminism as ‘gaining social equality with men, since they are continually reminded in their everyday lives that all women do not share a common social status’. Hooks (2000) clarifies that within the social context of these disadvantaged women, their own males are exploited and oppressed and have limited social, political and economic power. It follows that such women do not share in the aspirations of a social movement that proclaims gender equality because to do so would result in only a marginal improvement in the lives of working-class and poor women.

In an Australian Indigenous context, Moreton-Robinson (2000) suggests that Indigenous people reject feminism. She asserts that ‘the subject position middle-class white woman has been and is enmeshed in a historically specific feminist discourse where it constitutes the norm and remains invisible, unnamed and unmarked’ (p. 95).

Moreton-Robinson (2000) argues that feminism is constructed from a white middle-class female perspective, which fails to acknowledge white women’s role in the oppression and colonisation of her people. She identifies foremost as an Aboriginal person who experiences racism, rather than as a woman who experiences sexism. In this sense, the white women feminists glossed in her work as ‘subject middle-class white women’, cannot possibly align their own experiences to Aboriginal women (or women of colour), and neither can they proclaim a collective shared social oppression as the result of gender alone. Moreton-Robinson (2004) has also been critical of a ‘Western white hegemony’ that has insidiously become normalised in the production and legitimisation of knowledge, particularly in
Australian academia. She is an advocate of all academics stating their race and colour and revealing their otherwise invisible discourse dominance.

Although I acknowledge these criticisms made by women of colour, not all indigenous women dismiss feminism, and some promote it as a powerful lens through which to interrogate and understand the effects of colonisation (Green, 2007). Today, most colonised indigenous people are subjected to Western ideologies of gender identities and relations through a process of socialisation that includes Christianity, education, Western patriarchy and capitalism (St Denis, 2007). This may make feminism a valid tool for understanding social power dynamics of domination present in both Indigenous and non-Indigenous communities alike. The challenge is not in the applicability of feminism but rather, as Mani (cited in St Denis, 2007, p. 43) states, in ‘how to argue for women’s rights in ways that are not complicit in any way with patriarchal, racist or ethnocentrist formulations of the issue’.

Hooks (2000) agrees that when feminist theory is defined by the popular notion of ‘equality between the sexes’, we are not compelled to examine social systems of power domination and our role in its maintenance and perpetuation. Such simplified definitions of feminism allow ‘white women’ to maintain hegemony and control of its theory development and praxis. This leads many oppressed and disadvantaged women to reject feminism. Hooks (2000, p. 28) instead argues for feminist discourse to include the diversity of the social and political realities of all women, so that it can centralise the experience of women and give attention to the most disadvantaged of women: those who have experienced the least benefit from research, social change and political movements. Hooks (2000) advocates a different liberating goal of feminism, which she describes as ‘the struggle to end sexist
oppression. Its aim is not to benefit solely any specific group of women, any particular race or class of women. It does not privilege women over men’ (p. 28).

Acknowledging both the criticisms of and the support for feminism, I have persisted in its use to influence the research process, including the collection and interpretation of data. Triangulation of feminism with decolonising theories may have lessened its weakness and enhanced its application to this complex research setting.

Decolonising theory.

Decolonising theory is an influence in my work. In my research, I am confronted with the realities of working with people and a culture that are colonised. Humprey (2001, p. 197) states that the ‘the concept and practice of “research” is intimately bound with histories of colonisation’. This makes the space where research epistemologies and the process of colonisation meet, an important intellectual space to explore. Historically, dominant Western research had its philosophical origins in positivism, which reasoned that the world is expressed through ‘universal laws’ that explain and predict our surroundings (Hughes, 2001). Positivism privileged forms of ‘scientific rationalism’ and believed in an elite importance and superiority of scientifically derived knowledge. Research conducted according to this paradigm sought to understand causational relationships between events and an underlying governance of order (Hughes, 2001). It was concerned with testing theories through measuring and quantifying objective physical phenomena (Lewis & Barnes, 1997).

The emergence of this scientific discourse coincided with European aspirations of global imperialism. Smith (1999) suggests that as the world beyond Europe began to be ‘discovered’, Western scientific thinking framed the interactions between indigenous and non-indigenous people. Scientific dominance was used to
subordinate, legitimise and exclude the different ways of understanding, knowing, being and doing that were widespread before the arrival of Europeans. Early paradigms of science fostered disciplines and scientific philosophical reasoning, such as biology, evolutionary theory and psychology, which reasoned indigenous people as ‘objects’ of scientific inquiry (Rigney, 2001, p. 3). Inherent in this process was the subjugation of indigenous people, who were represented as the antithetical ‘Other’ (Attwood, 1992). The construction of the ‘Other’ resulted in a discourse of racialised difference (Rigney, 1997, p. 634). This was not only satiation of scientific curiosity but also purposive assertion of power and dominance over indigenous people (Rigney, 2001).

Anthropologists using ethnographic methods to record culture were also implicit in this colonising process of ‘Othering’. Gribich (2006) states that these methods involved people being researched as if they were ‘members of a separate species, rather than as part of the continuum of the same species’ and that this research representation is acknowledged as part of a ‘colonial mentality’ (p. 153). Smith (1999) states that ‘research’ became inextricably linked to European colonialism and imperialism, making it ‘one of the dirtiest words in the indigenous world’s vocabulary’ (p.1). Such Eurocentric biases resulted in the construction of mutually supporting relationships between those with power and knowledge and those without (Attwood, 1992). As Hart and Whatman (1998) suggest, the colonists reserved the power to define the authenticity of indigenous people’s traditions and to make political demands based upon their own superiority.

In the Australian context, early encounters between colonists and Indigenous people fuelled Western science as the ‘truth teller’ (Rigney, 2001). Racial theories such as polygenesis and social Darwinism came to the forefront of scientific
investigation, leading to the development of racialist science, which grew in popularity in the fields of anthropology, archaeology, anatomy, physiology, histology and palaeontology (Rigney, 2001). Phrenology was used to popularise the notion of Aboriginal people being cognitively deficient, and the concept of a ‘great chain of being’ was used to justify the status of Aboriginal people as the lowest of all human beings (McGregor, 1997, p. 5). In 1969, Memmi (cited in Battiste & Youngblood Henderson, 2000, p. 134) intimated that colonialists used racist strategies to maintain social control and power over Indigenous people. These strategies included using science and research to create powerful stereotypes of Aboriginal people by stressing the real or imaginary differences between colonists and Indigenous people, by assigning values of superiority and inferiority to these differences for the benefit of the colonists, by making these values finite through scientific rationalism and research, and, finally, by using these values to justify colonists’ privileges or aggression (p. 186).

The hegemony of science and its knowledge production became an integral part of colonial administrations across the world (Hettne, 1995) and, in Australia, informed the rationale for various government policies and practices that dealt with Indigenous people. For example, Moore (1994, p. 14) suggests that the polygenesis theory was used to justify land alienations and killings, and the ‘stolen generations’ and assimilation policies perpetuated by the belief in social Darwinism. Bennet (1999, p. 14) suggests that government administrators became ‘obsessed’ by the scientifically inspired ‘purity’ of Indigenous blood. The concentration or dilution of blood by miscegenation directly related to various degrees of Aboriginality. Major legislation was enacted to control and protect Aboriginal people based on their perceived Aboriginality. As Gray (2011, p. 42) discusses, Baldwin Spencer, a Northern
Territory administrator in the early 1900s, had clearly distinguished policies for ‘full blood’ and ‘half-caste’ Aboriginal people. This social milieu led to what Smith (1999) describes as a history that still offends the deepest sense of humanity in Indigenous people.

Smith (1999) states that colonisation has brought ‘complete disorder to colonised people, disconnecting them from their histories, their landscapes, their languages, their social relations and their own ways of thinking, feeling and interacting with the world’ (p. 28). She elaborates further by stating that the practice of research is inextricably linked to European colonialism and imperialism. It is from this theoretical stance that decolonising theorists question the ethics, morals and conduct of research that targets indigenous people or their communities. It is important that contemporary research methodologies move beyond pure scientific inquiry and instead contribute to broader social agendas, such as strengthening indigenous capacity, privileging indigenous knowledge, promoting better health outcomes and utilising culturally safe and appropriate research techniques. This is a process that Smith (1999) terms ‘decolonising’, with the end intention being ‘indigenising’.

**Research Design**

Influenced by feminist and decolonising theories, my qualitative research uses an ethnographic design relying on iterative cycles of data collection spanning a six-year (2007–2013) research relationship with the Saint Fiacre community. Ethnography has culture at its ‘essence’ (Liamputtong, 2009, p. 3). It involves the ‘intellectual work of learning a new cultural system’, followed by the process of translating between the studied culture and another culture—usually the researcher’s own (Atkinson & Pugsley, 2005, p. 229). Although participant observation is often
the mainstay of ethnography, I used additional data sourced by diverse methods alongside historical sources to synthesise the final research results. Embedded in the ethnographic tradition, the research design crossed several disciplines: anthropology, midwifery, linguistics, history and public health. See Table 4.1 for an overview of the study design related to the four discrete publications and for outlines of the papers, participants and sources, methods, data analysis and research inquiry focus. The separate methods will be discussed later in this chapter.

The ethnographic design was complemented by an emphasis on Aboriginal history that until now has remained undocumented in Western academic writing. This silence in the historical record may well be attributable to colonisation. As Rose (1996, p. 6) explains, the Western patriarchal power structures of colonisation have led to many male-dominated professions practising with the assumption that Indigenous women never possessed social power and thus have no ‘socially relevant knowledge and history’. The inclusion of a historical perspective to women’s experiences in Saint Fiacre strengthens the research design because it validates Indigenous women’s knowledge and ways of knowing the past. As Indigenous researcher Smith (1999) contends, coming to know the past is part of the ‘critical pedagogy of decolonization’ and that to ‘hold alternative histories is to hold alternative knowledges’ (p. 34).

**Ensuring cultural sensitivity and community participation.**

Community involvement should be a basic component of all Indigenous research design (National Medical and Health Research Council, 2003; Smith, 1999) and forms the foundation from which cultural sensitivity can be practiced. My research design accommodated specific features to ensure cultural sensitivity and community participation. This included appointing a cultural mentor, forming a local
reference group, training and employing Aboriginal research assistants and establishing research relationships with the Saint Fiacre Kanamkek-Yile Ngala Museum.

**Cultural mentor: Mrs Concepta Wulili Narjic.**

Mrs Narjic assumed the role of cultural mentor for the research project in Saint Fiacre. She has given permission and is comfortable in being publicly identified in this role. The research would not have been possible without her assistance, guidance, companionship and advice concerning all cultural matters. In my previous honours research, Mrs Narjic was determined suitable for the role of cultural mentor because she demonstrated the following characteristics:

- fluent speaker of Aboriginal language/s in Saint Fiacre
- ability and experience in translating primary data from Aboriginal language to English
- high competence in cross-cultural communication
- proficiency in Aboriginal cultural protocols and practices
- understanding and respect for confidentiality
- ability to conduct interviews and assist with the analysis of data

(Ireland, 2009, p. 60).

Mrs Narjic was recruited again into this position due to her proven record of accomplishment in the role and her status in the community as a cultural bearer with expertise in women’s business. Mrs Narjic is herself a retired Aboriginal health worker, and in the recent past worked in an innovative role with the Northern Territory Department of Health as a traditional midwife based in Darwin. She has
always had an active role and interest in women’s business matters in Saint Fiacre, combining cultural and biomedical knowledge about sexual and reproductive health in her work.
<table>
<thead>
<tr>
<th>Paper</th>
<th>Participants or data sources</th>
<th>Methods</th>
<th>Analysis</th>
<th>Research focus</th>
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<tbody>
<tr>
<td>1</td>
<td>Archive collections from the KYN, NT, OLSH &amp; AIATSIS.</td>
<td>Remote community-based fieldwork Observation and participation Fieldwork notes Historical method Semi-structured interviews (n = 22)</td>
<td>Western Chronological Historical content</td>
<td>Historical context of women’s reproductive experiences</td>
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<td></td>
<td>Publicly available NT perinatal statistics</td>
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<td></td>
<td>Retired female Aboriginal health workers (n = 8)</td>
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<td>Non-Aboriginal female health practitioners (n = 7)</td>
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<td>Previous community residents (n = 2)</td>
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<td></td>
<td>Religious-trained and employed non-Aboriginal health practitioners (n = 6)</td>
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<tr>
<td>2</td>
<td>Health practice manuals (n = 6)</td>
<td>Reading and quasi statistics</td>
<td>Content and Discourse</td>
<td>Historical context of women’s reproductive experiences</td>
</tr>
<tr>
<td></td>
<td>Publicly available NT perinatal statistics</td>
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<tr>
<td>3</td>
<td>Senior women in Saint Fiacre (n = 20)</td>
<td>Remote community-based fieldwork Observation and participation Fieldwork notes Historical method Group reproductive ethnophysiology drawing and language sessions (n = 10)</td>
<td>Ethnographic narrative</td>
<td>Cultural and linguistic constructions of reproduction</td>
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<td></td>
<td>NT and OLSH Provincial archives</td>
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<td>4</td>
<td>Young women (n = 12)</td>
<td>Remote community-based fieldwork Observation and participation Fieldwork notes Semi-structured interviews (n = 9) Group reproductive ethnophysiology drawing and language sessions (n = 10) Focus groups (n = 10)</td>
<td>Thematic</td>
<td>Cultural and linguistic constructions of reproduction</td>
</tr>
<tr>
<td></td>
<td>Senior women (n = 19)</td>
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</table>

Note. 1 = ‘Paperbark and Pinard’; 2 = ‘The logics of planned birthing place’; 3 = ‘From wanhpans to wombs’; 4 = ‘Jumping around’; KYN = Kanamke-Yile Ngala Museum; OLSH = Provincial archives of the Daughters of Our Lady of the Sacred Heart; AIATSIS = Australian Institute of Aboriginal and Torres Strait Islander Studies; NT = Northern Territory.
Local reference group.

Local reference groups, sometimes also known as ‘critical reference groups’, are a successful means of ensuring community participation, and they have been used in other research projects working with remote Aboriginal communities (Kildea, Barclay, Wardaguga, & Dawumal, 2009). A local reference group comprising five core members was established in Saint Fiacre. These members were senior Aboriginal women of cultural authority, Aboriginal researchers and, at times, other self-selected women from the community. The purpose of the local reference group was first to guide the research process as a whole and then to provide specific advice on Aboriginal research methodologies, assist with recruitment of participants, analyse and validate the data and ensure cultural safety throughout the entire research process. The local reference group also undertook final community approval of the four submitted research papers.

The local reference group worked by informal structured meetings, where core members adopted an Aboriginal-led consultancy model, whereby women used their own verbal networks, kinship and political pathways to discuss, seek feedback and approve aspects of the research on behalf of myself. This meant that feedback sometimes took several weeks to be issued. It was not my place to impose or demand the conventions of what I deem a more Western-styled and conventional local reference group—that is, one where uniformity, structure and written minutes would be kept. Instead, I opted to keep records of the interactions in my fieldwork diaries, and I grew to trust (and admire) the Aboriginal-led consultancy.
Training and employment of Aboriginal research assistants.

Four Aboriginal research assistants who live permanently in Saint Fiacre were recruited via the local reference group. In public presentations, people have questioned the semantics of the position title ‘Aboriginal research assistant’, suggesting that it does not represent the crucial contributions made by Aboriginal people involved in research projects, but I respectfully remain confident that this is an apt and respectful description of their roles and responsibilities in our research process. The research assistants were given basic training in conducting research using ethnographic methods. The training involved informal workshop sessions over a two-week period concerning methodology, documentation, confidentiality, research goals, interviewing techniques and managing risk and safety. Training included interview role-playing, recording notes and instructive examples of ethical principles, such as confidentiality in research. All research assistants spoke both English and the dominant Aboriginal language of Saint Fiacre. Three assistants had prior research experience working with academics on linguistic projects but all were new to ethnographic techniques. Their relevant skills and experiences are summarised in Table 4.2. One junior recruit (D), although lacking the same skill set and prior research experience as the other women, was essential to building rapport with young female participants and worked exclusively on this aspect of the project. The research assistants and I worked together in a relationship similar to the apprenticeship model, in which ongoing assistance, guidance and mentoring was always available. The Aboriginal research assistants were paid in their role, and work-related equipment was provided free, such as reading glasses for ensuring clear vision of participant information sheets and consent forms, notebooks for making any field notes and stationery for handwriting and drawing.
Table 4.2

*Skill Set and Prior Work Experience of Aboriginal Research Assistants*

<table>
<thead>
<tr>
<th>Skills and Work Experience</th>
<th>Research Assistants</th>
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<tr>
<td></td>
<td>A</td>
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<tr>
<td>English speaker</td>
<td>X</td>
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<tr>
<td>Dominant Aboriginal language speaker</td>
<td>X</td>
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<tr>
<td>Basic English literacy skills</td>
<td>X</td>
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<tr>
<td>Basic Aboriginal language literacy skills</td>
<td>X</td>
</tr>
<tr>
<td>Intermediate English literacy skills</td>
<td>X</td>
</tr>
<tr>
<td>Intermediate Aboriginal language literacy skills</td>
<td>X</td>
</tr>
<tr>
<td>Advanced Aboriginal language literacy skills</td>
<td>X</td>
</tr>
<tr>
<td>Advanced English literacy skills</td>
<td></td>
</tr>
<tr>
<td>Basic numeracy skills</td>
<td>X</td>
</tr>
<tr>
<td>Speaker of more than one Aboriginal language</td>
<td>X</td>
</tr>
<tr>
<td>Prior linguistic research experience</td>
<td>X</td>
</tr>
<tr>
<td>Prior ethnographic research experience</td>
<td></td>
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<tr>
<td>Health-related work experience</td>
<td></td>
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<tr>
<td>Conference presentations</td>
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</table>

*Epistemology of paid employment.*

I have always encountered different understandings of work–rest patterns while engaging and working with Aboriginal research assistants. Every day, the work flow was unpredictable and unique. This unpredictability became challenging with regard to planning research goals, and I adapted by always extending the time estimated to undertake a given task. The research assistants often had other needs that we needed to resolve before we could do ‘research work’. These included family and personal transport to and from the shop; provision of food and drink; organising of childcare; medical appointment attendance; paracetamol supply; first aid attention; quit smoking counselling; family dispute counselling; Centrelink, taxation office and bank liaison; budgeting and money saving advice; vision testing and purchasing of reading glasses; parenting advice; drug dependency referrals, connecting with
country through bush trips; purchasing of electricity power tickets; explanations of
the Australian taxation and superannuation system; and baking of cakes for family
birthday celebrations. In the spirit of reciprocity, these diverse needs were always
met, and only then were we able to pursue the research tasks.

The research assistants contributed by identifying, locating and liaising with
participants so they could attend research sessions; facilitating the process of gaining
informed and ongoing participant consent; interviewing participants; and assisting
with recording language terminology. They also took me to historical locations
around the community, sourced and identified various plants and animals of research
significance and chaperoned me during public ceremonial events and night-time
discos. The research assistants also assisted me with accessing local archives and
with the process of data validation and analysis. One assistant transcribed the female
Murrinh Patha sexual and reproductive vocabulary. In all of these capacities they
worked and consulted closely with members of the local reference group.

Saint Fiacre Kanamkek-Yile Ngala Museum.

A research relationship was established with the Kanamkek-Yile Ngala
Museum. The museum is a community-based organisation that broadly seeks to
collect and record artefacts, stories and photographs of historical significance to the
Saint Fiacre community. Permission was sought to access the local archives, and
pathways were established for the return of data generated in the process of this
research. Research participants were asked about donating their story recordings and
photographs back to the community via the Kanamkek-Yile Ngala Museum. As part
of the consent process, participants were asked if this could occur and how they
would like access to the material to be managed.
In many instances, the opportunity to repatriate cultural history back to the community was ensured, despite the material not having direct relevance to this research project. For example, some participants shared their personal Saint Fiacre photographic collection. Only a small portion was relevant to this research, but their whole collection was scanned and digitally returned back to the community. In this way, community members could access images of old friends and family members from the past. This is a valued and enjoyable pastime in Saint Fiacre, despite known cultural sanctions on viewing images deceased persons commonly associated with Aboriginal culture.

**Research Rigour**

Liamputtong (2009) states that rigour refers to the quality of qualitative research and that it is also a tool for measuring the worth of qualitative research findings. Internal rigour can be examined in the personal skills and experience of the researcher. Strategies to ensure rigour can be demonstrated in the research design and process and in the involvement of participants and peers outside of the research team.

The internal rigour of this type of research, to a large extent, ‘hinges’ on the researcher, in that it relies on their personal skills, astuteness and competence in undertaking fieldwork (Patton, 1990, p. 36). My rigour as the lead researcher is underpinned by my relationship with the Saint Fiacre community, which now spans almost ten years (2006–2015). It is enhanced by cross-discipline training and experiences. Western biomedical training and clinical experience in remote-area nursing and midwifery contributed sound practical and scientifically reasoned perspectives in my research. Medical anthropology and qualitative research training and experience allowed me to discover the deeply personal and subjective meanings that humans construct to explain their experiences. Although these paradigms are
antitheses, their intertwining allows novel perspectives on health issues. They are also a microcosm of the ‘subjectivism’ and ‘objectivism’ encountered in the provision of Western biomedical health care—that is, the unpredictable health outcomes of medical treatments used without regard for the human patient’s unique biological nuances and sociocultural circumstances. Similarly, my academic supervisors came from three disciplines: medical anthropology, midwifery and history, which nurtured the cross-pollination of research paradigms.

Two of several strategies that can be used to ensure the rigour of the research design are the choice of methods and prolonged engagement and fieldwork (Liamputtong, 2009, p. 24). In this research, the ethnographic framework was a robust choice for investigating the cultural constructions of reproduction. Lengthy periods of community participation and observation were complemented by other carefully chosen methods, such as interviewing and drawing. These chosen methods enabled ‘thick descriptions’ (Geertz, 1973) of women’s perspectives, which are reported in the research findings. Prolonged engagement and fieldwork are also demonstrated in the iterative cycles of remote community-based and archival fieldwork sessions, which spanned a six-year research relationship with the community. Archival immersion complemented my community-based fieldwork and involved lengthy periods of engagement with cultural artefacts and documents, which, just like people, had their own character and stories to tell.

Rigour in the research process involved triangulation, which is the most powerful means of strengthening credibility in qualitative research (Liamputtong, 2009, p. 26). Several strata of data triangulation occurred—methodological, analysis, researcher, theoretical and interdisciplinary—ensuring the trustworthiness of research findings. The strata are represented in Figure 4.1. For example, the data
generated from participant interviews about midwifery care in Saint Fiacre were corroborated by various participants (Aboriginal and non-Aboriginal), by historical archival documents, by photographs of the hospital buildings and by Northern Territory life-history oral recordings of mission staff. Likewise, data generated from ethnophysiology and anatomy drawing sessions were cross-referenced with historical documents, linguistic advice, translators, dictionaries and other participant opinion.

Figure 4.1. Triangulation strata used to enhance the research rigour.

Lastly, rigorous strategies involving the research participants and outsiders were used at several stages during the generation of data and research findings. In the first instance, data underwent a cycle of checking and amending by the participants, a process also known as ‘member checking’ (Liampittong, 2009, p. 28). This validated data was then used for collaborative data analysis and, in turn, formed the basis of the research findings. Research findings were then checked by the Aboriginal research assistants with the involvement of the local reference group and cultural mentor, resulting in a layered process of validation. In a final demonstration of the
use of external strategies to ensure rigour, the research findings have undergone peer review through journal publication and conference presentation.

**Methods**

**Ethnography and fieldwork.**

I used ethnography to produce ‘thick descriptions’ (Geertz, 1973) of women’s life in Saint Fiacre. Ethnography requires the researcher to know in great depth the people, group or community of research interest. This can only be achieved through fieldwork, whereby the researcher is immersed and engaged with the community in a process of prolonged contact (Liamputtong & Ezzy, 2006; Thorne, 2000). Conquergood (1991) states that fieldwork:

Requires getting one’s body immersed in the field for a period of time sufficient to enable one to participate inside that culture. Ethnography is an embodied practice; it is an intensely sensuous way of knowing. The embodied researcher is the instrument. (p.180)

In this very physical manner, I have undertaken iterative cycles of fieldwork, spanning a six-year research relationship with the community. Prior to this, I had worked in the community as a nurse and midwife, which privileged me with additional insights into the lives of Saint Fiacre’s people. Fieldwork in a tropical Australian remote Aboriginal community is physically taxing. The weather is always hot and extreme and often humid and the mosquitoes and sand flies are always hungry for human blood. The limited practical resources, such as fresh food, groceries and car-hire, make basic research logistics challenging and, sometimes, impossible. The community infrastructure is substandard, with frequent cuts to electricity and running water, while accommodation options are limited, costly and
most often unpleasant. On several occasions I was sick with vomiting and diarrhoea due to bouts of gastroenteritis, and I was one of several unlucky people to contract a treatment-resistant strain of otitis externa (ear infection) during a community outbreak. My face swelled, and I required treatment with intravenous antibiotics for one week. This was much to the amusement of community members, who suffer exceptionally high rates of ear infection but had never seen a case so severe that a drip was required. My physical frailty was widely discussed.

The ‘thick descriptions’ (Geertz, 1973) generated through ethnography, although rich and detailed, can only be a partial representation. In describing the process of ethnography, Scheper-Hughes (1993) explains not only the complexity and subjectivity of fieldwork but also the personalised nature of how an ethnographic account is generated:

The ethnographer, like the artist, is engaged in a special kind of vision quest through which a specific interpretation of the human condition, an entire sensibility, is forged. Our medium, our canvas, is ‘the field’, a place both proximate and intimate (because we have lived some part of our lives there) as well as forever distant and unknowably ‘other’ (because our own destinies lie elsewhere). In the act of ‘writing culture’ what emerges is always a highly subjective, partial and fragmentary—but also deeply felt and personal—record of human lives based on eyewitness and testimony. The act of witnessing is what lends our work its moral (at times almost theological) character. So-called participant observation has a way of drawing the ethnographer into spaces of human life where he or she might really prefer not to go at all and once there doesn’t know how to go about
getting out except through writing, which draws others there as well, making them party to the act of witnessing (p.xii)

This quote resonates with my fieldwork experiences. It describes so well not only the intimacy that is achieved in fieldwork but also the distance that the researcher maintains, with the knowledge that our destiny or ‘homeland’ lies elsewhere. In a sentiment that is echoed by many other Aboriginal people in Saint Fiacre, one man explained:

Many white people come and go, come and go from this place, but me I will always be here and it is here that I live and will die too. You know, I will be buried in the ground down there at the cemetery.

**Participant observation and insider/outsider status.**

Ember and Ember (2004) suggest that participant observation is defined as:

living among the people being studied—observing, questioning, and (when possible) taking part in the important events of the group. Writing or otherwise recording notes on observations, questions asked and answered, and things to check out later are parts of participant-observation. (p. 38)

Due to the complexity of social life, ethnographers record many dimensions of their observations. It is suggested that these dimensions can be artificially separated into the domains of space—physical layout of the place(s), actor—range of people involved, activity—a set of related activities that occur, object—the physical things that are present, act—single actions people undertake, event—activities that people carry out, time—the sequencing of events that occur, goal—things that people
are trying to accomplish, and feeling—emotions felt and expressed (Reeves, Kuper, & Hodges, 2008, p. a1020). The observations or situations sampled are opportunistic and occur as ethnographers live immersed within the community studied. For me, this involved spending extended periods in Saint Fiacre, shadowing women in their daily lives. This included visiting country (see Figure 4.2 and Figure 4.3), camping, hunting, fishing (see Figure 4.4) sitting around at camp, shopping, picnicking, driving around, sharing meals, watching ceremonies, spending time with extended family groups, and attending other community activities in Saint Fiacre, such as the school dormitory opening day celebrations.

Figure 4.2. Accompanying women during fieldwork to dig up roots for use as a natural dye in their fibre-weaving.
Figure 4.3. Plant-based materials collected during fieldwork to be used for dye to colour women’s fibre-weaving orange, purple and black.

Figure 4.4. Fishing with women during fieldwork.
I had ‘mixed’ privileges, moving between being an outsider and an insider. I was, of course, always perceived as an ‘outsider’, being non-Aboriginal and not speaking fluent Murrinh Patha, but this was tempered by my knowledge of families, country locations and community events through my work as an outstation nurse and clinic midwife. I certainly moved closer towards ‘insider’ status as my language knowledge increased and then in the later stages of my fieldwork by becoming pregnant. As a woman in my mid-thirties, my pregnancy enhanced my cultural congruence and social acceptability. I did know that my delayed childbearing was of great concern to many women, who simply assumed that I must have been experiencing ‘big problems’ getting pregnant. My explanations of first wanting to acquire a job, travel and have adventures before having a baby were met with confusion and strong disapproval. Therefore, my pregnancy, albeit long overdue from the community’s perspective, brought a sense of relief and contentment to many of the older women (see Figure 4.5).
Figure 4.5. Concepta Wulili Narjic and pregnant me during fieldwork. We are standing in Wulili’s country.

My embodiment of third-trimester pregnancy during fieldwork brought me closer to the women and allowed me to participate rather than to just ‘observe’. Small children would ask repeatedly, ‘Who is the father?’ Women would rub and pat my abdomen, guessing at the sex of the baby. As this was my first pregnancy, I was in a liminal stage, with no experience in childbirth or mothering. Feeling the vulnerability of the uninitiated, I was especially attuned to advice offered and the birthing stories shared. When returning to the community after the birth of my son, the old women were a little shocked and proud to hear me report that I had pushed him out as the old ladies instructed—on the ground kneeling and on my heels. During fieldwork visits, I kept paper and pen diaries in which I detailed general events, thoughts, feelings, insights and frustrations (see Figures 4.6 and 4.7). I also made computer-based written notes after each specific research session.
07/09/2012

I am 31 weeks pregnant now. No running water in the house all day. I am using the rented truck every day. The truck is filled with as many idiosyncrasies as the fieldwork itself. My pregnant stomach now scrapes on the steering wheel. It's a very battered old double-cabin ute. The back tray has two upturned screen doors and sheets of canvas fixed together with twists of fencing wire. This creates shade, which keeps my water cool. Each of the four doors opens, closes and locks in a different manner. The driver’s door lock handle does not work and the window is permanently jammed. You have to leave the small triangle accessory window open so I can reach around inside and manually open the lock. The passenger door is opposite in that the window does not wind up and you still have to reach in and use the inside handle. The handbrake does not work and on the rare occasions it is needed you must spread your foot over both brake and accelerator to rev the engine and stop it from conking out. The fuel tank is bashed in and damaged. When I fill it up, I have to hold the fuel pump upside down otherwise it cuts out, even if there is no fuel visible. The gauge does not work and always sits on empty. This is helpful because if needed I can lie with the ‘evidence’ that I do not have enough fuel to drop a crowd of people home. The seats remain moist in the built-up humidity, are covered in fine sand granules and smell like wet dogs. I have just dropped the woman home after a session of rechecking the language recordings. Poor MM has very bad hygiene and the toilet still smells like a urinary tract infection, long after she is gone. I also have to change the cover on the lounge where she sat for a short time—it smells too much. The other women appear to not notice. I offered to take her to the clinic but she declined. I notice that everyone seems to take turns at using the toilet; I think they enjoy the locking door and toilet paper. The women politely start-off sitting on the lounge but then resort to sitting on the floor. So I always move the furniture to the side and spread a blanket on the ground. I made sandwiches for everyone between everything else and put out a big bowl of oranges. They all are eaten and stashed in bags but one is
politely left-?for me I presume. I make a black-tea in a large black saucepan and leave it on the ground in the middle of the circle. The women dip their own cups in and self-serve. At lunch break everyone talked a lot about AN and CP being hungry for tobacco and their smokes. After everyone leaves, I sweep up the orange peels and used tobacco balls from under the lounge and chairs.

*Figure 4.6. Extract from fieldwork diary, 7 September 2012.*
Tired after not sleeping well, I was up for a few hours in the middle of the night. This morning I want to connect with VN (JUNIOR RESEARCH ASSISTANT). Start off with flat tyre, which I manage to change despite pregnant belly. Then road closures to Manthape [OUTSTATION]—only way there is the long round-about way, which takes three times as long. I know VN will only be awake around 11:00. She wants to visit her father in Darwin jail and stay in my house in Darwin when I finish up the fieldwork.

Boyfriend has hit her on the head again and she is pregnant. Her telephone number changes most weeks and sometimes every few days—this makes getting in contact difficult. I drive out to Manthape the long round-about way and to talk with her about her plans for coming into Darwin and also working with me today. I explain clearly ‘I can offer one person a free lift in—there will only be room for one person’—this is not important ie. the saving money part. I explain ‘You can only stay until Wednesday—then Brin (my partner) and I will be busy with getting ready for our baby’. ‘Like buying Kimbi’s (nappies)?’ she asks. I reply ‘Yes and I need a quiet holiday before the baby arrives’. I change the subject, ‘Can you work with me today? I would like to collect some stories and get you to keep me company while we talk with the young girls’. She goes quiet, avoids eye contact and sits down on the concrete floor. I know from this response that it is not a good time. ‘Is now a bad time to do work?’ I ask. She remains very quiet and I sit the silence out for at least a minute. ‘Yes—it’s not a good time. I will be busy at the casino making money for the Darwin trip when I stay with you, Sarah’ she answers. I am confused as I am offering her paid employment for the day. ‘Oh, don’t most people lose money at the Casino?! I thought there was only one winner at card games? If you work with me today, you will be paid money straight into your bank account. Safe money—you can’t lose it like you can at the casino!’ I suggest. She remains sitting quietly and so do I, respectfully averting my eyes. After another silence she says ‘Sarah, my sister buried sea turtles down the end of this road under the tree’. Its takes me
a while to realise she is talking about small dead turtles that came from the fertilised eggs that have been gathered as bush tucker from the beach. ‘Oh’, I exclaim with recognition. ‘They are my sister’s totem animal’, she says. We sit quietly again and then I accept defeat and say ‘Ok, if you are so busy today, I will leave and let you get on with your business.’ ‘Can we get a lift with you to the other side Sarah?’ I am now feeling exasperated because of all the time and energy I feel I have wasted. I hop into the truck and confirm I can give her a lift but she had better hurry because I am busy with work to do today. She wakes up her boyfriend, washes her face and they both get in. I drive them back the long way, which takes twice as long as it would take them to walk the direct route across the creek. I drop them at a house where a small crowd is gathered around a circle of gambling card players. I shout ‘Good luck for the casino!’ and drive away. I notice my spare tyre seems to be getting flat too.

Figure 4.7. Extract from fieldwork diary, 27 September, 2012.

**Interviews and focus groups.**

The Aboriginal research assistants and I worked together to facilitate interviews and group focus sessions, where experiences of fertility and reproduction were explored through both common and individualised perspectives. Interviews, which involve a focused conversation with a research participant, are a mainstay of qualitative research techniques. Interviews explore the ‘complexity and in-process nature of meanings and interpretations that cannot be examined using positivist methodologies’ (Liamputtong & Ezzy, 2006, p. 56). The aim of an interview is to ‘elicit rich information from the perspective of a particular individual and on a selected topic under investigation’ (Liamputtong & Ezzy, 2006, p. 43).
Focus groups are also a technique aimed at understanding rich contextualised meanings but involve a ‘group of people from similar social and cultural backgrounds … who gather together to discuss a specific issue with the help of a moderator’ (Liampittong & Ezzy, 2006, p. 65). In contrast to interviews, focus groups aim to elicit common perspectives held by a group rather than those of an individual. Focus groups require less prior knowledge about the participants, and they are very useful for finding out about the ‘perspectives and experiences of people who have different cultural and social backgrounds’ (Liampittong & Ezzy, 2006, p. 67). See Appendixes 2, 3 and 4 for examples of interview theme guides.

**Ethnophysiology drawing and language recording.**

Visual methodologies are recognised as adjuncts to other standard social science methods, such as interviewing (Guillemin, 2004b). Drawing as a technique for understanding illness and health has in the past been limited to studies with children but is now emerging as an innovative and novel method for understanding the health experiences of people of all ages (Guillemin, 2004a, 2004b). Drawing methods have been used in a variety of situations with adults, with Morgan, McInerney, Rumbold & Liampittong (2009) stating they have a particular utility for researchers in health sciences who are working on sensitive topics and with vulnerable participants (p.127).

Drawing techniques are also helpful to explore cultural interpretations of the human body and, in particular, the relativism between ‘lay’ and medical concepts of the body. These sorts of cultural configurations of the human body are sometimes referred to as ‘ethno-anatomy’ (body structure) and ‘ethnophysiology’ (body function). Anthropologists have highlighted that lay understandings of the body are marginalised by authoritative medical knowledge (Irwin & Jordan, 1987; Jordan,
1980; Lupton, 1999), but many people appraise and interpret their health without medical knowledge. Drawing techniques have frequently been used to understand women’s cultural constructions of reproduction and fertility and their associated impacts on health (Brewis, 1994; Cornwall, 1992; de Bessa, 2006; MacCormack & Draper, 1987; Obermeyer, 2000; Shedlin, 1979; Sobo, 1993).

The Aboriginal research assistants and I used an exploratory life-cycle narrative approach to record women’s ethnophysiology, ethno-anatomy and the Aboriginal language terms that describe female sexuality, fertility and reproduction. We ambitiously worked between three languages and two dialects. A spreadsheet of targeted terms was compiled, and this was used to guide the overall direction of the sessions. Specifically, participants were asked to discuss and comment on the journey a newborn baby girl will make through life. Participants were provided with pens, pencils and crayons and large sheets of paper on which explanations of body structure and functions could be drawn and elaborated upon (see Figure 4.8). When group consensus was met on a particular language term, participants delegated language speakers to digitally record the word on a Dictaphone.

*This figure has been removed for electronic dissemination but is available in a hard copy of the thesis held in the Charles Darwin University library.*

*Figure 4.8. An ethnophysiology drawing and language session.*
Historical methods.

Qualitative research techniques were complemented by an emphasis on historical methods. My academic training is primarily in medical anthropology, and it would be misleading to declare myself a historian. However, I came to understand very early in this research process that Aboriginal women’s sexual and reproductive health cannot be adequately understood if history is ignored. History is essential to understanding the process of colonisation and its gendered impacts on Aboriginal women, their sexual bodies and their reproductive experiences. Although it is outside the scope of both my academic training and this thesis to provide a lengthy critique on historiography, it is important to briefly conceptualise, first, the issue of truth in the production of history and, second, issues of cross-cultural historical practice in a remote Aboriginal community.

From my perspective as a health researcher, qualitative inquiry and history appear to share a close philosophical association evident in their outward rejection of positivism. Although both disciplines seek to arrive at a given ‘truth’, they implicitly function with an understanding that multiple ‘truths’ may exist at once and that ‘truth’ is only ever constructed. In the case of qualitative research, truth is constructed through close scrutiny of the meaning of the research findings; in history, truth is constructed through close scrutiny of the historical sources. As Carr (1987) explains, history is produced through an interactive process between the ‘historian’ and the ‘facts’, but, importantly, the resultant historical construction is always imbued with the personal agendas and biases of the historian. These agendas and biases are the by-products of the historian’s own sociocultural circumstances. Carr (1987, p. 39) explains history as ‘a continuous process of interaction between historian and his [or her] facts, an unending dialogue between past and present’ (p.
39). Based on this understanding, Curthoys and Docker (2010) carefully question whether this then means history is fiction. After much consideration, they decide to neither accept history as the product of the ‘rigorous scrutiny of sources’, nor to reject it as a creative literary form. Rather, they choose to acknowledge its inherent duality—which they term ‘doubleness’—as the exact reason for humans’ enduring practice of and fascination, enjoyment and love for history (Curthoys & Docker, 2010, p. xii).

An Australian example of the malleability of historical ‘truth’ is evident in the public portrayal of the ‘history wars’, in which the facts of racially motivated frontier violence against Indigenous people has been passionately debated (Reynolds, 1982; Windschuttle, 2002, 2003, 2009). As Curthoys and Docker (2010, p. xii) make clear:

The temptation to declare that the historian can objectively establish the truth about the past is to be resisted. There always has to be a question mark hovering over any claim to having attained an objective, let alone scientific status for one’s finding.

History is also importantly about ‘power’ (Smith, 1999, p. 34). In Westernised societies, it is the historian who has power to choose whose history counts and which history is worth remembering. For many Indigenous people, this means history has been used as a tool of colonisation to exclude, marginalise and ‘Other’ (Smith, 1999, p. 34). Global diversity in people’s experiences of colonialism has shaped and influenced the reasoning of history scholars. For some scholars of Indian history, experiences of colonialism have resulted in the conceptualisation of postcolonial ‘subaltern studies’ as a form of critical historiography (Chakrabarty, 2000). In comparison to South-East Asian and Indian communities, many indigenous
people from the Americas, New Zealand and Australia continue to experience the ongoing effects, rather than legacies, of past colonialism. Byrd and Rothberg (2011) suggest that although subaltern and indigenous studies appear to share close intellectual alliance in that both are attempting to understand ‘colonial logics’, many indigenous people have continued to distance themselves from postcolonial critiques of the past.

While Smith (1999, pp. 29–30) concedes the widespread criticisms of Western-historiography, she also claims that history is crucially important to indigenous people because it offers a way of ‘understanding the present and that reclaiming history is a critical and essential aspect of decolonisation’ (pp. 29–30). The challenge, therefore, is how to practice history that is critical of power relationships and is able to transcend Western discourse for the beneficence of indigenous people.

Use of historical methods in my research was grounded on a critical awareness of the colonising legacy of history. I worked in close collaboration with the cultural mentor, local reference group, research assistants and participants to create a space that valued Indigenous knowledge and experiences. Although unable to fully militate against my position of power as a non-Indigenous researcher, several strategies were used to actively share power. For example, nearly all Saint Fiacre participants recorded their stories in Murrinh Patha, which was a direct act of reclaiming and renaming their history for the purpose of enriching and teaching their own people.
**Aboriginal historical practice.**

Due to colonisation, the notion of ‘Aboriginal history’ in Australia is a contested space, eliciting a spectrum of responses ranging from ‘colonialist appropriation and exploitation’, to a decolonising practice where Indigenous people may gain ‘control over the past and present’ (McGrath, 1995, p. 390). Due to this contested nature, McGrath (1995) suggests that the process (i.e. method/practice) is equally as important as the product (i.e. historical discourse). Therefore, it is important to acknowledge differences in how Aboriginal history may be conceptually conceived and then experienced.

Based on fieldwork with Gurindji Aboriginal people in northern Australia, Hokari (2002) provides insightful reflections on his experiences in cross-cultural historical practice. He writes about Aboriginal history as an embodied practice, explaining that unlike an academic Western paradigm that situates history chronologically in the past, Aboriginal historical practice transcends linear placement, meaning that it is alive, regenerative and happening everywhere at once.

For the Gurindji people, landscapes, bodies and objects all contain memories that can be triggered through human visitation and interaction. People’s reiterative practice of telling or hearing these memories, through the medium of story-telling, maintains and—I suggest—‘rebirths’ the ‘past’ into the present. Hokari (2002) argues that this means historical practice is essentially an embodied one, which relies on relationship: the movement of people through the physical places of their homeland. Conceptualised from the perspective of his Gurindji informants:

History should be listened to, seen, and felt around yourself in your everyday life. History is something your body can sense, remember, and practice. (Hokari, 2002, p. 215)
Hokari’s (2002) discussion of Aboriginal historical practice resonates with how Aboriginal people experience history in Saint Fiacre. It also assists in explaining the crucial importance they place on spending extended time with people in their country and community. Women were always offering information serendipitously triggered by the landscape, a passer-by or an object in our near surroundings. For example, when driving to visit an outstation, we passed a small hill, which triggered a session of story-telling among the women in my car. They recounted the story of a cave on the hill, where the old men hid the young girls when the mission priest asked for them to be given over so they could be raised in the dormitory by the nuns. Although we had spent some time talking about the dormitory in the days proceeding, it required this physical interaction between the women and their country for this important historical information about ‘resistance’ to be remembered. The research assistants and I always explained our history work as simply ‘story-telling work’, and from our experience the best approach was to ask a participant if they would like to ‘tell us a story about … ’. Stories were most rich when we visited the sites of historical significance or went out bush to find and hold in our hands the plants or shells that were used in midwifery.

In my research, a variety of historical practices were utilised, including serendipitous and targeted visits to places both out bush and in the town, story-telling and recording, identifying and sourcing historically important objects (i.e. midwifery tools) and group examinations and discussions of historical photographs and publications sourced from archives and other research participants.

Archival method.

In additional to my remote community-based fieldwork, I personally undertook months of archival immersion, spending time familiarising myself with a
variety of letters, photographs, reports, diaries, fieldwork notes and government documents. Burton (2006, p. 6) explains that archive collections are in ‘dynamic relationships, not just to the past and present, but to the fate of regimes, the physical environment, the serendipity of bureaucrats, and the care and neglect of archivists’. This means archival documents are ‘figured’—that is, marked by their production and then, perhaps less visibly, marked by the processes of their collation, storage and ongoing access. All of these factors assert influences on the historical meaning and interpretation of archival material.

Burton (2006, p. 6) aptly describes archival collections as a type of ‘contact zone’ in which ‘physical, emotional, intellectual and political encounters’ occur between the scholar and the collection. The archives that I consulted were in a variety of locations, and indeed some of these visits affected my understanding of the documents themselves. For example, one collection was held in a convent. I had never before visited a Western religious convent and the experience was new and memorable. Although the sole purpose of the visit was to review and search out leads in the boxes of paper, I learnt almost as much by witnessing the lives and routines of the religious order that played out in my surroundings. This experience allowed me to better understand the context of the production of the religious documents and experience first-hand the vested wealth and power of the institution, clearly evident in the large brick building and expansive grassed grounds.

Over the course of my research, I consulted archival sources that were held in the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) Library and Archives, Canberra; the Daughters of Our Lady of the Sacred Heart (OLSH) Library and Archives, Kensington, NSW; the Northern Territory Health Library Historical Collection, Darwin, NT; the Northern Territory Archives, Darwin,
NT; and the Kanamkek-Yile Ngala Museum Archives, Saint Fiacre, NT. Of particular importance was the voluminous collection of the work of Stanner, the respected anthropologist (see Figure 4.9). I have spent so many hours translating his slanting scrawled handwriting that I feel he is a kindred spirit posthumously assuring and supporting me, almost as much as my living academic supervisors.

Review of these historical documents followed the usual conventions of source criticism. This included interrogating the genealogy of the document, considering the genesis and originality of the document, formulating the interpretation of the document, understanding the authorial authority and questioning the competence and trustworthiness of the observer (Howell & Prevenier, 2001, pp. 60–68). During archival immersion, I made review notes in my fieldwork diaries and, when possible, copies of the documents for future referencing.

Figure 4.9. Visiting the WEH Stanner archive boxes.
Location of Saint Fiacre Data Collection Sessions

The data collection sessions occurred in locations that were mutually agreeable to the Aboriginal research assistants, the participants and me. For the collection of culturally sensitive information and for larger group sessions, my private residence at Saint Fiacre was the preferred location. We worked on a large blanket spread on the ground and, when possible, in a shaded location outdoors. Women were offered tables, chairs and sofas but were always most comfortable sitting and working from the ground. The location provided privacy, and often an outdoors overhead fan gave relief from the tropical heat and humidity. Tea, cake, water, fruit and juice were always available during the sessions, and we would stop for lunch, which I also prepared and supplied. Transport was provided to and from the sessions.

Often, there was a sense of retreat during the sessions. Women commented that they enjoyed being away from the humbugging, noise and caring responsibilities for their grandchildren and great-grandchildren. As the seasons changed and the rains started, the women sometimes brought along weaving projects (see Figure 4.10). As we talked and discussed subjects, they would work at stripping away the succulent flesh of hemp using a piece of wood and the sharp metal edge of a Log Cabin tobacco tin, in preparation for the fibres to be twisted on their thighs into rope.
Figure 4.10. An example of women’s fibre work and the first knots of a dillybag.

For smaller groups and individual sessions, some women opted to attend my house, but most often we interviewed people in their own place, such as in the nursing home rooms or courtyard and in private houses. When undertaking work on the historic mission’s health services, we made site visits to the original locations, recorded map locations and videorecorded walking tours of the remaining old hospital buildings and the girl’s mission dormitory.

**Data Analysis**

Analysis of the data did not occur as a ‘discrete’ phase of the research but occurred throughout the entire project. Qualitative data analysis is not always
linear—rather, it occurs during the whole process of research when ‘concepts, categories, and themes are identified and developed’ (Liamputtong & Ezzy, 2006, p. 226). Pope, Ziebland and Mays (2000) confirm that data analysis often takes place alongside collection, allowing the researcher to refine questions and develop pathways of inquiry. Four methods of analysis—thematic, discourse, content and historical—were applied to the collected data.

**Thematic analysis.**

Thematic analysis is used in the research paper titled ‘Jumping around’ (see Chapter 8). Thematic analysis is seen as a foundational method for qualitative analysis and involves the ‘identifying, analysing and reporting of patterns within the data’ (Braun and Clark cited in Liamputtong & Ezzy, 2006, p. 284). Four generalised steps were taken to shape the analysis process: data immersion, coding, creating categories and identifying themes (Green et al., 2007). Written transcripts, drawings, photographs, fieldwork diaries, audio recordings and participant observations were read, watched, viewed and listened to numerous times, leading to the identification of codes of descriptive labels. These were applied throughout the data material until a sense of broader analytical categories could be identified; the coded data was then clustered around these categories. The final step of analysis was the creation of explanatory and interpretive thematic domains, allowing women’s experiences to be understood from a sexual health perspective. The thematic domains were, as Markovic (2006) suggests, contextualised back into the research aims and related to relevant literature and theories from a health perspective.

For example, in the paper titled ‘Jumping around’, descriptive codes emerged from the data, such as ‘physical symptoms’, ‘causation’ and ‘treatment’. These codes were then commonly clustered around the broader analytical category of ‘sexually
transmitted infections and bloodborne viruses’. This category was then assigned to the thematic domain of ‘sexual health literacy’, allowing the data to demonstrate significance and meaning to young women’s sexual health.

**Discourse analysis.**

Discourse analysis is used in the research paper titled ‘The logics of planned birthplace’ (see Chapter 6). Some discourse analysers use quantitative processes to numerically assess the frequency of specific content categories in a text (Lupton, 2004); however, I focused on the qualitative sociocultural meanings ‘hidden’ in the texts. Lupton (1992, p. 145) describes this as the way in which text produces a ‘dominant ideology or belief system’. She describes this analysis as being centred on how the language and style of the text is presented to the reader. Structural content was noted, such as the stylistic use of terminology, grammar and conceptual devices. Contextual content was discerned by relating the text to the ‘social, political or cultural’ environment of its production. As Lupton (1992, p. 148) states, ‘proponents of discourse analysis make no claims as to the objectivity or universal truth of their insights’. Therefore, I subscribe to a view of reality in which ‘truth’ is only ever constructed and positioned by particular sociopolitical contexts. I acknowledge that my analysis is influenced by my gender, biomedical training and experience and by my non-Aboriginal background.

**Content analysis.**

Content analysis is used in two papers, titled ‘Paperbark and pinard’ and ‘The logics of planned birthplace’. In these papers, content analysis is used in a simple manner to quantify details in the data according to predetermined criteria. Bryman (cited in Liamputtong, 2009, p. 282) states that content analysis should ideally be
analytical, systematic and replicable. Hsieh and Shannon (2005) propose there are three methods of content analysis: conventional, directed and summative. Directed content analysis is the method used in both papers and is distinguished from the other methods by the use of a predetermined criterion, designed and formulated from previous research or theory. In the research papers, the criterion is listed as questions formulated from maternal health and midwifery discourse and literature. The questions concern factors of known common importance in maternity care: choice, birthplace location, care practices, resources, practitioner and model of care.

**Historical analysis.**

Historical analysis was used in the paper titled ‘Paperbark and pinard’. Historical analysis, otherwise known as ‘historical interpretation’ is a process whereby researchers ‘decide what evidence to privilege, which to suppress, which to ignore’ (Howell & Prevenier, 2001, p. 69). It is not so much a methodologically stepped process but rather the complex intellectual work of comparing sources to establish contradictions and confirmations and then weighing up and assessing the validity of so-called historical facts established from the sources (Howell & Prevenier, 2001).

In the context of my cross-cultural collaborative research, this process was complicated, but also enriched, by the need to move between two cultural constructions of ‘historical time’—that is, chronological and linear ‘Westernised time’ and regenerative and happening-everywhere-at-once ‘Aboriginal time’. As Hokari (2002) states, this conceptual divide is unavoidable in cross-cultural history making but does not mean that mutual understanding and communication is not possible. Rather, he suggests it requires the historian to be humble and non-dominating.
In my historical analysis, I transcended the cross-cultural time divide, primarily through the practice of ordering data around named ‘place’ rather than ‘time’. By place, I mean the different locations where women have experienced childbirth, such as out bush or at the Sacred Heart hospital’. This means that research participants and I spoke of historical change not conceptualised through the Western calendar (e.g. during the 1960s) but rather through naming the place of childbirth. Although I concede that these places have in themselves an overt Western chronology, this practice importantly allowed Aboriginal women to naturally locate their history as embodied in a place that was real and open to experience. Over this ordering of data to named places, I was able to superimpose a chronology of Westernised time and then link it to other archival sources.

I sought to use as many sources as possible to establish strength and texture in the historical interpretation. Sometimes this results in a strong and densely knitted historical weave, but when time or sources are limited or accounts fragmented, only a fine and lightweight weave is possible. I focused on establishing Carr’s (1987) traditional historical notions of change and continuity and then that of causality. For example, these notions are important in understanding the history of birthplace locations. Using historical analysis, source-recorded birthplace locations were chronologically arranged and reviewed for patterns of continuity and change. When continuity and change patterns were clearly established, theorising around causality began. This involved making links between birthplace change and any broader social, infrastructural and cultural influences. The evidence to support these links was then carefully assessed and with consideration deemed to be a historical ‘fact’. History can be dramatically altered if alternative sources become available. This
means that rigour is only measured by the sources available and used at the time of
analysis.

**Recruitment of Participants**

Aboriginal and non-Aboriginal female participants were purposively recruited to the project. Aboriginal men do play an important role in the construction of reproduction and fertility in Saint Fiacre, but local community leaders advised that it was not appropriate or desirable to have a non-Aboriginal white female research this topic with men. Aboriginal participants were recruited using the ‘message stick’ sampling technique. The Aboriginal research assistants, the local reference group and cultural mentor Mrs Narjic verbally invited potential participants to the research. This technique has been successfully used in other research in a remote Aboriginal town (Ireland et al., 2010). Message sticks targeted women appropriate to the individual research foci. As such, a cohort of young women, senior women with language skills and cultural authority and retired health workers were approached. The technique involved a verbal message stick being relayed, inviting participants to the research. If a potential participant responded to the message stick and agreed, the non-Aboriginal researcher was then introduced and the woman consented to be involved in the research. As a result of this method of subject recruitment, it is uncertain how many women in total were invited, or declined, to participate. Some women, such as nuns and non-Aboriginal retired midwives, were approached individually via phone, email or letter, and their interest in being involved in the research was sought.

There is no established technique for justifying sample size in qualitative research. In this study, the sample size was reached through a consideration of the need to balance practical time frames, budget and travel costs and the concept of data
saturation. Liamputtong and Ezzy (2006) suggest that data saturation occurs when ‘additional information no longer generates new understanding’ (p. 86). The identified number of participants was therefore modified according to the constraints of time when undertaking fieldwork and when saturation of the data occurred. A balance was also sought between the diversity and depth of material collected. For example, rapid data saturation occurred when recording Aboriginal language breast-development terms, but it took much longer for saturation to occur when discussing female-genital terminology. As reported in the findings, there remain some discrepancies between the reported female-genital terms. To compensate for this lack of saturation in the earlier stages of data collection, we sought extraneous opinions from multiple women, which continued to confirm widespread discrepancies in the terms. We continued to consult with more women, and it became clear that the ‘discrepancies’ themselves were actually a marker of saturation. This then allowed us to importantly understand the discrepancies as an artefact of larger cultural impacts on Aboriginal language, which are affecting the transference of intergenerational reproductive knowledge.

Sample

Five separate cohorts of participants were recruited into the research as a whole. These included:

- Cohort 1: senior Aboriginal women with language skills and cultural authority ($n = 19$),
- Cohort 2: young Aboriginal women ($n = 12$),
- Cohort 3: non-Aboriginal former health workers and former residents ($n = 8$),
• Cohort 4: religious non-Aboriginal former health workers \((n = 7)\)

• Cohort 5: Aboriginal former health workers \((n = 8)\).

All Aboriginal women who participated have lived permanently in and come from the Saint Fiacre community. Data generated from the separate cohorts contributed to the findings of the individual papers in different ways. For example, Cohorts 3, 4 and 5 generated data used in the paper titled ‘Paperbark and pinard’. The data generated from the Cohorts 1 and 2 was used in the paper titled ‘Jumping around’. The data generated from Cohort 1 was exclusively used in the findings of the paper titled ‘From \(wanhpanhs\) to wombs’.

Cohort 1 was diverse in age, language, clan group and country affiliation. The women functionally spoke a total of three languages and two dialects and represented 13 separate clan groups (see Table 4.3). The participants in cohort 2 ranged in age from 16 to 33 years and included both mothers and non-mothers. All but one of these young women identified with the Aboriginal age-grades of kardu madinhbuy and kardu palngun (see Table 4.4).

All non-Aboriginal participants were happy to be publicly identified, but their identity has been masked for consistency and to assist with protecting the identity of the research site. Aboriginal health workers were also comfortable in being publicly identified by their Aboriginal name\(^7\), thus offering a screen of outsider identity protection. The former Aboriginal health workers represented eight separate clan groups (see Table 4.5). The combined worker cohorts spanned all the epochs of Saint Fiacre.

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\(^7\) Aboriginal names are now not formally recorded on any government identification documents. In the past, health services in Saint Fiacre recorded the newborn baby’s ancestral Aboriginal name on the birth registration certificate. Common practice was to record it as the baby’s middle name. This Western recording practice has been phased out, but people in their fifties often have their Aboriginal names on official documentation, including their local hospital record. Aboriginal names are the predominant names used to call out and refer to others among the Saint Fiacre people.
Fiacre health provision, ranging from the bark clinic to the square donga clinic (see Tables 4.5, 4.6 and 4.7).

Table 4.3

**Selected Participant Characteristics of Cohort 1: Senior Aboriginal Women with Language Skills and Cultural Authority**

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age now</th>
<th>Clan</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helen</td>
<td>68</td>
<td>Yek Maninh</td>
<td>Maninh</td>
</tr>
<tr>
<td>Georgina</td>
<td>49</td>
<td>Rak Dirrangarr</td>
<td>Wgintjiti</td>
</tr>
<tr>
<td>Catherine</td>
<td>59</td>
<td>Kardu Thay</td>
<td>Kungarlburl</td>
</tr>
<tr>
<td>Shelia</td>
<td>77</td>
<td>Yek Maninh</td>
<td>Maninh</td>
</tr>
<tr>
<td>Abagail</td>
<td>70</td>
<td>Outside Saint Fiacre</td>
<td>Peppermenarti</td>
</tr>
<tr>
<td>Eleanor</td>
<td>66</td>
<td>Kardu Kuna Thimam</td>
<td>Kutchil</td>
</tr>
<tr>
<td>Rose</td>
<td>50</td>
<td>Yek Nadirri</td>
<td>Nardirri</td>
</tr>
<tr>
<td>Anna</td>
<td>72</td>
<td>Wakal Bengkunh</td>
<td>Kubuyirr</td>
</tr>
<tr>
<td>Susan</td>
<td>60</td>
<td>Yek Yedder</td>
<td>Yeddar</td>
</tr>
<tr>
<td>Sue</td>
<td>66</td>
<td>Kardu Kura Thimam</td>
<td>Kutchil</td>
</tr>
<tr>
<td>Janet</td>
<td>82</td>
<td>Rak Palumpa</td>
<td>Pulumpa</td>
</tr>
<tr>
<td>Eucharia</td>
<td>78</td>
<td>Yek Nangr</td>
<td>Nangu</td>
</tr>
<tr>
<td>Mary</td>
<td>77</td>
<td>Yek Nardirri</td>
<td>Nardirri</td>
</tr>
<tr>
<td>Theresa</td>
<td>70</td>
<td>Rak Wunh</td>
<td>Thalmaba</td>
</tr>
<tr>
<td>Josephine</td>
<td>67</td>
<td>Yek Nairdirri</td>
<td>Nadirri</td>
</tr>
<tr>
<td>Louisa</td>
<td>79</td>
<td>Rak Malgin</td>
<td>Mardangu ngame</td>
</tr>
<tr>
<td>Melissa</td>
<td>59</td>
<td>Rak Malgin</td>
<td>Mardangu ngame</td>
</tr>
<tr>
<td>Janice</td>
<td>91</td>
<td>Yek Nangu</td>
<td>Nangu</td>
</tr>
<tr>
<td>Georgina</td>
<td>58</td>
<td>Kardu Diminin</td>
<td>Saint Fiacre</td>
</tr>
</tbody>
</table>
Table 4.4

*Selected Participant Characteristics of Cohort 2: Young Aboriginal Women*

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age now</th>
<th>Age-grade</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Olive</td>
<td>32</td>
<td>Palngun</td>
<td>Yes</td>
</tr>
<tr>
<td>2 Margaret</td>
<td>29</td>
<td>Palngun</td>
<td>Yes</td>
</tr>
<tr>
<td>3 Julia</td>
<td>17</td>
<td>Madinhbuy</td>
<td>No</td>
</tr>
<tr>
<td>4 Anastasia</td>
<td>18</td>
<td>Madinhbuy</td>
<td>Yes</td>
</tr>
<tr>
<td>5 Agnes</td>
<td>21</td>
<td>Madinhbuy</td>
<td>No</td>
</tr>
<tr>
<td>6 Selina</td>
<td>31</td>
<td>Palngun</td>
<td>Yes</td>
</tr>
<tr>
<td>7 Novella</td>
<td>16</td>
<td>Madinhbuy</td>
<td>No</td>
</tr>
<tr>
<td>8 Ursula</td>
<td>20</td>
<td>Palngun</td>
<td>No</td>
</tr>
<tr>
<td>9 Winifred</td>
<td>21</td>
<td>Palngun</td>
<td>Yes</td>
</tr>
<tr>
<td>10 Eden</td>
<td>22</td>
<td>Palngun</td>
<td>Yes</td>
</tr>
<tr>
<td>11 Halena</td>
<td>16</td>
<td>Madinhbuy</td>
<td>No</td>
</tr>
<tr>
<td>12 Madonna</td>
<td>33</td>
<td>Keke</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Table 4.5

*Selected Participant Characteristics for Cohort 5: Aboriginal Former Health Workers*

<table>
<thead>
<tr>
<th>Name</th>
<th>Clan</th>
<th>Country</th>
<th>Health service epoch</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Nganawintharr</td>
<td>Kardu Kuma</td>
<td>Yerrpilam</td>
<td>Tin shed; Sacred Heart Hospital; Square Donga Clinic</td>
</tr>
<tr>
<td>2 Yilimu</td>
<td>Rak Dirrangarr</td>
<td>Nama</td>
<td>Square Donga Clinic</td>
</tr>
<tr>
<td>3 Merridharr</td>
<td>Yek Nadirri</td>
<td>Nadirri</td>
<td>Square Donga Clinic</td>
</tr>
<tr>
<td>4 Magarntarr</td>
<td>Wakal Bengkunh</td>
<td>Karrangu</td>
<td>Tin shed, Square Donga Clinic</td>
</tr>
<tr>
<td>5 Tadiwulili</td>
<td>Yek Yedder</td>
<td>Yeddar</td>
<td>Square Donga Clinic</td>
</tr>
<tr>
<td>6 Thalamba</td>
<td>Rak Wunh</td>
<td>Thalmaba</td>
<td>Tin shed</td>
</tr>
<tr>
<td>7 Tuykem</td>
<td>Yek Nairdirri</td>
<td>Nadirri</td>
<td>Tin shed</td>
</tr>
<tr>
<td>8 Kurdintipip</td>
<td>Kardu Diminin</td>
<td>Saint Fiacre</td>
<td>Square Donga Clinic</td>
</tr>
</tbody>
</table>

Table 4.6

*Selected Participant Characteristics of Cohort 4: Religious non-Aboriginal Former Health Workers*

<table>
<thead>
<tr>
<th>Name</th>
<th>Health service epoch</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Sister Eva</td>
<td>Square Donga Clinic</td>
</tr>
<tr>
<td>2 Sister Maxine</td>
<td>Sacred Heart Hospital, Square Donga Clinic</td>
</tr>
<tr>
<td>4 Sister Naomi</td>
<td>Bark Hospital, tin shed</td>
</tr>
<tr>
<td>5 Sister Erika</td>
<td>Square Donga Clinic</td>
</tr>
<tr>
<td>6 Sister Patricia</td>
<td>Bark Hospital, tin shed</td>
</tr>
<tr>
<td>7 Sister Alana</td>
<td>Square Donga Clinic</td>
</tr>
</tbody>
</table>
Table 4.7

*Selected Participant Characteristics of Cohort 5: non-Aboriginal Former Health Workers and Former Residents*

<table>
<thead>
<tr>
<th>Name</th>
<th>Community role</th>
<th>Health service epoch</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Amanda</td>
<td>Health worker</td>
<td>Square Donga Clinic</td>
</tr>
<tr>
<td>2 Michelle</td>
<td>Health worker</td>
<td>Square Donga Clinic</td>
</tr>
<tr>
<td>2 Natalie</td>
<td>Health worker</td>
<td>Government Clinic</td>
</tr>
<tr>
<td>4 Claire</td>
<td>Health worker</td>
<td>Square Donga Clinic</td>
</tr>
<tr>
<td>5 Monica</td>
<td>Health worker</td>
<td>Sacred Heart Hospital</td>
</tr>
<tr>
<td>6 Carrolyn</td>
<td>Mother &amp; homemaker</td>
<td>Square Donga Clinic</td>
</tr>
<tr>
<td>7 Jane</td>
<td>School teacher</td>
<td>Sacred Heart Hospital</td>
</tr>
<tr>
<td>8 Georgie</td>
<td>Health worker</td>
<td>Square Donga Clinic</td>
</tr>
</tbody>
</table>

**Ethics**

*Gatekeeping and gaining community permission.*

To meet formal ethical obligations, an application was submitted, assessed and approved by the Menzies Health Research Committee and a sub-committee dealing specifically with research in Aboriginal communities (Application # HR-10–1429) (see Appendix 1). Letters of support from the community were obtained before the research commenced and were included in this application (see Appendixes 5 and 6).

Gaining permission from the community was a complex process involving adherence to cultural protocols because the research was about women’s business. On advice from my cultural mentor, Mrs Narjic, I was asked to begin the process in 2009 by talking with senior Kardu Diminin women and a traditional landowner of Saint Fiacre, Mrs Theodora Narndu. I was fortunate to have a pre-existing
relationship with Mrs Narndu from previous community consultations when I worked at the clinic. As a traditional landowner, Mrs Narndu was at this time the culturally appointed senior woman for the Kardu Diminin people, responsible for approving and managing women-centred enquiries concerning Saint Fiacre. Although there was also a senior male traditional landowner, discussions were only held with Mrs Narndu because our project was concerned with women’s business. Mrs Narndu was the research gatekeeper, and I required her support, permission and blessings to proceed. Despite technology advancements, person-to-person communication is still the only way to do business in Saint Fiacre. It was therefore necessary to fly in and be physically present in the remote town to undertake these discussions.

Negotiations and discussions were undertaken on several occasions with Mrs Narndu. As the research also involved recording stories of historical significance, it was suggested that discussions should also occur with the Kanamkek-Yile Ngala Museum in Saint Fiacre. Community museum archivist Mr Mark Crocombe, who is respected as a cultural custodian in the community, was approached and the research discussed. It was important to provide a lengthy period for my proposal to be reviewed and discussed. Mrs Narjic, Mrs Narndu and Mr Crocombe gave written support and permission for me to undertake the research. It took around 10 months from our first discussions to signing the letters of support. This opportunity to provide adequate decision-making time and not rush has been important to other researchers when gaining access to work in Indigenous communities (Meadows, Lagendyk, Thurston, & Esiner, 2003).

Community permission is based on relationship. It has not been a ‘one-off’ confirmation but rather a continuous process of checking, rechecking and validating
my ongoing permission to proceed. My ability to proceed has continuously been judged by my character, behaviour and actions while in the community. My behaviour in this relationship needed to honour both the community’s cultural protocols and those ethical obligations set before me by my university and the ethics committee. Smith (1999), in discussing gaining permission, suggests:

> Consent is not so much given for a project or specific set of questions, but for a person, for their credibility. Consent indicates trust and the assumption is that the trust will not only be reciprocated but constantly negotiated—a dynamic relationship rather than a static decision. (p.136)

Although Smith’s (1999) comments were intended for an audience of Indigenous researchers, her advice is well suited to a non-Aboriginal researcher working with Aboriginal people.

**Participant consent process.**

All non-Aboriginal participants were given a participant information sheet (see Appendix 7) to keep and a consent form (See Appendix 9) to complete. After reading the forms, opportunities to ask questions were given, and participants were then asked to give their written consent. In some instances, participants were located a long distance away and participated via email or telephone. In this situation, participants were asked to confirm their consent via email or record it verbally. I checked off each section of the consent form in consultation with them during this process.

**Participant consent process in Saint Fiacre.**

In Saint Fiacre, the process for gaining consent was modified to ensure that participants clearly understood the research. It is recognised that many people in
Saint Fiacre have low literacy skills (Taylor, 2010); for this reason, women had the choice of receiving a paper copy of the participant information sheet or listening to a recording of it in Murrinh Patha, the dominant language spoken in the community (Ford & McCormack, 2007; Street, 1987). All women opted to listen to the recording, and only one woman wished to also have a paper copy. Aboriginal research assistants skilled in Murrinh Patha and English assisted in bridging communication gaps with participants, many of whom were not skilled in English or preferred to converse in their own first language. Opportunity was also given for participants to discuss the recording among themselves. Recording participant information sheets into an Aboriginal language to assist with the process of gaining consent is a technique that has been used by other researchers in remote Australian communities (Chenhall, Senior, & Belton, 2011, p. 15).

The recording was either played to individual participants via a digital MP3 player and headphones or, most often, to a group via a stereo amplifier and speakers. Using the stereo was a particularly helpful technique because I was able to increase the volume for those participants with hearing difficulties. It was common for participants to have hearing difficulties, due sometimes to advancing age but also to the high burden of inner ear disease common in remote Australian Aboriginal communities. All women opted to hear the recording; therefore, only verbal consent was given and the consent form signed by a witness. Other researchers working with illiterate women and in cross-cultural settings have found that verbal consent is the most sensitive and appropriate way to gain informed consent from participants (Liamputtong, 2010; Meadows et al., 2003).
Recording the participant information sheet.

The task of recording the participant information sheet into Murrinh Patha, to use in the consent process, was lengthy and complex. I initially approached a qualified translator with the original participant information sheet approved by the ethics committee as meeting the standards of plain English. The translator declined the work, stating, ‘I feel the task would become more achievable if forms were rewritten in plain English first’ (Rachael.M, personal communication, June 11, 2011). This highlighted tensions on a continuum between what Guillemin and Gillam (2004) describe as procedural ethics and ethics in practice. Guided by reflection on my ethical obligations to my participants and the need for clear communication, I realised I needed to translate the ethics committee version of plain English into ‘Aboriginal plain English’. I began this process by identifying the parts of the information that were the most crucial to communicate and created a checklist of them:

- who I am and what I want to do
- the type of data that I would like to collect
- how I will collect the data
- participation is not compulsory
- how I will store the data that I collect and what it will be used for
- personal identification is optional
- withdrawal at any time is OK, even if you say yes at the beginning
- grievance procedure and what to do if I am doing things wrong.
I employed a female Murrinh Patha translator from the Aboriginal Interpreter Service, Darwin. As the work involved women’s business, the gender of the translator was crucial, and I was required to adhere to common cultural gender division protocols. Guided by the translator’s advice, we used my checklist to create a plain Aboriginal English document with first-person narration to explain the research. Once this was drafted, we reviewed the document, highlighting any words that could not be directly translated into Murrinh Patha, words such as ‘confidential’, ‘nurse’ and ‘university’. We needed to decide whether the word could be read aloud in English or whether it would require further explanation in Murrinh Patha. Obviously, it would be crucial to explain words such as ‘confidential’ but less important to explain the word ‘nurse’ because people in Saint Fiacre comprehend and use this English word. We then collaboratively checked for concepts or ideas in the participant information sheet that could be misunderstood. This was important because our topic involved sensitive information about sexuality and childbirth. In one instance, we were using the term ‘playing up’ to describe bad or unethical research conduct. However, this was abandoned when it became clear that it was possible for the term to be misinterpreted as the researcher behaving in a sexually promiscuous manner.

When we had refined the document, we were ready to record it on a digital Dictaphone. It was decided unnecessary to record the English and Murrinh Patha together, because it would make listening to it cumbersome and lengthy. We recorded the document in individual paragraph ‘takes’. The translator preferred me to read aloud one paragraph at a time. I would then press record and she would make the Murrinh Patha translation. If we made a mistake, which we did a few times, we only needed to rerecord the single paragraph and not the entire document. Once we
had the paragraphs recorded, I downloaded free software to stitch the separate recordings into one audio file. This resulted in a recording that was five minutes and 13 seconds in length, which could then be used in the process of gaining informed consent.

**Data collection and translation.**

As part of the process of informed consent, permission was sought from participants for research data to be collected in a variety of ways. Data collection methods included written notes (paper and pen), audio recordings and drawings on paper, videorecordings and photographs. Participants were also asked to indicate their preference regarding data use in the event that they passed away. This questioning is important to ensure respect for the cultural wishes of some Aboriginal people who may believe it is disrespectful to talk about or see pictures of people who have since passed away.

Aboriginal participants were given the option to choose the language in which they wanted to discuss and record their contributions. Many women’s motivation for participating in the research was their wish to have their knowledge and experiences kept safe for future generations; therefore, they preferred to record in their first Aboriginal language. This was both encouraged and respected. Data generated in or with mixed Murrinh Patha narration underwent simple translation at the time of collection, either by Aboriginal research assistants or cultural mentor Mrs Narjic. At a later time, the same data recordings were translated by a female interpreter from the Aboriginal Interpreter Service, Darwin. The same interpreter was booked for each job, which allowed consistency for data to be triangulated.
Sacred and secret data.

Participants identified different layers of access to the data that was generated. This ranged from general public access to gender-restricted access and closed access. Consultancy on access to the material was undertaken at every step of the research process and in collaboration with cultural mentor Mrs Narjic. To honour these ethical obligations, this thesis has a gender-restricted and closed section, according to the specific wishes of the participants, local reference group and cultural mentor.

Location of identity.

Throughout this research process, there has been tension concerning the identification of the research site. Although current convention suggests it is best ethical practice to conceal the identity of the research site, this is practically fraught in my research approach, which is both ethnographic and historical. The rich descriptions produced in an ethnographic account and the need for substantial factual detail in a historical account often means that little effort may be required to deduce the research site location. This possibility has been openly discussed with participants. They were comfortable about the chance of this happening and know that if ever publicly questioned I will never confirm the research site. Conversely, some of the participants expressed regret that I would not be telling the ‘whole’ story because they would like to be publicly acknowledged for their positive contributions, as Aboriginal health workers, to the Saint Fiacre community. All mention of the research location in the reference list has been omitted.

Limitations
All research suffers from some limitations, which affect its reliability and generalisability. This research is threatened by the limitations of size and gender.

Size.

Qualitative research collects very rich, detailed, specific information from a small number of people and settings. Patton (1990) cautions that although this results in a deeper understanding of the people and setting being researched, it may further reduce the social generalisability outside the research context. This is clearly a limitation of this research, which was undertaken in one community. However, it is also important to note that Saint Fiacre is one of the largest remote Aboriginal towns in Australia. Its relative size, compared with otherwise much smaller communities, allowed a diversity and depth of data to be collected that would not have been possible in a smaller town. This could make the research results useful for other remote Aboriginal communities and health services and, if so, would enhance the social, but not statistical, generalisability.

Gender.

Liamputtong and Ezzy (2006) suggest that the gender of the researcher is an important influence on the conduct of fieldwork and the representations of the people being studied. This project is limited by its gender bias because only women were invited to be participants. The research, along with my community presence while undertaking fieldwork, was supervised and mentored by senior Aboriginal women, who told me it is not appropriate that I research the role of men. The project methodology was endorsed by the women of Saint Fiacre within a traditional cultural framework that enforces gender divisions. It would have been disrespectful and unethical for me to work outside of these community-established guidelines. Clearly
though, Aboriginal men have an important role and large influence on women’s fertility and reproductive health.

**Conclusion**

This chapter has outlined the research orientation, theoretical framework, methodology, ethical concerns and limitations. It has explained how and why the research was done in the manner undertaken. The challenges and the opportunities of qualitative cross-cultural research have been explored in the context of my research with women in Saint Fiacre. The chapters that follow are the four separate submitted papers. As this is a thesis by publication there is some redundancy, which is unavoidable.
Chapter 5:

Paperbark and Pinard: A Historical Account of Maternity Care in One Remote Australian Aboriginal Town

Statement of Authorship

By signing the Statement of Authorship, each author certifies that their stated contribution to the publication is accurate and that permission is granted for the publication to be included in the candidate’s thesis.

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<td>2) Suzanne Belton</td>
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<td>3) Ann McGrath</td>
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<td>4) Sherry Saggers</td>
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<td>5) Concepta Wulić Narjic</td>
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Figure 5.1. Statement of Authorship for publication: ‘Paperbark and pinard: A historical account of maternity care in one remote Australian Aboriginal town’.
Paperbark and Pinard: A Historical Account of Maternity Care in One Remote Australian Aboriginal Town

Authors: Sarah Ireland, Suzanne Belton, Ann McGrath, Sherry Saggers and Concepta Wulili Narjic

Abstract

Background and Aim: Maternity care in remote areas of the Australian Northern Territory is restricted to antenatal and postnatal care only, with women routinely evacuated to give birth in hospital. Using one remote Aboriginal community as a case study, our aim with this research was to document and explore the major changes to the provision of remote maternity care over the period spanning pre-European colonisation to 1996.

Methods: Our research methods included historical ethnographic fieldwork (2007–2013); interviews with Aboriginal women, Aboriginal health workers, religious and non-religious non-Aboriginal health workers and past residents; and archival review of historical documents.

Findings: We identified four distinct eras of maternity care. Maternity care staffed by nuns who were trained in nursing and midwifery serviced childbirth in the local community. Support for community childbirth was incrementally withdrawn over a period, until the government eventually assumed responsibility for all health care.

Conclusions: The introduction of Western maternity care colonised Aboriginal birth practices and midwifery practice. Historical population statistics suggest that access to local Western maternity care may have
contributed to a significant population increase. Despite population growth and higher demand for maternity services, local maternity services declined significantly. The rationale for removing childbirth services from the community was never explicitly addressed in any known written policy directive. Declining maternity services led to the de-skilling of many Aboriginal health workers and the significant community loss of future career pathways for Aboriginal midwives. This has contributed to the current status quo, with very few female Aboriginal health workers actively providing remote maternity care.

**Keywords:** midwifery, history, remote, Aboriginal women, Australia, ethnography

**Introduction**

In Australia’s Northern Territory, Indigenous women account for 36% of all mothers. Of these women, the majority (64%) live in rural and remote areas, unlike the majority of non-Indigenous mothers, who live in regional areas (95%).\(^1\) Aboriginal women in remote areas are the least likely of all Australian women to have choice and control over their pregnancy care, choice of care provider or planned place of birth.\(^2\) Currently, remote maternity services recommend the routine evacuation of all pregnant women into regional areas to give birth in hospital, with only antenatal and postnatal care offered in the woman’s home town.\(^3\) Prior to the regional centralisation of maternity services, Aboriginal women in some communities elected to give birth in their community-based health clinic. These clinics were closely aligned to contemporary definitions of a primary maternity unit\(^4\); maternity care was provided by midwives and Aboriginal health workers without on-site obstetrical, anaesthetic, laboratory or paediatric support.
It has been demonstrated in other parts of the world that primary maternity units can provide equitable and accessible maternity care to women with low-risk pregnancies\textsuperscript{4} and also culturally safe and empowering maternity care to women from an all-risk Indigenous population, without compromising safety.\textsuperscript{5,6} In the absence of clear evidence demonstrating an improvement in perinatal outcomes from the centralisation of maternity services,\textsuperscript{2,7} the re-introduction of primary maternity health services to support childbirth in select remote Aboriginal communities has been suggested as one way of addressing Aboriginal maternal and infant health inequity. It has also been proposed as a way of satisfying the long-standing requests of Aboriginal women to give birth on their ancestral home country.\textsuperscript{7–10} Despite this, there is a dearth of literature that historically contextualises changes to remote maternity services in the Northern Territory. Historical perspectives on maternity care are important because by gaining a deeper understanding of the past, clinicians, researchers and policy makers can better manage and respond to the challenges that can occur when developing and maintaining midwifery-led maternity services.\textsuperscript{4} Our purpose with this paper is to historically contextualise the changes to maternity care in remote areas of the Northern Territory. To do so, we use as a case study the maternity health care experiences of women and health practitioners in one remote Aboriginal township from pre-colonisation to 1996.

**Research Site**

The research site is a remote Northern Territory Aboriginal township named *Saint Fiacre* (pseudonym). Aboriginal people have lived in this area for hundreds of generations, representing many thousands of years of continuous occupation. In the years preceding the establishment of a religious mission, people in the area experienced vicarious contact with Europeans via an Aboriginal trade route.
supplying foreign substances: tea, tobacco, sugar, cloth and metal. Ceremonial and trade travellers visiting the nearby colonial capital had been exposed to the English language and, over time, a few returned home with the ability to comprehend and speak the new tongue. In the early 1930s, as the pressure of colonisation increased, neighbouring tribes began to disintegrate, posing a threat to the tribal lands of others and leading to widespread conflict, disarray and fear. The encroaching colonisation weakened the people in the Saint Fiacre region; their social reality and order was unravelling at the edges.

In the mid-1930s, the Catholic Missionaries of the Sacred Heart established Saint Fiacre as a mission at a temporary coastal location until some years later when it moved to a permanent inland site. There was no hostility recorded towards the all-male missionaries, whose supply of foreign goods such as tea and tobacco were openly welcomed. The mission catered for Aboriginal people who belonged to the area’s 23 clan groups and represented several separate languages. The people organised themselves socially into a complex kinship network with associated ceremonial obligations and broadly divided themselves into the ‘saltwater’ and ‘freshwater’ people. The permanent site of the mission was on the traditional lands of one clan, which resulted in gradual linguistic intimidation and assimilation until one Aboriginal language came into dominance. With inadequate supplies and resources to support the whole population, the mission ran a rotating roster, whereby groups of people belonging to the same clan took turns to work and receive rations from the mission. When not in attendance at the mission, they returned to their clan estates and lived as they had done so before the mission started. Nuns from the Catholic order Daughters of Our Lady of the Sacred Heart were employed briefly in the months prior to the Second World War but were evacuated due to wartime concerns.
about their safety. The nuns returned immediately after the war and contributed to
the mission community by providing, among other services, mainstream biomedical
health care and Western education.

Today Saint Fiacre remains one of the largest and most remote Aboriginal towns in
the Northern Territory. The regional referral centre is approximately a one-hour
flight away, and the community remains inaccessible by road during the wet
monsoon season. A community health centre, financed and run by government,
services the health needs of the town. Despite the existence of a purpose-designed
childbirth room in the health centre, no planned births occur there.

**Gaining Permission**

Working with permission from and in partnership with Aboriginal women, this
research forms part of a doctoral study investigating women’s health. Ethical
approval for the research project was granted by Charles Darwin University and the
Menzies School of Health Research Ethics Committee with a subcommittee dealing
specifically with Aboriginal research (Application #HR-10–1429). Letters of written
support were obtained from the community. A local reference group comprising
senior women community leaders, Aboriginal health workers and other interested
individuals oversaw the overarching project. The local reference group provided
support, advice and direction throughout the research process, including with the
research objectives and methodologies.

Concepta Wuilili Narjic has been the cultural mentor for the project, providing
leadership and advice on all aspects of Aboriginal research methodology and
recruitment. Several Aboriginal research assistants who live permanently in the
community were recruited, trained and paid to assist with data collection. Due to the
sensitive topic of reproduction, they requested anonymity; however the cultural mentor is comfortable with being publicly identified.

**Methods and Participants**

This historical ethnographic study, completed during a six-year (2007–2013) relationship with the community, involved iterative cycles of data collection. Research rigour was ensured by collaboration with Aboriginal women, prolonged community engagement, triangulation of research methods and participant validation.\(^{12}(pp23–29)\) Data collection methods included ethnographic fieldwork in the community; community observation and participation; field site visits to buildings and places of historical significance; written field notes; and semi-structured interviews with retired Aboriginal and non-Aboriginal health professionals. During the semi-structured interviews, the interviewees used a theme guide to elicit the health workers’ recollections of scope of practice, clinical experiences and training.

We also conducted an archival review of collections held at the local community museum, Northern Territory; Daughters of Our Lady of the Sacred Heart Convent, Kensington, New South Wales; and the Australian Institute of Aboriginal and Torres Strait Islander Studies, Canberra, Australian Capital Territory.

Non-Aboriginal participants were identified via archival material and word-of-mouth suggestions offered to the first author, who then approached potential participants to seek their participation. They were given written information, and consent to an interview (in-person, phone or email) was sought and gained. Only one participant declined to be interviewed due to her poor health and advancing age.

Aboriginal participants were recruited by the fifth author with the assistance of the Aboriginal research assistants and the local reference group, who used the ‘message
stick’ sampling technique to verbally invite potential Aboriginal participants to the research. This method has been successfully used in previous research in a remote Aboriginal community. Message sticks purposively recruited female health workers who had been involved in the provision of maternity care. The technique involved a verbal message stick of invitation to participate. If a potential participant responded positively to the message stick, the non-Aboriginal researcher was introduced to her and the woman consented to be involved in the research. Due to this method of recruitment, we are uncertain how many women were invited and how many declined to participate. An audio recording of the project information sheet and consent form was played to all participants in their first Aboriginal language. Depending on the participants’ literacy levels and personal preferences, either written or verbal consent was gained. The fifth author and/or an Aboriginal research assistant witnessed the consent process and documented it in writing on a consent form.

**Analysis**

The data were sorted chronologically, from past to present. Although year dates were used as often as possible, many of the Aboriginal participants’ perceptions of time were not delineated according to Western calendar years. Instead, many used significant personal life events, such as the birth of their children or the arrival or departure of work colleagues, to describe and mark the Western concept of time. Throughout the research process with Aboriginal women, the first author, where possible, attached these markers of time to known datable events, such as the date of birth of a child, and then linked them to Western chronology.

Once the data were chronologically sorted, four distinct health-service eras were apparent: (1) Wrapped in Paper Bark: Pre-colonisation-1946, (2) Bark Clinic and a
In total, we recruited 23 females to participate in the project. This included retired female Aboriginal health workers \( (n = 8) \), non-Aboriginal female health practitioners \( (n = 7) \), previous community residents \( (n = 2) \) and religious non-Aboriginal trained health practitioners employed under the auspices of the Catholic mission \( (n = 6) \).

**Wrapped in Paper Bark: Pre-Colonisation–1946**

This first era of maternity care, characterised by Aboriginal-led midwifery, spanned from pre-colonisation to 1946. Prior to the establishment of the mission, Aboriginal-led midwifery care had been in practice for countless generations, spanning many thousands of years. According to Aboriginal research participants and local oral history recordings, caregivers were the community’s *kunugunu*—older women. Known and familiar to the pregnant women, these women were skilled in providing maternity care. Those who looked after women during labour and birth were known more specifically as *wakalmanthirriyegarl*, or midwives. Midwives had a culturally constructed role, and they were publicly identified by amputation at the distal phalange of their right index finger. The amputation was expertly conducted by winding the coarse thread of a spider’s web between the nail’s end and the first joint,
which constricted the flow of blood leading to a process of gangrenous auto-amputation.

Midwifery care normally occurred in the country clan estate of the woman’s husband, where the woman resided after marriage. The *kunugunu* were experienced in recognising the earliest signs of pregnancy as the darkening and enlargement of the breast nipples, subtle changes in face shape and colour changes to the skin creases on a woman’s neck. They kept a close watch over women during pregnancy, enforcing food taboos to ensure the wellbeing of the foetus and to prevent excessive maternal bleeding after childbirth. Behaviour restrictions ensured the woman’s spiritual safety from a mythological creature. Childbirth was a gender-restricted event, with only females present. A secluded birth-camp was constructed, providing basic shelter, privacy and warmth. Childbirth occurred in an upright position, with the parturient woman kneeling over a prepared, bark-lined pit in the ground. The *wakalmanthirriyegarl*, midwife, knelt behind the labouring woman in a supportive position, named in an oral history recording\(^\text{14}\) as *pumantherriabath*, and kneaded the labouring woman’s lower spine and sacrum with her bent knees. When the birth of the baby was imminent, another female attendant sat at the front of the woman and offered encouragement until the baby was born through the force of gravity and maternal contractions, sliding unassisted into the pit. The umbilical cord was cut and, depending on the practice of the midwife, sometimes tied with bush string. The placenta was born in the same manner and then disposed of, along with the surrounding soiled paperbark lining, by burial in the same pit. Post-partum care ensured that the woman had rest, nutritious food and adequate hydration, but also that she adhered to post-partum dietary restrictions. Adequacy of breastmilk supply
was monitored, lactation advice offered and two sentinel rites of passage ceremonies performed for the baby and mother in the immediate post-partum period.

These practices, reported by Aboriginal participants, suggest that Aboriginal midwives were skilled in creating an environment that would promote normal physiological vaginal birth for a labouring woman. Aboriginal midwifery practice was characterised by a physically and emotionally safe birth-camp; physical warmth and comfort; non-pharmacological pain-relief techniques such as active walking, heat, massage and psychosocial support; an upright birth position with parted legs to increase the dimensions of the pelvic outlet; and minimal interference or examination of the perineum during parturition. Their practice certainly decreased the risk of iatrogenic complications such as puerperal sepsis from repeated vaginal examination, but left a midwife with few interventions for managing obstetric emergencies. Two emergency interventions reported by Aboriginal participants were painful ant bites to encourage respiratory effort in a non-rousable newborn and the midwife using her amputated finger stump as an instrument for clearing an infant’s occluded airway.

For the most part, midwives and older women providing maternity care made use of resources found in the natural environment; Aboriginal participants identified different usages of species according to the environmental location. Participants reported rocks, various species of juvenile shells and, later, traded foreign metal razor blades as being used for cutting the umbilical cord. Bush string, made from twisted plant fibres, was also sometimes used to constrict the umbilical cord. According to a local oral history recording, the stump was kept dry after birth by dabbing it with a botanical medicinal powder, and the baby’s skin was rubbed in a protective emollient of animal fat and red pigment to reduce the chance of skin infection. All interviewees and sources indicated that various species of paperbark
were an important resource used in numerous ways during and after childbirth: as a maternal heat pack to soothe and comfort, as a soft and absorbent liner for the birth-pit and the surrounds upon which a labouring woman would kneel, as a blanket to wrap the infant and woman, and for baby carriers. Breastmilk supply could be enhanced by consuming mangrove worms. According to Aboriginal participants, the ceremonial skills of the *kunugunu*, supported physical healing and the ongoing emotional resilience and wellbeing of mother and baby. If used, mission-acquired foreign medical resources were basic. According to a government inspection report, medical equipment included common ailment treatments in use by the mission priest, such as castor oil, turpentine, magnesium sulphate, iodine, quinine, bandages and dressings, but no surgical instruments. There was no hospital or infirmary building.

Maternal care practices were self-governed and socially constructed, with people’s cultural beliefs and practices influencing and determining midwifery decisions and actions. Childbirth was a gender-exclusive event; men were strictly prohibited. There is some evidence that after the establishment of the mission the founding priest-in-charge may have assisted women during obstetric emergencies. The priest had no medical background, but at least two Aboriginal women recounted that he was ‘a father, nurse, doctor and midwife too’. An anonymous archival letter suggests he had undertaken some training to assist in difficult births. Given the established gender exclusiveness of Aboriginal midwifery, it is remarkable that the male priest intervened in some women’s pregnancies and birth. This narrative may well be inaccurate; alternatively, as a non-Aboriginal male ‘outsider’ and a religious representative the priest may have been able to transgress lawful boundaries without punishment or negative consequence. Despite the uncertainty over his role in obstetric care, it is certain that he undertook the treatment of a range of health
problems, such as the tropical illness of ‘yaws, sores, wounds and diseases of all sorts’.\cite{16,18(p4)}

Pregnancy and childbirth were placed within a lifecycle approach that acknowledged as normal, an inherent but necessary risk in reproduction. Great agency and autonomy was placed on a foetus through the belief that pregnancy was the result of a pre-existing ‘spirit child’ making its presence known to its intended mother and father. Some spirit children, called \textit{wakal mulunthuna}, were conceived from the hiding place of leaves and were undesirable, resulting in one type of pregnancy in which the foetus was deemed \textit{wakal wiye}—a bad, wrong or diseased foetus.\cite{19} Often the \textit{wakal mulunthuna} were conceived by single young women and, the spirit child having never made their presence known to a man, were fatherless. Multiple births were also perceived as problematic and were economically challenging for a nomadic family. According to narratives shared by Aboriginal participants, often the midwife encouraged only one of such babies to live, usually choosing the largest and healthiest of the siblings. In both situations, soon after birth the unwanted baby was buried in the earth. Abortion practices, such as self-inflicted trauma to the abdomen, were known as resulting in the wilful death of a foetus but these were perhaps less frequently practiced than infanticide.

**Bark Clinic and a Tin Shed Hospital: 1946–1965**

The second era of maternity care saw the arrival of the first medically trained mission staff nun in 1946 and the establishment of health-designated buildings in the mission village. The era was characterised by the colonisation and displacement of Aboriginal-led midwifery and the caring roles of \textit{kunugunu}—older women, and the \textit{wakalmanthirriyegarl}—midwife. These distinct roles were eventually taken over by
middle-aged Aboriginal females working as birth attendants under the instruction and supervision of formally trained Western nurses and midwives who also worked as nuns in the mission. There was a gradual transition in the changeover of primary maternity caregivers, which coincided with the construction of health-designated buildings in the mission village. By the early 1960s, the *wakalmanthirriyegarl* was no longer in practice; instead, all childbirth care was provided by religious nurses and midwives working alongside Aboriginal birth attendants in the hospital. When on duty, Aboriginal birth attendants were required to wear a white pinafore uniform over their mission-issued ‘calico’. Mission policy required all females while staying in the mission precinct to cover their genitals with ‘calico’, a rudimentary skirt often made from repurposed flourbags or sugarbags.

During the transition period, Aboriginal-led maternity care and Western maternity care alternated and fused. The mix of care depended on the pregnant woman’s bush-to-mission rotating work roster and her proximity to the mission, where she could access Western health care. In the late 1940s, after the substantial hospital building was established, bush camp births were quickly superseded, with women preferring to give birth inside the mission hospital. During late pregnancy, in preparation for giving birth, women camped close to the hospital and abstained from being out bush. According to non-Aboriginal participants, Western pregnancy care included basic biomedical surveillance including checking blood pressure, measuring the fundus, auscultating the foetal heart using a pinard stethoscope and assessing the mother’s general wellbeing. Childbirth occurred behind a screened partition in the corner of the women’s ward on a Western bed that encouraged the adoption of a medicalised supine position for birth; however, some women who had previously experienced
childbirth in a bush camp squatted on the bed. The third stage was physiological and blood loss was carefully assessed.

The Western midwives were skilled from their metropolitan Australian hospital-based training to deal with a range of obstetric emergencies. One Aboriginal health worker recalled the medical equipment including three metal syringes (sizes 1, 3 and 5 cc) with four reusable needles of each size, kerosene-powered refrigerator for storing medicines, stethoscope, sphygmometer, thermometer, uterotopic drugs, weight scales, oxygen, basic surgical instruments and a range of antibiotics. Cotton gauze strips were boiled, sterilised, ironed and then used to constrict the umbilical cord before cutting with a metal razor blade. After birth the mother was washed, fed and encouraged to stay in the hospital for some days to recover from the exertion of childbirth. Through an apprenticeship model of training, the Aboriginal birth attendants became skilled in Western care techniques, and in interviews, the nuns praised them for their reliability, efficiency and ability to learn new skills.

The wireless radio in the priest’s house could be used to communicate with hospital and medical staff in town, but the reception was often poor due to the weather. Women with foreseeable childbirth problems were encouraged to leave Saint Fiacre before the onset of labour and in acute obstetric emergencies, aeromedical evacuation was possible. However, both acute and non-acute evacuations were very infrequent because, according to non-Aboriginal participants, women were fearful of their safety in town and would only agree to transfer if the circumstances were dire.

The first health-dedicated building was in a rudimentary shelter known as the Clinic Pirru—Bark Clinic, constructed from stringy-bark sheeting and locally milled timber. There was only basic shelving for storing dressings and medicine. With no
separate rooms or privacy in the Clinic Pirru, women continued to give birth out bush in clan country estates or at camps in the mission village. According to interviews with founding health staff, clinic staff attended village births rarely during the early mission era. They did so only on request from a woman’s family if she was experiencing hardship. By 1950, the Tinshed Hospital had been created from two prefabricated corrugated-iron Sidney Williams huts, which were surplus from wartime. Sidney Williams huts, also known as Comet huts, were used by the thousands in remote Australia because they could be transported as flat packs, were easily dismantled for use at an alternative location and, being constructed from corrugated iron and steel, could withstand extreme tropical weather and termite attack. Aboriginal and non-Aboriginal health workers recalled the huts as joined with a central partition, allowing for a lockable storeroom for medical supplies. The separate huts had gendered entrances and accommodated a ten-bed ward for females and children on one side, and a five-bed male-only ward on the other. For the first time, the female-only ward created the physical space and privacy necessary to allow childbirth to move from an outdoor bushland location to an inside hospital setting. A screened partition constructed from bark sheeting and hung cotton in the corner of the room served as the labour ward. The floor was earthen, made from a compressed termite mound; this was later improved upon with a concrete-slab floor. The uninsulated building was exceedingly hot in the tropical climate, and there was only a portable battery-powered fan to ease a labouring woman’s discomfort from the heat. A generator-powered single electrical bulb could be used to light the ward at night, but more frequently kerosene lanterns were used.

Medical surveillance and Western midwifery care was augmented by prayer and saint veneration, perceived by both Aboriginal and non-Aboriginal women alike to
enhance the safety of a labouring woman in the Tinshed Hospital. During a woman’s labour, the Aboriginal birth attendants honoured Saint Gerard Majella (patron of expectant mothers). On the arrival of a maternity case, the attendants would light a lantern or candle under a statue of the saint, which was positioned on a small ledge in the corner of the labour ward. According to one of the elderly nuns interviewed, she introduced this practice after her midwifery training at Saint Margaret Hospital, Sydney. During her training, veneration of Saint Gerard had been routine in caring for women in labour. The cotton curtains that shielded women during labour not only provided for modesty but also spiritual prophylaxis from the risks of childbirth, with a large red hand-embroidered appeal on the curtains: ‘St Gerard, pray for us’.22

Maternal health practice at this time was dominated by the values and beliefs of Catholicism and the Western biomedical model. Catholic values were pro-natal and encouraged reproduction, with the mission giving a bonus ration to parents upon the birth of their baby. In 1953, the parents received ‘tobacco three sticks each, one pipe each, one mirror each, one comb each, one calico each’ and the baby received ‘baby clothes etc, provided by the sister in charge of hospital’. The bonus rations not only encouraged reproduction but also provided an incentive for women to give birth in the hospital setting. According to research participants, neither contraceptives nor contraceptive advice were offered, and the nuns, believing that abortion and infanticide practices were immoral, excluded them from maternity care. Western biomedical knowledge allowed screening of pregnant women, with one nun reporting that the preferred practice was for all ‘foreseeable obstetrical’ problems to be managed outside the remote setting of Saint Fiacre. If the midwife had cause to worry about a pregnant woman, the woman would be referred and sent by plane for medical care in town.
The Sacred Heart Hospital: 1967–1980

The third era of maternity care was characterised by a purpose-built health building, which opened in 1967. Aboriginal participants reported that the building was known as the Sacred Heart Hospital, a reference to the religious order of the nuns who staffed the hospital. The first piece of infrastructure designed to cater for the growing health needs of a burgeoning mission population, the Sacred Heart Hospital included a one-bed labour ward and a two-bed post-partum recovery ward. After the construction of this building, Western midwifery care in a local hospital setting dominated throughout the era. Maternity care continued to be provided by Western-trained non-Aboriginal midwives and Aboriginal birth attendants; however, now the religious nuns also worked alongside non-religious and lay nurses and midwives employed as hospital staff. Aboriginal birth attendants were given a broader role at the new hospital, with extended responsibilities as generalised Aboriginal health workers. This role was esteemed within the community and, according to Aboriginal participants, encouraged by the nuns as a favoured vocation for young women after leaving school. The female Aboriginal health workers’ uniform was a zip-front full-length blue dress, cut below the knees. All women living at the mission had now adopted Western-styled feminine clothing, which covered their genitals, breasts and torso, and they no longer used the mission-issued ‘calico’ to conceal their body.

Archival research and interviews with Aboriginal women have demonstrated that during this era, mission policy dictated that young children were to be reared in a dormitory system removed from parental care. By now, the younger women apprenticed as Aboriginal birth attendants had been reared in this style and received structured Western schooling, which had resulted in higher levels of English literacy and numeracy. Influenced by their religious upbringing, numerous Aboriginal
teenage girls aspired to be jointly trained as both nun and health worker. According to Aboriginal participants, many of these teenagers attempted the training but only two were successful in becoming religious health workers; the local community knew them as *Chista thipman*—black sisters.

Maternity care was now colonised, and Western care dominated. The people of Saint Fiacre no longer had a bush-to-mission rotating roster but instead resided permanently in very basic corrugated tin shelters in the village precinct. Pregnant women’s health was monitored, and medical screening was undertaken by fly-in fly-out male medical officers. Consultation between doctors, the pregnant woman, family members and hospital staff allowed planning for some births in town. Although the airstrip was unsealed and unlit, landing remained possible during all seasons, albeit with some difficulty at night. Pathology screening of body fluids was introduced, including screening for blood-borne sexually transmissible diseases. In such cases, appropriate treatment was given. An increasing range of medicinal drugs was available, which included uterotropic drugs, antibiotics, opioid analgesia and childhood immunisations. Venous and neonatal umbilical cord cannulation was practiced for advanced resuscitative procedures in an emergency. Basic observational instruments continued to be used to monitor temperature and blood pressure, and on-site blood glucose testing and urine analysis was possible. Communication continued via wireless radio transmission, and the ‘radio shack’ across the road from the hospital was not conveniently accessible in an emergency.

When women presented to the hospital in established labour, active childbirth was encouraged, with many women walking around boab trees in the hospital grounds. When labour intensified, the woman was moved into the privacy of the labour ward, a one-bed room centrally located next to the nursing sister’s office, with a glass
window between the two to enable observation of the progress of labour from a distance. In the labour room, the woman continued to squat during the contractions, but a bed was always used for the birth. Aboriginal birth attendants and close female family members kept constant company with the woman during her labour. Prayer and the veneration of saints continued as an important adjunct to Western maternity care. According to the Aboriginal health workers interviewed, the statue of Saint Gerard was transferred to the Sacred Heart Hospital, and to guard the labouring woman from hazards, the Aboriginal birth attendant ritually placed a ‘relic medal’ on a chain around the labouring woman’s neck on her admission to the labour ward. Some non-Aboriginal health workers also recalled a picture of Saint Gerard hanging above the bed in the labour room.

The birth of the placenta continued to be physiological, and the umbilical cord was clamped with a ‘peg’. The infant was routinely suctioned after birth, swaddled in blankets and kept separate from its mother until she had been cleaned and washed by the Aboriginal birth attendants. Cord care included an initial dabbing with Betadine, followed by daily application of methylated spirits. According to the memories of one non-Aboriginal health worker, women stayed at the hospital for several days of post-partum recuperation, receiving nutritious meals from the hospital kitchen and having their vaginal blood loss monitored. When lactation was established and the infant’s skin pigmentation had darkened, the woman and her infant returned to her home camp. For some women, this stay in hospital ensured their physical safety, as some women needed refuge from hostile family relations and the threat of intimate-partner violence. Childbirth remained a gender-restricted event.

Maternity care practice continued to be dominated by the values and beliefs of Catholicism and the Western biomedical model. According to information shared
during interviews with participants, written medical notes were kept and so too was a birth register, which recorded pertinent information including the mother’s and father’s name, date of birth, foetal presentation and birth outcome. Only in extreme circumstances was contraception offered; most women were unlikely to request it because they had no knowledge of Western contraceptive methods or techniques. In one case, the visiting medical officer deemed a woman who had given birth to six children within a two-year period (with separate quad and twin pregnancies) a candidate for contraceptive medication, and religious staff trained in nursing and midwifery indirectly supported the decision. According to non-Aboriginal health workers interviewed, in the late 1970s a cluster of multiparous women returned from town-based maternity care having undergone tubal ligation with little understanding of its permanent contraceptive effect. Subsequently unable to get pregnant, many of these women experienced distress, tension and violence in their relationships with their intimate partners. Many women expecting their first baby were sent to town for childbirth—it being a medical preference to ensure the adequacy of the woman’s pelvis. A few women subsequently had planned caesarean sections.

Although biomedical and Catholic values dominated maternity care decisions during this era, a midwifery philosophy was also evident in decision-making that centred care on the pregnant woman’s individual needs and regarded birth as a significant but normal life event. Both acute and non-acute transfers to town occurred only with the permission of the woman. Hospital staff members were willing to prioritise the wishes of a woman and her family rather than medical opinion. For example, a non-Aboriginal health worker recounted how they supported a number of women who declined evacuation after the birth of their premature infant. The staff members were
willing to give extended care and assistance, feeding the infant with a nasogastric tube and supporting the mother while she established breastfeeding.


This fourth and final era of maternity care was characterised by government-initiated withdrawal of hospital services and the instigation of an out-patient model of health care. This involved a clinic, which was open only during business hours and an attached one-bed birth unit. According to Aboriginal women’s childbirth histories, by 1985, locally supported childbirth services had been withdrawn, and by 1996, full responsibility for the health care of Saint Fiacre’s people was assumed by the state. All pregnant women attended town at 38 weeks gestation for ‘confinement’ at a Christian accommodation hostel, and planned childbirth occurred in hospital. During the decades after 1985, unexpected births still occurred in the community, but childbirth services were not routinely provided or supported.

During the period when maternity services were provided, care providers continued to be female Aboriginal birth attendants who worked in the now formalised role of Aboriginal health workers. They practised alongside and in cooperation with religious, lay and non-religious Western-trained nurses and midwives. When childbirth was relocated away from Saint Fiacre, there was an abrupt cessation of the reciprocal caring of Aboriginal women by other Aboriginal women during pregnancy, labour and childbirth. Aboriginal health workers continued to dress in their blue uniforms and were now undertaking formal Western training. They obtained certificates of course accomplishment, attended regular scheduled tutorials at the clinic and travelled away for urban practicum placements to enhance their clinical skills. The role of the Aboriginal health worker now encompassed more-
autonomous practice. In interviews with non-Aboriginal health workers, Aboriginal health workers were described as sometimes teaching extended practice skills, such as suturing, to new nurses and midwives who had only worked in urban hospitals.

According to nuns interviewed, by the late 1970s, the Sacred Heart Hospital building had become dilapidated, and health services soon relocated to a small square green donga adjacent to the main hospital building. ‘Donga’ is an Australian term referring to a temporary makeshift portable dwelling. The donga served as a small clinic with another donga attached that served as the labour and birth room. The closure of the hospital was thought to be at the direction of the territory government, which was now financially contributing to health services and favouring a ‘fly-out and evacuate’ model of health care, rather than the alternative of providing in-patient care in a local hospital ward setting.

Emergency medical resources continued to increase and included drugs and equipment for advanced life-support practices. Obstetric Ventolin and uterotropic drugs were available, as was a neonatal humidicrib. Contact was made with medical services in town via VHF radio, which research participants recalled as being very difficult to use at night, when they were regularly only able to rouse other state radio listeners in Queensland or Western Australia, who would then have to relay important messages back to medical services in town. A non-Aboriginal health worker remembered that in 1987 a standard telephone landline was finally connected, which made long-distance medical consultations the easiest they had ever been in the history of the Saint Fiacre mission. In a dire emergency, medical support was close to a one-hour turn-around, though according to all health workers interviewed, it was more common to wait two to three hours for medical help to arrive. The airstrip, although still unsealed, was well constructed and regularly
maintained, enabling most planes to land during all seasons. However, there was still no lighting and if an evacuation occurred at night, the airstrip had to be illuminated by hand-lit kerosene lanterns or car headlights.

Antenatal care was formalised by the adoption of standardised protocols contained in *The bush book.* Gestation could only be established based on fundal height or quickening, as many women had their babies spaced close together and conceived while still breastfeeding and amenorrheic. Care focussed on biomedical screening and testing of women for the common complaints of anaemia, diabetes, poor nutrition, sexually transmissible infections, urinary tract infections and renal failure. The midwives and nurses considered sub-standard housing, poor sanitation and a nutritionally deficient diet as the cause for many antenatal and neonatal problems in Saint Fiacre, such as anaemia, urinary tract infections and prematurity. Aboriginal health workers broadened their clinical roles. Non-Aboriginal research participants recalled that Aboriginal health workers offered linguistic assistance and cultural brokering, and were often the first to recognise a woman was pregnant and to refer her for care with the clinic midwife. The clinic staff made a special effort to assist women who lived outside the mission township and ran outstation clinics in an attempt to provide more-equitable access to health care for pregnant women. Some women were living on outstations, small settlements on clan-group ancestral lands. The 1970s were characterised by political and social ferment, resulting in some Aboriginal people choosing to return and resettle on their ancestral land. Regular antenatal care involved monthly visits until 28 weeks gestation, fortnightly visits until 36 weeks and weekly thereafter. Such visits involved a physical examination, including weight, blood pressure, urine testing and a fundal examination. Routine medication during pregnancy comprised iron, folic acid and calcium.
women were also encouraged to be regularly reviewed by the male medical officer, who visited every three weeks by plane.

In the earlier part of this era, women continued to seek local childbirth care, provided by carers who spoke their language and shared their cultural background. Now, drawing on information sourced from research interviews and others\textsuperscript{25} women mostly presented to the clinic only when in established labour and were then admitted to the attached birth unit. The midwife and Aboriginal health workers provided for all the ‘physical and psychological’ needs of the woman during her labour.\textsuperscript{25(p13)} A supine position for the second stage of birth was encouraged by the use of a bed, and although obstetrical stirrups were on hand, they were not routinely used. Many women laboured while chewing on a mild stimulant of tobacco rolled in ash. The leaves of a native tobacco plant were chewed during pre-colonisation times, but this commercially procured dried tobacco was introduced by the missionaries as a form of payment, including it in ration bundles. The birth of the placenta continued to be physiological, and uterotrophic drugs were on hand for women who had excessive bleeding. As it had done for centuries preceding, the act of childbirth remained an event attended only by female practitioners and close female family members.

Research participants recalled that with no hospital kitchen and no staff to provide rotating care, women stayed at the clinic for only 24 hours after the birth and were then discharged to return to their home camps. The poverty of living conditions at home camps and poor maintenance of sexual and perineal hygiene were of great concern to the midwives, who worried about maternal puerperal infection as well as neonatal sepsis while the infant’s umbilical stump was not healed and its immunity immature.\textsuperscript{25} At times, the mother’s poor attendance at the clinic for postnatal care
made assessment and management of these issues more difficult. Contraception was
not routinely offered, although if medically prescribed, the religious staff continued
to indirectly support its use through quiet tolerance. Although it was perceived that
Aboriginal women did not wish to limit their family size, at least one non-religious
midwife thought contraception may have been advantageous and well accepted by
women as a means for lengthening the space between pregnancies. It was common
for women to have had more than five pregnancies or to have given birth to five or
more infants.25

Maternity care practice remained influenced by both religious and biomedical beliefs
and values. The bush book24 at this time provided a standardised approach to
undertaking remote health care in an Aboriginal community, but according to
research participants, in Saint Fiacre it was a reference rather than a policy dictate.
For example, The bush book discussed contraceptive use, but contraception was
never routinely offered as part of post-partum care. This cohort of nuns, perhaps
being younger, appeared to be more critically reflective in their health practice. They
had started to identify complex issues that they considered worthy of formal
guidance, which they sought by writing to a Catholic moral theologian. They sought
guidance on scenarios such as contraceptive use for females with intellectual
disabilities, contraceptives and vaginal douching for female rape victims, and the
support of condom use with the emerging threat of HIV in remote Aboriginal
communities.26 These complex issues were clearly situated within a feminist
paradigm, as the nuns showed an awareness of a gender-based power dynamic that
limited Aboriginal women’s ability to negotiate and decline sexual intercourse.
Although in conflict with Catholic philosophies, they recognised that contraception
and condoms may have been the only practical way in which a woman in those social
environments could protect herself from unwanted pregnancy, infection or disease. The nuns also expressed great moral concern that many women were giving uninformed consent to reproductive health procedures, such as tubal ligations, abortions and hysterectomies, and many of the women who were undertaking such procedures remained unaware of the implications and permanency.

Maternity care practice was also shaped by biomedical values that sought to classify women according to obstetric risk. Non-Aboriginal participants recalled that medical screening and history taking were used to decide which women should be asked to travel and give birth in hospital in town. All participants concurred that it was considered best practice for only ‘normal births’ to occur in the Saint Fiacre birth unit. According to a journal source, women meeting any of a set of criteria were discouraged from staying for childbirth. The criteria included a first or greater than fourth pregnancy; foetal malpresentation; multiple pregnancy; maternal heart disease, hypertension or diabetes; severe anaemia; or an obstetric history complicated by a previous caesarean section, prolonged labour or post-partum haemorrhage. Despite the intention that these women travel in late pregnancy into town, they did on occasion give birth in the local clinic before an evacuation was possible. All women sought assistance from and attended the clinic for childbirth, and there was no demonstrated preference for unsupported birth at a home camp or in a bushland estate. In addition to these criteria, any woman could also elect to have her baby in town, with all costs met by the state. Despite this availability of choice, few woman took it up; town was generally disliked for being an unsafe place, and most women preferred to be cared for in familiar surroundings and by Aboriginal health workers who spoke their language.
Discussion

Over the past 75 years, Aboriginal women in Saint Fiacre have experienced dramatic changes in maternity care: how, where, what and with whom. For the most part, these changes to maternity care have occurred without considered consultation, advice or input from the women and families affected. Colonisation of traditional reproductive knowledge and practices was the catalyst for a new Aboriginal maternity caregiver role. This pioneering health role saw young Aboriginal women, without cultural midwifery status or knowledge, apprenticed to Western-trained nurses and midwives in the provision of maternity care. Although perhaps not the intention, this approach was a highly effective apparatus for colonising Aboriginal childbirth practices, rapidly undermining the authority of culturally appointed midwifery practitioners and destabilising many centuries of local reproductive practices. Over the following eras of maternity care, the scope of practice of the female Aboriginal birth attendant broadened and professionalised into the formal career pathway of what became known as the ‘Aboriginal health worker’. Female Aboriginal health workers who looked after the Saint Fiacre community were readily accepted by pregnant women as their maternity care providers, and they were highly esteemed and valued by both their own people and their non-Aboriginal colleagues. Aboriginal health workers made significant and lasting contributions to the wellbeing of women in their community, often doing so by bridging Aboriginal, European, Christian and biomedical world views, with the added expertise of practising in numerous languages. Across each of the historical eras of maternity care, an additional important factor in the provision of successful maternity services has been the personal approach of non-Aboriginal nurses and midwives, who have supported
and valued the contributions made by Aboriginal women in caring for other local women.

The introduction of Western maternity care appears to be one of a range of factors that led to a sustained population increase in Saint Fiacre, and in turn demonstrates both the success and the effects of providing primary maternity care and planned childbirth in a local setting for remote Aboriginal women. Although suggested that additional factors spurred population growth, including ‘mission-induced sedentariness’\textsuperscript{27(p228)} leading to increased fertility and better child survival, it cannot be ignored that steady increases in the population through the 1950s, peaking in the 1960s,\textsuperscript{27(p222)} also coincided with the establishment of health care services. Importantly, this included the arrival of Western-trained midwives, the establishment of dedicated health buildings and a hospital, and the provision of skilled and resourced primary maternity service coupled with the active participation and involvement of Aboriginal women.

When the mission began, the population was recorded as 138 people, and of this total only 47 were children (24 male and 25 female), with one demographer\textsuperscript{27(p219)} suggesting that this figure represented only a select portion of the population or, more likely, that the infant mortality rate was high. The likelihood of a high rate of infant mortality affecting the population’s demography is also reflected in comments made by an anthropologist who accompanied the mission’s founding party. The anthropologist noted the people to be in a poor psychological and physical state, suffering among other things from a high infant mortality rate and a population that had been depleted of women of child-bearing age through hostile kidnapping by neighbouring tribes.\textsuperscript{28} In addition, a 1936 comprehensive review of the mission, undertaken by a medical assistant, noted with concern that there were no ‘babes in
arms’ to be seen and he saw only one woman who was pregnant. The medical assistant believed ‘if conditions go on as they are without help, the tribe in a few generations, will cease to exist’. Yet by 1950, after pioneering health services had been established, which involved the combined practice of Western and Aboriginal maternity care providers, the population had grown to 310. In 1952, the same anthropologist remarked in a newspaper article that the people of Saint Fiacre had been ‘reproducing so fast that their numbers may double within the next 20 years’. He attributed much of this population increase to the ‘good medical services now available’. With targeted midwifery care that nurtured pregnant woman and their newborn infants, the introduction of primary maternity services may well have been pivotal in the long-term resilience of Saint Fiacre people, whose population in the year 2003 numbered 2,260.

Historical examination of the health infrastructure and maternity care services demonstrates responsiveness towards the goal of providing health care to a growing population. The territory government, despite an established trend of population growth and growing demand for primary maternity services, eventually withdrew all childbirth care and services from the local setting. To date, no historical documents or government policy on hospital birth have been located in publicly accessible national or territory archives or in the collection housed in the territory hospital library that could illuminate the reasoning behind such a radical change in health-service provision. It seems that it coincided with larger Australian-wide agendas of centralising and consolidating the location of birth from regional to urban hospitals. Therefore, the withdrawal of birth services can only be understood in hindsight as perhaps an attempt to address ongoing poor maternal and infant health outcomes by providing ‘better’ maternity care services. In 1979, a government source noted that
for some years territory policy was to encourage Aboriginal woman ‘to deliver their babies in hospital’ rather than the presumably remote ‘health centre’, especially if there was any risk of ‘abnormality’, and that the percentage of women electing to have their babies in hospital had increased from 27% in 1965 to 75% in 1979. The territory-wide withdrawal of remote local childbirth services was a blunt approach because it failed to acknowledge the wide range of skills and resources available to Aboriginal women and their infants in different remote settings.

Unlike perhaps in other under-resourced localities, the women in Saint Fiacre had access to childbirth in a clean and hospitable setting with trained Aboriginal and non-Aboriginal health staff who were skilled in midwifery care and access to timely evacuation by plane in the case of emergencies. In addition, women reported a high sense of satisfaction with and acceptance of the local maternity health services. At the time, they were given the choice to give birth in close proximity to their family and young children, in a familiar environment enhanced by spiritual qualities, with a known and trusted Western midwife and an Aboriginal health worker who, sharing the women’s culture and language, could support and reassure during the challenges of giving birth.

For many non-Aboriginal staff members who provided maternity care in Saint Fiacre and participated in this research, it was difficult to understand why childbirth services were withdrawn. As health infrastructure and technology improved, it was perceived that community birth could only become safer and less hazardous. As one of the religiously trained midwives said:

It is a great pity that the women have to go into town … what reason do they give? If I remember correctly we didn’t lose either mum or bubs during
deliveries and were able to evacuate anyone who needed to go. And that was when there were no resident doctors!

Participants in this research did not recall any incidences of maternal or neonatal death attributable to either the care or lack of care during childbirth. There were, of course, incidences of premature infants with very low birth weight dying due to an incompatibility with life, but participants who reported these deaths believed the same outcome would have occurred in a tertiary hospital setting. Historical statistical analysis of neonatal and maternal health outcomes as a measure of maternity care quality is fraught with challenges in Saint Fiacre. This is due to the relatively small population size, incomplete records, missing local birth registers, inconsistent reporting of data variables and inconsistent Aboriginal ethnicity reporting practices. There are, however, the private fieldwork records of the anthropologist who accompanied the founding mission party, which document births and deaths in Saint Fiacre over the years 1935–1973. Although it is not possible to cross reference the anthropologist’s data to enhance its reliability, simple analysis of his records demonstrates an exceedingly high infant mortality rate ranging from 76 to 333 deaths per 1,000 births in the years 1935–1949, after which the rate trends downwards. It is possible to compare the anthropologist’s Saint Fiacre data with the Aboriginal infant mortality rate for the entire Northern Territory over the years 1965–1973, the heyday of community-based childbirth. When five-year averages are compared, Saint Fiacre shows consistently lower rates of infant mortality than the rest of the Northern Territory during the same periods (see Figure 1). The exact relationship between Saint Fiacre’s infant mortality rate and childbirth location remains unclear; however, it does demonstrate that if evaluated on one key indicator of population health, local
health services of the time were performing well when compared with the rest of the territory.

Figure 1. Aboriginal infant mortality rates in moving five-year averages for the Northern Territory and Saint Fiacre. Source: Stanner \(^{32}\) and Northern Territory Government Department of Health.\(^{31(35)}\)

The women of Saint Fiacre quietly witnessed the withdrawal of childbirth services; along with the multitude of other significant changes that colonising forces continued to impose on their daily lives. In a gendered history shared with many other Indigenous and non-Indigenous women alike, their right to reproductive choice was silently overlooked by a hegemonic medical system, and the distress of leaving home and family for extended periods to give birth in town was theirs to silently bear. For female Aboriginal health workers, the withdrawal of childbirth services dramatically limited their scope of clinical midwifery practice and abruptly prevented career pathways for future Aboriginal midwives. The social status and value of these Aboriginal health workers who assisted women during childbirth continued to persist for many years in the community. More than a decade after the cessation of
childbirth services in Saint Fiacre, some of these retired Aboriginal health workers informally practised, supporting their own female family members to undertake childbirth in the town because the health services offered no alternative to hospital childbirth in Darwin.\textsuperscript{33}

The historical trend for removing support of remote-based childbirth services is evident for other Indigenous and colonised people in remote settings. Most notably are the remote northern-Canadian Inuit communities, whereby the mid-1970s standard maternity care was the ‘evacuation’ of all pregnant women to give birth in hospital, often far-away in southern Canada.\textsuperscript{34} For these Inuit communities midwifery was an essential expression of their traditional culture\textsuperscript{34–36} and the geographical removal of childbirth perceived as an act of ‘disrespect’ and neglect’ but also as a ‘colonialist approach’ to the provision of maternity and health services to Indigenous people.\textsuperscript{34 (p387)} At the same time as childbirth services in Saint Fiacre were restricted and eventually withdrawn, remote Inuit women on the Hudson Bay coast re-introduced childbirth services to their community through the opening of the \textit{Puvirntuq Maternity} in 1986. With a philosophy that was committed to the involvement and education of local Inuit health workers and an approach that was based on the principles of community development, this successful model for maternity care has since inspired other similarly remote Inuit settlements, to bring childbirth back to their home community.\textsuperscript{34}

\textbf{Conclusion}

The maternity care experiences in the community of Saint Fiacre of both Aboriginal and non-Aboriginal women alike highlight the rich history of midwifery practice in remote settings in the Northern Territory. Women’s experiences unearth a unique
local context, where pioneering Western midwifery acted as an apparatus of colonisation first and then, with the passage of time, as an instrument of care for nurturing Aboriginal women’s resilience. Although the decision to withdraw local childbirth was likely well intentioned, it has come at a significant cost to the women. In reproducing and sharing their history, Aboriginal women help us to better understand the future challenges of providing remote midwifery that truly ‘cares’ rather than ‘colonises’.

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Chapter 6:

The Logics of Planned Birthplace for Remote Australian Aboriginal Women in the Northern Territory: A Discourse and Content Analysis of Clinical Practice Manuals

Figure 6.1. Statement of Authorship for publication: ‘The logics of planned birthplace for remote Australian Aboriginal women in the Northern Territory: A discourse and content analysis of clinical practice manuals’.
The Logics of Planned Birthplace for Remote Australian Aboriginal Women in the Northern Territory: A Discourse and Content Analysis of Clinical Practice Manuals

Authors: Sarah Ireland, Suzanne Belton and Sherry Saggers

Abstract

Objective: The aim of this research is to review the content and describe the structural and contextual discourse around planned birthplace in six clinical practice manuals used to care for pregnant Aboriginal women in Australia’s remote Northern Territory. The purpose is to better understand where, how and why planned birthplaces for Aboriginal women have changed over time.

Methods: Content and discourse analysis was applied to the written texts pertaining to maternal health care and the results placed within a theoretical framework of Daviss’s Logic.

Findings: The manuals demonstrate the use of predominantly scientific and clinical logics to sanction birthplace. Planned birthplace choices have declined over time, with hospital now represented as the only place to give birth. This is in opposition to Aboriginal women’s longstanding requests and is not supported by robust scientific evidence.

Conclusions: Despite scientific and clinical logics dominating the sanctioning of birthplace for Aboriginal women, conjecture is apparent between assumed logics and evidence. There needs to be further critical reflection on why Aboriginal women do not have planned birthplace choices, and these reasons,
once identified, need to be debated and addressed both in research agendas and policy redevelopment.

Key Words: Australia, Aboriginal women, midwifery, remote, birthplace, discourse analysis

Introduction

Due to the increasing medicalisation of childbirth in Australia over the past several decades, the physical location for the planned place of birth remains a contested and debated issue in Australian healthcare settings and discourse (Australian College of Midwives, 2011; MacColl, 2009; The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2014). Planned non-hospital birth locations are often marginalised in health policy and planning, receive little government funding and, if desired by women, often prove difficult to access (Commonwealth of Australia, 2009; Dahlen, Schmied, et al., 2011; Dahlen, Jackson, Schmied, Tracy, & Priddis, 2011). As in the rest of Australia, the majority of births (97%) in the Northern Territory occur in hospital. However, the Northern Territory is unique in that 39% of all mothers are Indigenous and live predominantly in very remote and rural locations (Thompson, 2013). As there are only four regional maternity units that support childbirth services in the Northern Territory (Darwin, Alice Springs, Katherine and Gove), Indigenous women living in remote and rural locations are strongly discouraged from giving birth in their community. Instead they are required to transfer to regional centres to await labour and give birth in a hospital facility (Ireland, Narjic, Belton, & Kildea, 2010). A government health report suggests that this model of care has been incrementally favoured since the 1970s (Northern Territory Government Department of Health, 1980, p. 30).
Despite most births occurring in hospital, the Northern Territory also offers a homebirth service in the public primary healthcare system within the regional limits of Darwin and Alice Springs (Northern Territory Government, 2014). In 2007, among the 1% of planned homebirths in the Northern Territory, there were no Indigenous mothers. Despite having no participation in the regional homebirth services, around 4% of all Indigenous mothers did give birth outside of hospital settings in what is deemed an ‘unplanned location’ such as a remote health centre, in transit or at home. This contrasts with under 1% of all non-Indigenous Northern Territory mothers experiencing a similar unplanned birth outside of hospital (Thompson, Zhang, & Dempsey, 2012, pp. 6–7). Some of these ‘unplanned’ Aboriginal births may actually be intentional. Insights from research in one remote Aboriginal community demonstrated that up to 10% of women gave birth outside of a hospital facility in their community (Ireland, 2009), and that many of these women intended to do so by quietly resisting transfer to regional centres (Ireland, 2009; Ireland et al., 2010).

Historical health statistics (Northern Territory Government Department of Health, 1980) and narratives (Ireland, 2014) indicate that, in the past, many Aboriginal women could choose their birthplace and, if desired, were supported by health practitioners to give birth in their community. Aboriginal women over many years have spoken about the importance of having choice around the location for childbirth and what is perceived as the negative cultural and social implications of moving childbirth away from communities (Aboriginal Cultural Birthing and Parenting NSW, 2014; Carter et al., 1987; Hirst, 2005; Kildea, 2006; Kildea & Van Wagner, 2013). Yet their wishes have not been incorporated into clinical practice, with health practitioners still dictating obligatory evacuation to regional centres for childbirth.
We wished to explore why remote Aboriginal women in the Northern Territory are now not offered birthplace choice, by examining the clinical practice manuals that have, over time, guided decision-making by health practitioners in remote locations around the location for childbirth. Our interest lies in understanding the logic behind planned birthplaces and how clinical manuals have created the clinical realities in which pregnant women are now cared for.

**Daviss’s Theoretical Framework of Logic**

Daviss (1997) identified several principles used to inform decision-making during pregnancy, childbirth and postpartum. Identifying these principles can provide a helpful framework for understanding the competing knowledge systems that may lie beneath otherwise authoritative discourse, such as clinical practice manuals. Daviss’s work builds on Jordan’s (1992) theoretical concept of obstetrical authoritative knowledge. Jordan proposes that in any given situation several knowledge systems exist at once; however, one will gain ascendance due to its association with either a structural power base or through the system’s efficacy. The knowledge system that gains ascendance will dominate and become the authoritative way of viewing and managing the situation. Daviss (1997) deconstructed these knowledge systems into types of ‘logic’ that govern decision-making. Seven potential types of logics that underpin maternal care practices and their associated definitions are presented in Table 1.

This theoretical framework has previously been used to explore and inform changes to the ‘logics’ of birth settings in Arctic Greenland through a review of childbirth related literature (Montgomery-Anderson, Douglas, & Borup, 2013). This framework has similar potential for understanding changes to birthplace location in an
Australian setting because of a shared legacy of colonisation and removal of childbirth from Indigenous remote communities and its relevance in understanding how care decisions are reasoned.

Table 1

*Adapted definitions of Daviss's logics*

<table>
<thead>
<tr>
<th>Type of logic</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scientific</td>
<td>Evidence from science, including biology, physics and epidemiology, which statistically analyses health and disease patterns during reproduction.</td>
</tr>
<tr>
<td>Clinical</td>
<td>Derived by health practitioners from the physical assessment and examination of mothers and babies, and varies according to training, experience, knowledge, philosophy, and peer pressure. It is often presented as scientific logic but frequently has no scientific basis.</td>
</tr>
<tr>
<td>Personal</td>
<td>Knowledge that families and individuals use to balance what they may lose or gain from the decisions they make during pregnancy and birth. This may also be the personal logic that health practitioners use to evaluate the positive or negative affects a clinical decision may have on their future careers.</td>
</tr>
<tr>
<td>Cultural</td>
<td>Information concerned with the development or demise of the fundamental beliefs a particular society holds in relation to management of birth. This includes traditional community knowledge and spiritual knowledge.</td>
</tr>
<tr>
<td>Intuitive</td>
<td>Knowledge derived from a person who has become very familiar with a particular situation and can make decisions about it without relying on a particular category of logic.</td>
</tr>
<tr>
<td>Political</td>
<td>Knowledge relating to the consequences of what will be thought, done and viewed about birth by family, community, general public opinion and government policymakers. It is concerned with issues of who has the power of control over the birth process and what cultural institutions and values will be reinforced and perpetuated through the act of this control.</td>
</tr>
<tr>
<td>Legal</td>
<td>Concerned with defining liability and litigation resulting from decisions made during pregnancy and childbirth.</td>
</tr>
<tr>
<td>Economic</td>
<td>Concerned with assessing the costs and savings of different ways of caring for pregnant and birthing women; often concerned with the goals of saving, making or not losing money.</td>
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</table>

Settings

The Northern Territory is a geographically large (1,346,200 km²) region with the smallest population of all Australian states and territories. Of the total 229,711 people who live in the Northern Territory, approximately 27% are Aboriginal and Torres Strait Islander people. This is a much larger percentage than in other states, where only 4% or less of the population is Indigenous. In contrast to other states, 80% of the Northern Territory’s Indigenous people live outside the capital city in rural and remote locations (Australian Bureau of Statistics, 2015).

The Northern Territory Department of Health has endorsed the clinical protocols contained in the *Women’s business manual* for use by all clinical staff working in the 53 government health centres (Northern Territory Government, 2013). The practice manual is highly regarded and well used by all clinical practitioners (doctors, remote-area nurses, midwives and Aboriginal health workers) in remote Northern Territory health centres. It is designed specifically for the care of pregnant Aboriginal women in remote locations, but it is also used in the care of pregnant non-Aboriginal women who happen to be living in remote locations. The *Women’s business manual* replaced earlier editions of *The bush book* (Northern Territory Department of Health, 1979; Northern Territory Medical Service, 1973), which was the first clinical practice manual used to standardise remote healthcare practice.

According to the Northern Territory Government, each rural community is ‘diverse in social structure, infrastructure, politics and economic status’, ranging from small townships with a population of several thousand to minor isolated outstation settlements of a few people. Settlements are often separated by vast distances requiring airplane travel or days of four-wheel driving on unsealed roads. Some of
the larger settlements have a substantial non-Indigenous service-provider population, but the majority are Aboriginal people living on their traditional homelands (Northern Territory Government, 2012).

Permission

Working in partnership and with permission from Aboriginal women, this research is part of a larger doctoral study investigating women’s sexual and reproductive health in one remote community. Ethical approval for the overarching doctoral study was granted by the Menzies School of Health Research Ethics Committee and a subcommittee dealing specifically with Aboriginal research (Application #HR-10–1429).

Methods

Content relating to pregnancy and childbirth in six Northern Territory Department of Health endorsed clinical practice manuals over the period 1973–2008 underwent a combination of content and discourse analysis. As we were interested in the historical legacy of the manuals in shaping current maternity care, we omitted the most recent edition of the Women’s business manual (Congress Alukura, 2014), which was published in mid-2014 and, in our opinion, has not had time to influence current practice.

Content analysis was firstly used to quantify detail in the manuals according to predetermined criteria. The criteria were: What are the planned birthplaces? Who can choose birthplace? What terminology is used to refer to women and pregnancy? Is there cultural-related content on caring for Aboriginal women? Bryman (cited in Liamputtong, 2009, p. 282) states that content analysis should ideally be analytical, systematic and replicable. The first and second authors read the clinical practice
manuals several times, until they were able to confidently provide answers to the criteria. This was subsequently repeated for each edition of the manual and the written results collated in a table.

Discourse analysis was then used to examine the manuals’ structural and contextual dimensions leading to the expression of an authoritative knowledge. Lupton (1992, p. 145) describes this as how text produces a ‘dominant ideology or belief system’. She ascribes this analysis as being centred on how the language and style of the text is presented to the reader. Structural content was noted, such as the stylistic use of terminology, grammar and conceptual devices. For example, it was important to note the practice manuals’ use of terminology to describe women and pregnancy. Contextual content was discerned through relating the text to the ‘social, political or cultural’ environment of its production. It was therefore crucial to link the manuals’ content more broadly to the environment of Australian midwifery politics, consumer maternity reform and the medicalisation of childbirth.

The first and second authors triangulated the data by comparing the results for similar and dissimilar findings, contrasting the results from different editions of the manuals and comparing their findings, and through the evaluation of historical health statistics. Results were then placed within Daviss’s theoretical framework of logics and related back to health literature, enabling the results to be understood from a maternal and public health perspective.

**Limitations and Researcher Reflexivity**

As Lupton (1992, p. 148) states, ‘proponents of discourse analysis make no claims as to the objectivity or universal truth of their insights’(p. 148). Therefore, we as researchers subscribe to a view of reality in which ‘truth’ is only ever constructed
and positioned by particular sociopolitical contexts. We acknowledge that our analysis is influenced by gender, our biomedical training and experience and our non-Indigenous backgrounds. Our analysis is not intended to be representative of all ‘truths’, but rather, through theoretically situating changes in planned birthplace locations for Aboriginal women, we hope to gain better insights and new understandings into the current status quo. Two of the authors also have professional relationships with the manual: one as a midwife whose remote practice has been guided by the content of the manual, and the other as contributor to the content of one manual.

**Findings**

There is written evidence that for the past 35 years a standardised approach has been used to guide Western health care of pregnant remote-living Aboriginal women. Over the period 1973–2008, six practice manuals record different approaches to the planning of birthplaces and reflect a growing sophistication and professionalisation in remote health care.

**1973: The Bush Book: A loose-leaf manual for healthcare staff working in the rural areas of the Northern Territory**

This first edition of *The bush book* (Northern Territory Medical Service, 1973) is an initial attempt at the standardisation of remote healthcare practice. It is produced in an economical loose-leaf format bound with stationery pins, and the front cover is illustrated by a hand-drawn map of Australia (with the Northern Territory highlighted) and a presumably endemic piece of flora. The manual covers a wide range of health topics but includes only a small section on caring for pregnant women between Sections 4.1.1 and 4.1.5 (no page numbers).
In the text, two planned birthplace choices are the ‘isolated situation’ or ‘hospital’. The health practitioner is able to choose the best birthplace by assessing the woman’s history combined with the ‘examinations’ of her physical body and medical ‘investigations’ into her body fluids (blood and urine testing) and structures (chest X-rays). In the majority of the text, the pregnant woman is referred to as the ‘patient’; only once is she known separately in the text as a ‘pregnant woman’ and once as a ‘mother’. Late pregnancy is referred to as ‘confinement’ and childbirth as ‘delivery’. There is no cultural content on caring for pregnant Aboriginal women.

A section titled ‘Indications for hospital delivery’ includes a range of biomedical conditions that warrant either hospital referral or a planned hospital birth. It dictates that only ‘normal’ births should be conducted in the isolation of remote practice.

1979: Northern Territory Bush Book

This is the second edition of the manual (Northern Territory Department of Health, 1979) and reflects a more sophisticated production on quality gloss paper with stitched binding. The front cover features a photograph of an Aboriginal woman attending a campfire. The manual refers to two planned birthplace options as ‘hospital’ or ‘rural areas’. It continues to infer that birthplace should be chosen by the health practitioner after the assessment of the woman’s history, combined with the ‘examination’, ‘investigation’ and ‘observation’ of her body and pregnancy using biological markers.

The text continues to refer to late pregnancy as ‘confinement’ and childbirth as ‘delivery’ but more often situates the woman into the text. She is still referred to as the ‘patient’, but more frequently as ‘the pregnant woman’, ‘Aboriginal woman’, ‘mother’ and ‘woman’. The text remains adamant that only ‘normal deliveries should
be conducted in rural areas’ but offers the incentive that all women are eligible for financially assisted travel to town-based ‘confinement and repatriation’, inferring that those with no known indications but who ‘wish to be delivered in hospital’ are supported to do so. This is a significant inclusion because it is the first mention of a woman’s birthplace ‘wishes’. Although only fleetingly mentioned, the pregnant woman is acknowledged as having desires and hopes regarding where she gives birth. A list of biomedical conditions and past obstetrical complications are listed under the ‘Indications for hospital delivery’.

This edition marks the first inclusion of cultural content with a section titled, ‘Outstation patients’. This section explains that with the development of the outstation movement, many pregnant women would be less likely to receive as much antenatal care as wished. It advocates a family-centred approach for managing pregnant women identified as at-risk who live at an outstation, with a ‘view of securing adequate antenatal care and safe delivery’ (p. 44). It counsels the healthcare professional that people who choose to live at outstations have done so for important reasons and should be respected. It also provides communication advice to health practitioners, suggesting it is important that they ‘make apparent their sensitivity to the patient’s social needs and responsibilities as well as to their health problems’ (p. 44).

1990: Minymaku Kutju Tjukurpa—Women’s business manual

This is the first gender-exclusive practice manual (Nganampa Health Council Inc., 1990), instigated at the request of Aboriginal women who wished for a ‘separate

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8 The outstation movement refers to the voluntary relocation of Aboriginal people from settlements onto their traditional ancestral lands. These new camps are often known by the term ‘outstation’.
manual for women’s health rather than being included within a general standard treatment manual’ (np. introduction). Rather than just a small section on the care of pregnant women, this thick manual now covers many women’s health topics. The manual is funded by a grant from the South Australian Health Commission’s Social Justice Strategy; it is branded on the front cover with Aboriginal language and features a quality reproduction of an Aboriginal art piece. The artwork is interpreted as expressing the cultural themes of continuity, protection, gender seclusion and ancestral land ownership.

The manual refers to the planned birthplaces of ‘birth on the Lands’ (p. 69) or ‘hospital birth’ (p. 47) or ‘ASH [Alice Springs Hospital] delivery’ (p. 45; 66). For the first time, the text explicitly states that some women ‘desire’ to give birth to their babies on the Lands for social and cultural reasons (p. 66). The text capitalises ‘Lands’ in an acknowledgement of the importance of country to Aboriginal women. It forcefully states that women’s desires to give birth on the Lands ‘must be accepted’ by health practitioners and that they ‘need to balance the risks involved [with a non-hospital birth] with the woman’s informed wishes’ (p. 66). The text infers that the health practitioner still makes the birthplace decision, but it must be ‘balanced’, therefore informed, by the woman’s wishes.

The text no longer refers to late pregnancy as ‘confinement’ but continues to intermittently use the terms ‘delivery’ and ‘patient’. A list of biomedical conditions, past obstetrical complications/experiences and current pregnancy experiences are used to stipulate when birth should occur in hospital. The authority of this section is undermined by the caveat that ‘Not all contraindications are absolute’ (p. 68) and goes on to describe a possible situation where a young ex-petrol-sniffing pregnant
woman with a normal pregnancy could give birth outside of hospital ‘especially if she is extremely reluctant’ to go to a town hospital.


This second edition (Congress Alukura and Nganampa Health Council Inc., 1994) of the gender-exclusive manual mirrors the first edition in format and visual style. It is a spiral-bound production featuring the same Aboriginal language and artwork on an orange front cover. The manual refers to four planned birthplace options: ‘bush’, ‘community health centre’, ‘Congress Alukura’\(^9\) and ‘hospital’ (p. 76). The text clearly states the aim to ‘support women to birth safely and appropriately in the setting which they choose’ (p. 75). The planned birthplace is chosen by the woman and her family after discussion with the health practitioner. In a forthright manner, the text states that ‘a woman is not obliged to accept the advice offered’ (p. 80) and may have her baby in a non-hospital setting against advice. In this situation, the text advises the health practitioner to document in the medical notes all advice given and notify backup medical resources. A criteria and list of ‘medical risk conditions’ are provided to describe women who are appropriate to give birth either at Congress Alukura or at the hospital (p. 80). A caveat is inserted politely warning the health practitioner: ‘Please note that not all of the medical risk conditions below absolutely rule out birth out bush or at Congress Alukura’ (p. 80). Although the text concedes that most babies are ‘commonly’ born in hospital (p. 75), it advocates a need for health services to ‘develop policies and practices which reflect the choices that women are making’ (p. 76).

\(^9\) Congress Alukura, established in the 1980s, is a women-only primary healthcare centre that specialises in women’s, maternal and child health in a culturally appropriate service for Aboriginal women. It was started in the 1980s (CAAC, 2014).
The terminology of ‘patient’ is now absent, exclusively replaced with ‘woman’ and ‘mother’, reflecting a centring of the pregnant woman within the text. She is no longer regarded as a compliant ‘patient’ but as a woman with individual needs and wishes who should be respected and accommodated with her pregnancy and childbirth care. For the first time, the text recommends the use of and includes a culturally adapted Birth Plan template. In this plan, the woman’s preferences and desires are recorded for action when she gives birth. Although her presence in the text is now palpable, the term ‘delivery’ is still used, which continues to emphasise childbirth as a process separate from the mother, during which the baby is ‘delivered’ by the efforts of someone other than the mother.

The cultural content in this manual is substantial. Aboriginal culture and Western medicine are continually juxtaposed by the use of language such as the ‘Western obstetrical way’. Although formally unreferenced, there is cultural advice on the gender exclusiveness of childbirth, women’s law, ritual, choosing culturally appropriate birth attendants and the correct handling and disposal of the umbilical cord and placenta. For the first time, the text names and validates the practice of traditional birth attendants and Aboriginal health workers in the provision of culturally appropriate care to pregnant women.

1999-Minymaku Kutju Tjukurpa—Women’s business manual

As with previous editions, this manual’s (Congress Alukura & Nganampa Health Council, 1999) style and format reflects earlier ones. It is spiral-bound and branded with Aboriginal language and artwork on the blue front cover. With growing sophistication, the manual’s dense topics are now separated by numbered laminated dividers. Although the content is now contributed to by a growing list of
professionals, there is a legal warning on the second page absolving liability arising from the manual’s use, stating that it is ‘not an authoritative statement’. This is followed by a warning that although the manual uses precise short directives to meet its purpose as a clinical practice manual, this does not absolve health practitioners’ legal obligations to treat ‘Aboriginal women’ with dignity and respect, ensuring their rights as consumers of health care. These rights are made clear with an adaptation of consumer’s health rights regarding acceptance of health care, privacy, access and medical explanations in the woman’s first language.

The text refers to the planned birthplace options of ‘bush’, ‘health clinic in the community’, ‘Congress Alukura’, and ‘hospital’ (p. 116). The woman and her family remain the people who plan the birthplace after consultation with health practitioners. There is greater emphasis placed on hospital being the ‘safest option’ (p. 69) if she has medical risk factors and that the fearful and isolating effects of hospital can be ameliorated with support from relatives, Aboriginal health workers and hospital interpreters. It reinforces the notion that traditional ceremonies are still possible after returning home. The text still states that the ‘woman does not have to accept advice about risks but a big effort must be made to make sure she understands them clearly’ (p. 118). A section titled ‘Medical risks’ lists reasons to indicate that a hospital birth should be planned and reasons for ‘evacuating’ a woman to hospital. The text again cautions the health practitioner that these risks should be discussed with the woman and her family in a ‘balanced way’ (p. 118).

The terminology of ‘delivery’ is now absent in the text and replaced with ‘birth’ or ‘birthing’. Although still advocating the need to engage with the woman in birth planning, there is no longer a specific Birth Plan template. The omission of the Birth Plan softens the authority of the woman’s needs and places more emphasis on
negotiating needs rather than articulating them. There continues to be significant cultural content in the manual, and this is exactly the same as in previous editions. The linguistic juxtaposition of Aboriginal culture and Western medicine continues, and the text continues to refer to the practice of Aboriginal health workers and traditional birth attendants in the care of the pregnant woman.


The style and format of this fourth edition (Congress Alukura & Nganampa Health Centre Inc., 2008) remains the same but with a pink front cover. The legal warning absolving liability remains on the second page, and a further lengthy listing of expert contributors, reviewers and editorial subcommittees adds authority to the manual’s content. The planned birthplace in the text is ‘hospital’. It is neither the woman nor the health practitioner who decides the place of birth because the only planned birthplace is the regional hospital. The text states that all women ‘are strongly encouraged’ (p. 105) to give birth in hospital, and the health practitioner is urged to give information throughout pregnancy to ‘prepare the woman for this outcome’. The text emphasises the need of the health practitioner to engage with the woman through talking and working in a manner that seeks the woman’s ‘cooperation and involvement’ (p. 84). Yet this is only achievable if the woman is planning a hospital birth. If a non-hospital birth is desired, the woman is, by default, unable to ‘co-operate’ with the care on offer and must seek alternative arrangements.

The guidelines for antenatal care imply that birth will occur in hospital by including the recommended gestation for arranging a pregnant woman’s travel and then ‘transfer’ to a regional centre for labour and birth. There is no allowance for discussion with the woman regarding her birthplace plan and the text suggests that it
is the health practitioner’s responsibility as the implicit expert to inform the woman about the ‘practicalities’ of a hospital birth. The text on page 105 proceeds to list in detail all of the things the woman will need to be aware of and organise as she leaves her community to go to the regional hospital. This list of minutiae includes how she will eat, sleep and wash her clothes; items of clothing for herself and the new baby; and instructions on arrangements for care of her children left at home and choosing a female escort to accompany her.

The cultural content of the manual remains sourced from the second edition, which by now is 14 years old. The text mentions that this cultural information was ‘re-affirmed’ by representatives from the Alukura Cultural Advisory Council and Congress Alukura, but its lack of revision suggests a static quality in Aboriginal birth culture. There is no longer a linguistic juxtaposition of Aboriginal culture and Western medicine. This allows Western medical concepts to transcend to authority in the text. The cultural content in previous manuals was inserted in the antenatal care section. This meant health practitioners were required to consult and incorporate cultural considerations into the care they provided during a woman’s pregnancy. In this edition, it is inserted as an introduction to the section ‘Labour and birth’ (pp. 164–165). As planned births only occur in hospital, this section is only likely to be consulted during an imminent birth and thus not incorporated into care.

In the ‘Labour and birth’ introduction, there is section titled ‘Births “out bush”’, and this begins by stating that ‘births do still occur unexpectedly in the remote communities’ (p. 165) and that women do not always agree with ‘birthing in hospital’. Despite this acknowledgement, the next paragraph informs the health practitioner that if a woman presents in established labour, medical and midwifery colleagues should be consulted and that labour may be suppressed so the ‘woman can
be evacuated to hospital’ (p. 165). Discussion with the pregnant woman to ascertain her birthplace wishes or whether she would like her labour stalled is not mentioned in the text.

Discussion

Over the 35-year period represented by the texts, Aboriginal women have persisted in giving birth in non-hospital settings and at a higher rate than non-Indigenous women in the Northern Territory. However, over this period, the rate of community Aboriginal births has dramatically dropped from 61.7% in 1971 (Northern Territory Government Department of Health, 1980) to 4% in 2008 (Thompson, Zhang, & Bhatia, 2013, p. 7). Review of the clinical manuals demonstrates the dominant use of scientific and clinical logics to sanction planned birthplace. Using these logics, birthplace is chosen by the health practitioner through clinical examination of the woman’s body, and is guided by amassed epidemiological records to indicate gross patterns of reproductive pathology risk. But in the editions produced during the 1990s, there is an emerging but brief emphasis placed on the cultural, intuitive and personal logics. This coincides with a shift in the manual’s language and style, which focuses the discourse on the needs of the woman and her family. Emphasis is securely placed on the woman’s expertise and power to make her own birthplace choice, even if it conflicts with authoritative logic. She is able to use familiarity with her own body and baby, her community’s ancestral and spiritual knowledge and her prior personal experience to decide where she should give birth.

We argue that the positioning of the Aboriginal woman into the discourse, along with the inclusion of the Birth Plan are historical midwifery artefacts. These artefacts reflect a key tenet of midwifery practice—woman-centred care—and therefore
demonstrate the influence of the midwifery discipline in the discourse construction. We suggest that the Birth Plan was a midwifery intervention directly aimed at increasing the agency of Aboriginal women in the medical system. Since their advent in the early 1980s, birth plans have been used to communicate the emotional and physical needs of women during childbirth and often in medicalised hospital settings (Owens, 2009).

The midwifery presence in the discourse is likely attributable to the sociopolitical ferment of the 1970s and 1980s that saw urban Australian midwifery gain some political power and traction in relationship to the medical profession. This occurred through consumer-led reform that questioned the dominance of medicalised approaches to childbirth. Although largely driven by the consumer demands of wealthy, educated, urban-based Caucasian women, this movement reframed, as Reiger (2001) explains, both ‘ideas of social justice and women’s rights in order to include the management of birth, the care of babies and the needs of mothers’ (p. 12). Although this paradigm shift was somewhat delayed through geographic and social isolation, it provoked the midwifery profession to be critical and aware of Aboriginal women’s reproductive human rights in remote areas of the Northern Territory.

Yet, this woman-centred discourse is only transitory. By the 2008 edition, the woman is no longer at the focus of the discourse and is instead displaced, choiceless and endowed with a known birthplace destiny. The health practitioner is the expert and their role is to ensure the woman’s destiny is fulfilled. The careful ‘preparation’ of the woman makes her a malleable entity without personal autonomy who can be made to accept the preconceived medical destiny of a hospital birth. Beginning in 1994, there is also an emerging legal logic evidenced in advice to document in medical notes any comments regarding consumer rights. This strengthens in
subsequent editions, and by 1999 is documented in formal warnings about legal liability. We suggest that the derailment of Aboriginal women’s birthplace choices reflects a powerful transcendence in the Northern Territory of the medical profession over midwifery, which is then strengthened by litigation fears. Using an epidemiological construction of the pregnant Aboriginal woman as physically diseased and at-risk, the medical profession is able to rationalise omnipotent control to limit her personal autonomy and make her ‘safe’ while in hospital. In this context, ‘safe’ is defined using only scientific and clinical logics.

However, if these logics are used to investigate sanctioned birthplace, we stumble. A scientific logic would assume that regional centralisation of maternity services has, over time, been encouraged on the basis of improving Aboriginal maternal and infant health outcomes. Yet, to date, there appears to be no historical epidemiological evidence to robustly substantiate such a proposition (Monk, Tracy, Foureur, & Barclay, 2013). As with other attempts to link birthplace to perinatal death (Nove, Berrington, & Matthews, 2012), there remains many methodological challenges, such as the simple task of being able to identify an accurate record for the intended place of birth and/or the problem of statistically rare events (i.e. maternal mortality) in a low-volume population setting, all of which are unlikely to be resolved. Additionally, health statistics, particularly rates of births, are already known to be of poor accuracy in the Northern Territory (Johnstone, 2009). Although, there has clearly been a marked and dramatic improvement in the Aboriginal neonatal death rate, from 31.2 per 1,000 live births in 1973 (Northern Territory Government Department of Health, 1980) to 9.6 in 2008 (Thompson et al., 2013), its significance to planned birthplace is yet to determined.
Ironically, research evidences some risks and harm to Aboriginal mothers and babies from planned non-community hospital births. The fly-out model of maternity care involves women undergoing lengthy periods of sociocultural separation from their family and community, often for weeks at a time, accommodated in a regional hostel waiting to give birth. Women report that they live with the threat of harassment and violence from drunks and distant relatives who visit the hostel to solicit money and that they experience limited supply and poor security of adequate nutritious food. Many women report not eating for several days at a time in late pregnancy, which poses risk of serious suboptimal maternal nutrition and the halting of foetal growth (Kildea, 1999). Women also report distress at leaving their young children and worry for their welfare back in the community (Ireland, 2009; Kildea, 1999). Then, when accessing maternity care, women often encounter ‘shame’-provoking medical experiences, difficulties in communicating their needs with staff and widespread culturally insensitive care practices (Ireland, 2009; Ireland et al., 2010; Kildea, 1999, 2006). In addition, the safety of postnatal discharge for remote Aboriginal women is threatened by poor written documentation and frequent communication breakdowns between hospitals and remote health clinics. A lack of hospital-based clinical governance and responsibility for remote discharge planning has also been identified as a threat to the safety of remote-living Aboriginal mothers and babies (Bar-Zeev, Barclay, Farrington, & Kildea, 2012). International evidence certainly suggests that low-volume remote community maternity services with midwifery-led care, can be no more harmful than hospital-based services for an ‘all-risk’ indigenous population and may actually contribute positively to reforming problems of social dysfunction and enhancing community capacity (Houd, Qiuajuak, & Epoo, 2004; Van Wagner, Osepchook, Harney, Crosbie, & Tulugak, 2012). Yet, as Daviss (1997, p. 445)
articulates, what constitutes scientific evidence in the provision of maternity care will often depend on who has the most ‘political power’ rather than just ‘good science’.

It remains very likely that other factors, governed by different logics, such as economic constraints or issues of workplace recruitment and retention could provide compelling evidence for why Aboriginal women should not be supported to give birth in remote locations. If such prohibitive factors can be identified, rather than disguised in clinical practice manuals, with authoritative discourses using science and clinical assessment to limit women’s reproductive choice, they should be openly debated and then addressed in research agendas and policy redevelopment. The challenge for policy and practice document-makers is to enhance the transparency of the evidence they use in the rationalisation of Aboriginal maternal health practice and policy. This would have a twofold benefit: first, health practitioners could openly discuss the evidence with the women and families on whom it impacts; and second, future policymakers would have crucial information with which to judge some of the successes and limitations of a policy or practice directive.

Conclusions

Review of the six practice manuals has demonstrated dramatic changes over time in the way planned birthplaces have been sanctioned for remote-living Aboriginal women. Reflection on the manuals’ structural and contextual dimensions has highlighted a displacement of Aboriginal women in their childbirth experiences, a diminishing of their rights to reproductive choice and a marginalisation of their cultural childbirth practices. Despite the dominance of scientific and clinical logics to limit planned birthplace choices, we found no robust scientific evidence to support hospital as the only planned birthplace available. To the contrary, we found evidence
in current literature to support the validity of increasing choices to include
birthplaces that are in or nearer to Aboriginal women’s home communities. This
highlights a problematic and curious conjecture, in that it appears power, and not
necessarily scientific evidence, is being used to sanction planned birthplaces. Older
practice manuals document that pregnancy care was once centred on the Aboriginal
woman and her family, but now her needs have been displaced by the hegemonic
demands of a health system that sanctions a hospital far from her home as the only
place where she can plan to give birth. Through engaging in this research process, it
has disturbingly come to our attention that we (Authors 1 and 2) have been complicit
in the production and perpetuation of this authoritative discourse—both as
contributors to the content of practice manuals and as clinicians who have practiced
according to their protocols. We therefore pose this question to the reader: Have you
also been complicit?

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Chapter 7:

From *Wanhpanhs* to Wombs: The Ethnophysiology and Language of Female Fertility and Reproduction in One Remote Northern-Australian Aboriginal Town

**Statement of Authorship**

By signing the Statement of Authorship, each author certifies that their stated contribution to the publication is accurate and that permission is granted for the publication to be included in the candidate's thesis.

**Paper Title:** From *Wanhpanhs* to Wombs: the ethnophysiology and language of female fertility and reproduction in one remote northern Australian Aboriginal Town.

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*Figure 7.1.* Statement of Authorship for publication: ‘From wanhpans to wombs: The ethnophysiology and language of female fertility and reproduction in one remote northern-Australian Aboriginal town’.
From Wanhpanhs to Wombs: The Ethnophysiology and Language of Female Fertility and Reproduction in One Remote Northern Australian Aboriginal Town

Authors: Sarah Ireland, Suzanne Belton, Sherry Saggers, Ann McGrath, Concepta Wulili Narjic, Michael Walsh and Teresa Ward.

Abstract

Background and Aim: Despite health disadvantage and the known importance of culture, there is a paucity of research dealing specifically with how Indigenous women in Australia situate and talk about their sexuality and reproduction. This research aimed to describe women’s beliefs, knowledge, and language about their sexual and reproductive bodies in one remote northern Australian Aboriginal town.

Methods: Extended fieldwork in one remote community over a six-year period, participant-observation, written fieldwork diaries and ethnophysiology drawing and language-recording sessions.

Results: Women situate their sexuality and reproduction within a life-cycle approach governed by age-grades. Evident in Aboriginal language is a rich vocabulary describing the female life-cycle, fertility, pregnancy, childbirth and lactation. Current anatomical and physiological beliefs are not the same as those used in Western biomedicine. Some words are considered sacred and should not be publicly disseminated. Younger women often do not recognise key reproductive terms.
Conclusions: Localised constructions of the female body do not easily translate into Western biomedicine. This poses challenges to Western medical approaches when engaging Aboriginal women in health care and screening. More research is needed to evaluate, customise and culturally inform local approaches to sexual and reproductive healthcare.

*Keywords:* Aboriginal women, reproduction, sexual health, ethnophysiology, language, ethnography, Australia, remote

**Introduction**

Ethno-physiological explanations of the female body from around the world demonstrate the importance of culture and spoken language in the construction of women’s reproductive and sexual health (Belton & Whittaker 2007; Brewis 1994; Castaneda, Garcia, & Langer 1996; de Bessa 2006; Inhorn 2006; Jordon 1989; Nichter & Nichter 1983). Every society forms complex belief structures around human procreation, and it is argued that health interventions designed to improve sexual and reproductive health can only be successful if they consider the influence of culture. This may include the community’s ‘customs, values and myths’ surrounding fertility, sexual intercourse, pregnancy and childbirth (Castaneda et al. 1996:133). Despite profound health disadvantage and the known importance of cultural influence on health, there is a paucity of research dealing specifically with how Indigenous women in Australia situate and talk about the sexual and reproductive body.

Aboriginal and Torres Strait Islander women experience the worst reproductive and sexual health outcomes of all Australian women, with higher rates of sexually transmitted infections (Bowden et al. 1999; Kirby Institute 2012) infertility (Kildea
& Bowden 2000), cervical cancer (Australian Institute of Health and Welfare 2013),
maternal and infant mortality, low birthweight babies, teenage pregnancy (Li, Hilder,
& Sullivan 2012) and family violence (Al-Yaman, Van Doeland, & Wallis 2006;
Willis 2011). To address this unacceptable disadvantage will require a better
appreciation of how Aboriginal women culturally understand their bodies and health.
This paper describes women’s beliefs, knowledge and language about their sexual
and reproductive bodies in one remote northern Australian Aboriginal community.

Research Site

Saint Fiacre (pseudonym) is a large remote northern Australian Aboriginal
community that was once a Catholic mission. The town is isolated for approximately
six months of the year due to the monsoonal wet season but remains accessible via a
regular aeroplane service. The main regional centre is a one-hour flight away. The
town has a youthful demographic profile, with almost half the population under 15
years of age. Similar to other remote Aboriginal towns, residents here live with high
rates of preventable illness, disease, disability and death, which persist despite the
provision of Western medical health services. High levels of morbidity are starkly
reflected in the median age of death for Aboriginal people in the regional area,
estimated at 46 years (Taylor 2004:78).

The lingua franca of the community is one Aboriginal language. For most people,
English is their second language and is only used out of necessity when interacting
with people or organisations from the dominant Western outsider culture. The
leading Aboriginal language in the town has come to dominance since the
establishment of the mission on the traditional lands of its original speakers. Many
other languages are represented within the clan groups who now reside in Saint Fiacre, but these languages are in decline.

A government-run community health centre, staffed by nurses and doctors, services the health needs of the population, providing primary health care and an emergency after-hours service. Remote health professionals practice at a great disadvantage because they do not share a common culture, language or world view with their clients. The community health centre was once co-staffed by skilled Aboriginal health workers, but they have now all retired, resulting in a clinical absence of staff able to provide cultural mentoring and language translation assistance to non-Aboriginal workers.

**Gaining Permission**

Working in partnership and with permission from Aboriginal women, the research was part of a larger doctoral study investigating the social, cultural and historical factors underlying women’s sexual and reproductive health. Our research goals were known to overlap with the goals of the local Aboriginal language centre to record ‘gender sensitive’ terms in as many of the region’s Aboriginal languages as possible. There is urgency to this language documentation because the speakers of some of the languages now number less than ten and they are elderly.

Ethical approval for the project was granted by the Menzies School of Health Research Ethics Committee and a subcommittee dealing specifically with Aboriginal research (Application #HR-10–1429). Letters of written support were obtained from the community and other key stakeholders. The overarching project was overseen by a local reference group comprising senior women, female community leaders,
Aboriginal health workers and other interested individuals. The reference group provided support, advice and direction throughout the research.

Concepta Wulili Narjic was the cultural mentor for the project, providing leadership and advice on all aspects of Aboriginal research methodology and recruitment. Several Aboriginal research assistants who live permanently in the community were recruited, trained and paid to assist with data collection. Due to the sensitive nature of our project, it was their request to remain anonymous.

**Methods**

The ethnographic study was completed over a six-year period (2007–2013) and involved iterative cycles of data collection. Research rigour was ensured through collaboration with Indigenous women, prolonged community engagement, triangulation of research methods and participant data validation (Liamputtong 2009:23–29). Data collection methods included group ethnophysiology drawing and language-recording sessions ($n = 10$), extended ethnographic fieldwork in the community over a six-year period, community observation and participation and written field notes.

The fourth author, Aboriginal research assistants and the local reference group used the *message stick* sampling technique to verbally invite potential participants to the research, a technique successfully used in other research in a remote Aboriginal town (Ireland et al. 2010). Message sticks targeted only women with known language skills and a lifetime interest in *women’s business*. The technique involved a verbal message stick being relayed inviting participants to the research. If a potential participant responded to the message stick and agreed, the non-Aboriginal researcher was introduced and the woman consented to be involved in the research. Due to this
method of subject recruitment, it is uncertain how many women in total were invited or how many declined participation. A recording of the project information sheet and consent form was played aloud in the participant’s first Aboriginal language. Dependent on the participant’s literacy levels and personal preference, written or verbal consent was gained. The consent process was witnessed by the fourth author or an Aboriginal research assistant and documented in writing on a consent form. Twenty women aged between 49 and 91 years participated in the research. In total, the participants spoke three languages and two dialects and represented 13 clan groups. The sample group achieved diversity in age, language, clan group and country affiliation.

**Data Collection**

At the request of participants, data collection sessions occurred in the privacy of the non-Aboriginal researcher’s accommodation in the community. The female-only sessions were co-facilitated by an Aboriginal and non-Aboriginal researcher. The local Aboriginal language centre provided a spreadsheet of target terms they wished to be recorded, and this was used by the non-Aboriginal researcher to guide the overall direction of the ethnophysiology drawing and language sessions. Using an exploratory life-cycle narrative approach, participants were asked to discuss and comment on the journey a newborn baby girl will make through life. Participants were provided with pens, pencils, crayons large sheets of paper on which explanations of body structures and functions could be drawn and elaborated upon.

When group consensus was met on a particular language term, participants delegated language speakers, who then digitally recorded the word on a Dictaphone. Several recordings were made to compensate for variance in the speakers’ pronunciation or
voice quality. After the words were recorded, they were played back and checked by participants. This was replicated on separate days to ensure the term was correct. Some adjustments were made, especially in the less widely spoken languages. After collection of the terms, spelling workshops were undertaken with Saint Fiacre’s only Aboriginal female skilled in cross-cultural language spelling. Working alongside participants, she listened to the audio recordings and wrote the words according to a pre-established spelling protocol. She has had many years of experience working with the local Aboriginal language centre in this role. For the purposes of this paper, we have only reported on findings expressed in Saint Fiacre’s dominant Aboriginal lingua franca.

Explanations of women’s reproductive and sexual physiology were recorded by hand in written notes during the sessions. Drawings that accompanied the explanations were saved to supplement the handwritten notes. The notes were then typed, printed and read aloud to participants for checking. If an error was identified, changes were made and the cycle of checking recommenced until no errors were reported by the participants. The findings were then triangulated between the actual terms and reported explanations of physiology, linguistic literature, professional translator opinion, extreme and similar findings, participant-observations, cultural mentor advice, local reference-group discussions and notes made in fieldwork diaries.

Results

Noun classifications and worldviews

The dominant Aboriginal language spoken in the area and represented in these results divides nouns into approximately ten separate classifications, as listed in Table 1. These classifications provide revealing insights into how speakers logically
sequence and understand their world. For example, there is one noun class devoted exclusively to spears and another to striking forces.

Table 2

*Local noun classifications*

<table>
<thead>
<tr>
<th>Noun class</th>
<th>Nouns included</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kardu</td>
<td>Aboriginal humans: males and females; human spirits; kinship terminology</td>
</tr>
<tr>
<td>Ku</td>
<td>Animals, birds, insects and marine life; flesh and products from animals, non-Aboriginal humans; spirit world entities not classified as kardu; Christian god; female genitalia</td>
</tr>
<tr>
<td>Nanhthi</td>
<td>Most natural substances and objects; inedible parts of animals (e.g. feathers), human body parts; most natural phenomena; urine, menstrual blood and human milk; artefacts and implements; defensive weapons (e.g. shields); song and dance; introduced European objects</td>
</tr>
<tr>
<td>Da</td>
<td>Camps and living places; localities; time; seasons</td>
</tr>
<tr>
<td>Mi</td>
<td>Vegetable food items; fruit; faeces</td>
</tr>
<tr>
<td>Kura</td>
<td>Fresh water; rain; drinkable liquid that is not human milk</td>
</tr>
<tr>
<td>Thu</td>
<td>Striking forces; offensive weapons; thunder and lightning; playing cards</td>
</tr>
<tr>
<td>Thamul</td>
<td>All types of spears</td>
</tr>
<tr>
<td>Murrinh</td>
<td>Speech, language, names, places associated with talk or learning; non-Aboriginal songs; stories; legends; news</td>
</tr>
<tr>
<td>Thungku</td>
<td>Fire; firearms; electricity</td>
</tr>
</tbody>
</table>


Noun classifiers are very important in the context of what is known locally as ‘women’s business’. Walsh (1996:336) notes that all body parts fit into the *nanhthi* noun class with three exceptions: the female vulva, vagina and clitoris, which are all
assigned to the *ku* group. The reasoning behind the *Ku* prefix was not able to be fully explained by Walsh. Walsh (1996) commented on the reluctance of his language teachers to discuss such details further. He hypothesises that, as with English, which has words that mimic the shape or quality of male genitalia, such as ‘eggs’, ‘nuts’, ‘cucumber’ ‘salami’, language speakers have decided to classify this part of the female body into the noun class *ku*, which is generally reserved for foodstuff.

Although female genitals do indeed resemble some fleshy foods locally eaten, such as mud mussels, the *ku* classifier may also communicate reverence towards the female genitals in the same way that *ku* is used for supernatural beings or authoritative figures, such as *ku warnangkarl* (a witch doctor, singer or wise person). Participants were happy and willing to discuss the origins of the classifier but were unable to explain the logic for the noun deviation other than it was the practice of their ancestors to name it this way and hence they respectfully continue the practice. They explained the use of *ku* protocol in naming female genitals as ‘how the old people taught them’ and as it simply being in the manner of their ‘grandmothers’. By association, this is seen as being the proper and only correct way of referring to these body parts. Currently, however, younger girls are experimenting with the protocol and are favouring the classifier of *mi* (reserved for vegetable food stuffs) for female genitalia words, with some girls even denying *ku* as a legitimate classifier for the female genitals.

**Female age-grades**

Participants reported that females can be classified according to their age-grades. There are five age-grades, commencing with a child of any sex before puberty as *kardu mamay* and progressing to the female age-grades of *kardu mardinhpuy, kardu*
The age-grades are without an exact Western equivalent but demonstrate a female’s social status and her progression through the cycle of life, marking sexual development, fertility, reproduction and postmenopausal old age. Women explain that the age-grades are differentiated through the physical demonstrations of sentinel events, including breast development, pubic hair growth, menstruation and fecundity, sterility with the cessation of menstruation, and old age. In the public domain, the shape and development of a woman’s breasts are important factors in assigning her a correct age-grade. In the recent past, some age-grades were marked by ceremonial activity to celebrate a young girl’s first menstruation and provide her with instruction on personal hygiene and future responsibilities as a woman. This ceremony was a long-term cultural practice banned by missionaries in the 1930s but reinvigorated in the 1990s by senior women. This type of ceremony has not been practiced in over a decade, and older women lament its absence as now they consider their young women unskilled in the concerns of women’s business. One participant said:

We feel really sorry for the young ones now. No ceremony and they don’t know how to look after themselves. (Helen, 68 years, kunugunu woman)

Age-grades have perhaps encouraged a culture of close public surveillance of the human physical body, which leads to many comments about other people’s bodies. Fieldwork notes commonly recorded how people refer to an individual’s physical features, for example: ‘That fat one over there’, ‘She is the real skinny one’, ‘Long legs is not my friend’, or ‘Go and see doctor big eyes’. Such comments were nonchalant and not perceived by others as offensive, but at times they were said with a humorous overtone.

*Kardu keke and the deviant nugarn keke may also be used when referring to a middle-aged male.*
**Childhood development**

This keen observance of the physical body results in a well-developed sensitivity and awareness of the developmental milestones of childhood. This localised knowledge is encoded in language and is part of a mother’s close knowledge of her child. Participants recorded 19 milestones marking child development, from birth to attainment of physical and linguistic mastery in preparation for adolescence. These stages are listed in Table 2. Considering that the concept of childhood development was not contextualised into Western psychosocial theories until the last two centuries, the sophistication of these childhood age-grades in an ancient language reflects an early appreciation of childhood development. Regrettably, participants explained that many of these terms are now ‘old fashioned’ and predicted that some young mothers on hearing them will laugh and not understand their meaning. This suggests that knowledge of childhood developmental is being lost in younger mothers, who now represent the majority of the population.
### Table 3

*Childhood developmental milestones*

<table>
<thead>
<tr>
<th>Chronological progression of time</th>
<th>Language term</th>
<th>Developmental English translation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Newborn baby</strong></td>
<td><strong>Manangkaningi or mirringi [female]</strong></td>
<td>Newly born baby wrapped and carried in paperbark</td>
</tr>
<tr>
<td></td>
<td><strong>Wakal tidul [male]</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Wakal wemarda</strong></td>
<td>Still wrapped in paperbark but sitting on an adult’s lap [perhaps 3–4 days old]</td>
</tr>
<tr>
<td></td>
<td><strong>Wakal wurdarduy</strong></td>
<td>Able to move body and roll over</td>
</tr>
<tr>
<td></td>
<td><strong>Wakal murrinhdhay</strong></td>
<td>Making baby noises like ‘ooo’, ‘argh’</td>
</tr>
<tr>
<td></td>
<td><strong>Wakal dempinhimardadum</strong></td>
<td>Able to roll onto stomach, turning over</td>
</tr>
<tr>
<td></td>
<td><strong>Wakal kanawup dim</strong></td>
<td>Sitting up</td>
</tr>
<tr>
<td></td>
<td><strong>Wakal mampinthap</strong></td>
<td>Starts to practice crawling on hands and knees but does not move</td>
</tr>
<tr>
<td></td>
<td><strong>Wakal murrinhdhay ngala</strong></td>
<td>Stronger baby, talking noises</td>
</tr>
<tr>
<td></td>
<td><strong>Wakal dimpudeng</strong></td>
<td>Crawling</td>
</tr>
<tr>
<td></td>
<td><strong>Wakal dempirnturt</strong></td>
<td>Able to pull up to standing position but still shaky and unable to walk</td>
</tr>
<tr>
<td></td>
<td><strong>Wakal wurranpudeng</strong></td>
<td>Confident, faster and coordinated crawling</td>
</tr>
<tr>
<td></td>
<td><strong>Wakal pirretat pirrim</strong></td>
<td>Strong enough to stand steady</td>
</tr>
<tr>
<td></td>
<td><strong>Wakal wililime</strong></td>
<td>Starting to walk</td>
</tr>
<tr>
<td></td>
<td><strong>Wakal mi wulamath</strong></td>
<td>Able to be asking for food and breastmilk</td>
</tr>
<tr>
<td></td>
<td><strong>Wakal nungampinhart</strong></td>
<td>Starting to run around</td>
</tr>
<tr>
<td></td>
<td><strong>Wakal tharra me ngala</strong></td>
<td>Walking and running with strength and confidence</td>
</tr>
<tr>
<td></td>
<td><strong>Kardu wakal ngala</strong></td>
<td>Grown-up child before changes of puberty start</td>
</tr>
<tr>
<td></td>
<td><strong>Wakal murrinh bangamlele</strong></td>
<td>Strong and correct child speech</td>
</tr>
<tr>
<td><strong>Pre-adolescent child verging on puberty</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Breasts and lactation

Breast development and shape are the important markers in age-grades and are described by women in several ways. Western medical knowledge demonstrates that breast tissue is sensitive to reproductive hormonal changes during puberty, menstruation, pregnancy, lactation and menopause and that it also undergoes structural changes during the ageing process, which can be evident in the outward shape and consistency of the breast. After puberty, the breasts in young women are designed for the production of milk to nurture an infant and thus are densely glandular and firm. As women age, the adipose composition of the tissue slowly increases and the glandular milk producing tissue is depleted. When menopause is reached, the breasts are composed almost entirely of adipose tissue, leading to a softer and less taut appearance (Cancer Council Victoria 2009). Lactation may also change the shape, size and texture of the breasts and nipples. This is due to hormones, tissue expansion and retraction from changing milk supply and the infant’s frequent nutritive sucking and fondling. Although not rehearsed in Western medical concepts of hormones and tissue change, participants indicated a keen awareness of visual breast variations, using them as a public biological clock of sorts.

The breasts are referred to as *nanhthi ngapurlu* and the nipples as the ‘eyes’ of the breasts: *nanhthi ngapurlu kamarl*. Breastmilk is referred to simply as *ngapurlu*, and the physiological production of it remains unknown and mysterious to women. Some participants thought drinking fresh or powdered cow’s milk could assist or even produce breastmilk, and this was cited as the reason lactating pet dogs or cats should be given milk to drink. This cause-and-effect belief may have an historical legacy
from mission times, when clinical nurse sisters in the hospital gave nutritional milk rations to all lactating mothers. Ancestral knowledge also described the consumption of mangrove worms to enhance milk supply.

Breasts are described as nanthi ngapurlu pirinurduyi in early puberty when they begin developing by ‘coming out’ like hard small lumps that can be palpated under the skin, like small stones or peas. The word pirinurduyi exclusively describes this stage of breast development. The breasts are then referred to as nanthi ngapurlu thunpith, meaning they are sharply shaped and pointy. One participant described this shape as similar to ‘the end of a lead pencil’. Thunpith is also used to name a species of tree (thay thunpith) which is known in English as the red-flowered kapok and in Latin as Bombax ceiba from the Bombacaceae family (Nambatu et al. 2009:23). The timber from this tree is lightweight and in the past was used for constructing woomeras and canoes. When the trees are young, their trunks have sharp pointed thorns that look remarkably like growing breasts, hence its name being used to name this early phase of breast development. The third phase of breast development is nanthi ngapurlu ngala, meaning large breasts that are full in shape, firm and well-developed. With increasing age, this is followed by the final developmental term, nanthi ngapurlu bammat, which means the breasts ‘are falling down’ shaped—that is, long, sloping and pendulous. These breast shapes are linked to the progressive age-grades as shown in Figure 1.
Figure 1. Breast shape development according to female age-grades.

There term *nanthi ngapurlu kampuk* is used to describe milk-engorged breasts that become painful and lumpy during lactation. *Nanthi ngapurlu kampuk* is a condition known to occur when an infant is not suckling correctly. This is remedied by placing the nipple deeply into the infant’s mouth to encourage better attachment and by frequent feeding. A tree shares the same name (*thay kampuk*) but having no common English name it is known by its Latin name *Pouteria* (or *Planchonella*) *arnhemica* from the family Sapotaceae (Stuckey 2011). The tree has no known association with or likening to engorged breasts and among participants had no ethnobotanical use or significance. We note the term has been glossed as ‘breast cancer’ in one publication (Street 2012:10), but in this research it was rejected by participants who said that this condition occurs only during breastfeeding and is not a form of sickness. It is understandable how it could be glossed as breast cancer; lumps and pain may be common to both lactating engorgement and breast cancer. As a culturally congruent term, it may prove a useful starting point for discussing signs of breast sickness, but
to avoid communication problems it should not be used alone to describe the life-threatening illness of cancer.

**Figure 2.** Thorns on the trunk of a juvenile *thay thunpith* (red-flowered kapok), *Bombax ceiba* from the Bombacaceae family

**Sexual organs**

The women requested that the individual words for female sexual organs remain sacred and not be published, and their wishes have been respectfully observed. The external sexual organs are known by a collection of terms that describe the equivalent medical terms of *labia majora*, clitoris, urethra, vagina, female genitals, and female genitals located between the labia. According to our participants, all female sexual terms that use the *ku* classifier are sacred, and unlike other subject matters, such as breasts, we were instructed to not publicly discuss these. During fieldwork, we were taken to a dreaming site that venerated female genitalia and fertility. Although the terms reported remained the same, there was considerable
variance in where the participants anatomically placed the names, which suggested a blending of some terms and meanings over time. This may be an influence of the Catholic mission, when the use of Indigenous language was not encouraged and, according to research participants, speaking of genitals was considered profane and punishable. To effectively pass on ‘women’s business’ language and ancestral reproductive knowledge would have been very difficult in such an environment. As Walsh (1993) laments, once the intergenerational link in an unwritten language has been broken it may quickly disappear.

There were variances among other published sources regarding these terms. For example, Walsh (1996) described the word used for clitoris as meaning ‘nose’, when used with the nanhthi noun classifier. The shape of the clitoris certainly can be imagined as resembling the ‘nose’ of the female genitals and with the label for labia majora meaning the ‘ears’, this appears to be etically congruent and logical. A similar characterisation is used when the nipples are referred to as the ‘eyes’ of the breasts. However, the term for clitoris was disputed by research participants, who said that despite this word sounding similar to ‘nose’, it is a separate word with its own dedicated meaning and spelling. Instead, participants used the name reported by Walsh (1996) to refer to the inner female genitals, revealed when the labia are spread, and offered an alternative word for the clitoris, which shares its root name with that of an axe. Participants supported this by observing that the clitoris has the same shape as the head of a stone axe or tomahawk, an equally convincing explanation as that offered by Walsh.

A word was rediscovered referring loosely to the medical equivalent of the hymen which was recorded and glossed as hymen and belonging to the ku noun class in an unpublished language dictionary written by a priest from early mission times.
Participants reported this term as ‘old fashioned’ and currently not in common usage. They explained that the term has been replaced by the concept of how the vagina changes after childbirth. Put simply, a woman before vaginal childbirth has a *weyi denthap* (small closed passage) and after vaginal childbirth has a *weyi menthal* or *weyi ngala* (large open passage). This body concept did not refer to a discrete structure in the genitals, such as a hymen, that changed after first sexual intercourse. Although discussed only superficially in the role of sexual intercourse, we recorded the ‘men’s business’ terms that describe the words for male ejaculate, penis, erection and scrotum. The penis shares the same name as a species of poisonous snake but has the noun classifier for body parts assigned.

**Sexual development and reproductive cycle**

Women believe that female infants are born with a *nanhthi kaminherrkminhyerrk*, a single ovary, which at this time is immature and located in the lower abdomen. An ovary is described as being small, round and ‘without arms or legs’, similar to the egg of a bird or reptile, and as capable of mysteriously synthesising life. Animal ovaries are seen in many of the birds and animals hunted for bush food consumption. The presence of an ovary in bush tucker indicates that the creature is ‘nearly ready to have babies’. Participants reported from experience that the meat from a hunted female animal, which on dissection shows this indicator, will ‘taste dry’. Fresh-water turtles, geese and fish are examples of creatures known to have ovaries.

As the young girl matures, her body begins to change. Hair starts to grow under her arms (*kurlpurru wanthay*) and ‘a small track’ of pubic hair known as *kurlpurruwan* grows on her vulva. Her breasts also start developing, first ‘like hard little stones’ and then ‘sharp and pointy’. At this same time, the ovary starts to grow bigger and a
girl will experience her first menstruation. Menstruation, known as *nanthi mamurr warda*, means the girl is capable of becoming pregnant, but pregnancy at this stage is perceived as socially undesirable because she is deemed too young. Menstruation is the body’s way of cleansing. The menstrual blood is seen to be ‘no good blood’, full of accumulated poisons and toxins. The bleeding is positive because it ‘cleans out the body’. Menstruation is marked by the moon’s phase and can be followed and predicted by its cycle. The menstrual blood does not accumulate in her body but simply flows out through the opening of the vagina.

Over time, the young girl’s hair continues to grow thicker and denser under her arms, on her vulva and now also on her inner thighs. Her breasts become round and fuller, and her menstruation cycle is now regular as she matures into a young woman. If pregnancy occurs, her menstruation will stop and return after the birth of the child. The menstrual cycle continues as she ages, and, slowly, the internal ovary begins to lose its rigour, shrivelling, shrinking and drying up, ‘like old leaves on a tree’. This is known as *nanthi kaminherrkminhyerrk yibimpup*. Once it has dried up, menopausal cessation of menstruation occurs, and her breasts will sag and ‘fall down’. There were no spontaneously reported menopausal symptoms associated with this stage of life such as hot flushes, sweating, emotional disturbances or irregular bleeding patterns. Participants did not report fertility being linked to the menstrual cycle but only to the rigour of the internal ovary.

A woman’s libido peaks during the phase spanning the age-grades of *kardu mardinhpuy* and *kardu palngun* and slowly recedes in old age. As Catherine, a postmenopausal 68-year-old *kunugunu* participant joked, ‘My ovary is all dried up now and so is my sex!’ Having sex is known to be sometimes pleasurable, and this is referred to as *mandinhinhinh*. Participants commented that sometimes in the evening
you can see the young girls are ready to go out and meet the boys. As 66-year-old kunugunu participant Eleanor said:

The young girls are feeling good and are hungry for sex. We tell them to be careful with the boys, but they answer back ‘It is my own will to play around. This is my own body. I can walk around anytime’.

As with adolescents in other cultural settings, the younger girls in the community displayed varying degrees of knowledge about the reproductive cycle. None of the young women spoken with understood the term nanthi kaminherrkminhyerrk and could offer no alternative information, which suggests that transmission of cultural reproductive knowledge and language is in decline. One experienced professional translator, who often works in health settings, was also unfamiliar with this term.

**Pregnancy, loss and childbirth**

Conception, pregnancy and foetal development were described and drawn in detail. Pregnancy is believed possible when a sexually mature female has penetrative vaginal sexual intercourse with a male. Pregnancy occurs when a male’s ejaculate meets with her ovary, and this explanation appeared to be a Christian-mission-acquired understanding of conception. Although contemporary beliefs in the presence of kardu wakal ngarrithngarrith (spirit children) continue, recorded in the past as being solely responsible for conception (Stanner, 1936b), participants preferred to explain conception as occurring through sexual intercourse, where the ejaculate and ovary mingle, transforming into a small membranous ball called the nanthi wanhpanh. The foetus grows inside the nanthi wanhpanh, resting in fresh water, and is tethered to it by the nanthi thirrimeme (umbilical cord). The exact timing of when the ovary ceases to exist and the baby is believed to exist in human-
like form is difficult to ascribe. Participants thought maternal perception of a baby moving inside her body, known as mardawuteth, is an important marker in determining this. Early pregnancy is referred to as marda, which is also used to describe feeling satisfied with a full stomach after eating sufficient food. More-advanced pregnancy that is publicly visible is known as putput. One participant explained the beginning of early pregnancy:

The penis is like a garden hose and waters the seed inside of us, the baby grows from the nanhthi kaminherrkminhyerrk like a tree grows from seed.

(Catherine, 68 years, kunugunu woman)

Senior women recounted their understandings of foetal growth, development and birth. The woman’s menstruation during pregnancy will cease because the blood is required to grow the baby. As the baby grows, so too does the size of nanhthi wanhpanh, until eventually it can be seen and felt in the woman’s abdomen. The nanhthi wanhpanh protects the developing foetus, providing warmth and energy for growth. As a participant remarked, ‘the wanhpanh is just like a kangaroo pouch that keeps the baby safe and warm’. Without the attachment of the nanhthi thirrimeme, the foetus will die. This was likened to household appliances needing electricity to function. The nanhthi thirrimeme is:

like an electricity plug. If you pull out the end, the baby will stop living.

(Catherine 68 years, kunugunu woman)

The baby ‘feeds’ through the wanhpanh but exactly how this occurs is a mystery. It is thought that the baby receives food from the mother because the clinic nurses and doctors are always lecturing the young girls: ‘You need to eat good food so that baby grows strong’. There were discussions but no agreement on how the woman’s food
reaches the foetus and on the function of the wanhpanh being attached to the woman’s navel.

The foetus growing in the wanhpanh is seen to have its own will and autonomy. It is the baby who decides on the timing of birth. As one participant remarked, ‘The baby, it knows the time, day and month and knows when it’s the right time to come’. Close to the time of birth, the foetus turns (wakal wurdamperduy buybatnu warda) so that its head will face down in preparation for birth. It is possible to feel that the foetus has dropped down and is engaged in the pelvis (kardu yurruthurrut warda) by palpating under the woman’s sternum and comparing the breadth of horizontal fingers that fill the gap between there and the top of her protruding abdomen. When the foetus is ready to be born, it will break through the water (kura nungalurita) by punching or kicking hard at the wanhpanh.

Childbirth is referred to as wakal dimpak and the contractions as kardu damlurturt warda. Although childbirth is known by women to be physically taxing, there is confidence in a woman’s ability to give birth and it is not approached with fear. It is believed to be the woman’s responsibility to get the baby out of her body, and the infant passively responds to her physical efforts. Although most babies are born head first, it is known that some prefer to be born in a different way, such as feet (wakal me-re bammat) or buttocks (wakal lumpu-re bammat) first. It also known that as the baby falls out, it may cause tearing trauma to the tissue of the genitals, known as kardu pana nganaka ngarra wakal thangunu bammat – ka banganngingurruduk warda.

After the birth of the child, the wanhpanh and thirrimeme are expelled with the remnant ovary from which the wanhpanh and baby grew; this can be seen in the
bloody clots and meaty placental section of the wanhpah. Without pregnancy, the wanhpah ceases to exist in the female body. After childbirth, a new ovary grows in place of the expelled one, and without pregnancy, the cycle of cleansing menstruation recommences. The dominant Western medical understanding of internal reproductive organs consists of the uterus, fallopian tubes, ovaries and vagina, but participants did not share this notion of fixed internal organs. Naming of the internal anatomy was restricted to a single ovary, and the absence of any other internal organs was explained by the ephemeral nature of the wanhpah.

Women were aware that not all pregnancies and births are uncomplicated. Premature birth was known as wakal demnegewerr, meaning that the foetus is in a hurry to be born. One participant explained how, in premature birth, “That baby is not going to wait around in there. It wants to come out and see the sunshine.” The term demnegewerr may also be used to communicate general haste, as in, “I am in a hurry to get to the shops.” This term emphasises the belief in the autonomy of the baby in choosing the time to be born. Participants also knew that sometimes the baby could be influenced to come early because of maternal factors, such as sickness, emotional shock or other known causes of illness, including traditional sorcery. Miscarriage is known as wakal manthak, meaning that the baby is now ‘lost’ in the same manner as one can lose money or keys. The term wakal thirlminh is used in relation to a deceased premature baby or a stillborn baby, regardless of gestation. This term refers to the small size of a foetus and an inevitable incompatibility with survival. Participants remarked that this can also be observed in the premature births of puppies and kittens in the community. Use of this term reveals a known logic that the size, hence birthweight, of a foetus/creature is an important factor in its chances of survival.
Abortion is known as *wakal mampelip*, an exclusive term meaning the wilful killing of an unborn foetus. In pre-mission times, this was understood to have been achieved through forceful trauma to the abdomen and occurred in circumstances that made the birth of the infant socially difficult or unacceptable. This was the only instance given where a foetus does not assert its will in determining when it is born. Discussion around this term raised many questions regarding modern techniques for terminating a pregnancy. This included confusion around religious teachings, perceived cruelty towards the unborn foetus, and differences in opinion about when an ovary turns into an embryo. During interstate travel, two participants had seen anti-abortion protests and were sympathetic to this standpoint because of their Catholic religious beliefs.

**Discussion**

These findings are limited in their social generalisability because they deal specifically with one Aboriginal community, culture, and language. Despite this, they provide broad insights into how Aboriginal women in other remote communities may situate and talk about sexuality and reproduction. The findings are organised into broad domains that may be useful starting points for investigating women’s reproduction in other cross-cultural and cross-language settings.

The lead researchers were not trained in linguistics and are not fluent speakers of any of the Aboriginal languages spoken in Saint Fiacre; therefore, they were completely reliant on participants’ skills and the quality of the information they shared. However, a background in Western biomedical health has allowed anatomical terms to be explored at a level of detail that could challenge many linguists without a health background. This, along with the influence of cultural change, may account for variances discovered in the published meanings of some words. Being female also
allowed us to discuss many sensitive concepts that would otherwise be outside the scope of a male researcher or linguist.

While local women were enthusiastic participants in remembering and recording the language of women’s business, there remains a tension for us between archiving culturally threatened vulnerable knowledge and trespassing into the sacred and private. Colonisation has destroyed many Australian Indigenous languages, and of the more than 250 Indigenous languages once spoken in Australia, a current survey suggests that only 120 are still spoken and, of these, only 13 are in a strong condition—that is, being used by people of all ages and, in this process, being passed on to children. Around 100 Australian Indigenous languages are classified as critically or severely endangered (Marmion, Obata, & Troy 2014:xii). As elsewhere in Australia, the community of Saint Fiacre has been linguistically affected by colonisation, with many languages from the region under severe threat and now one that is strong and culturally evolving. Aboriginal people in Saint Fiacre have coped with the impacts of colonisation by developing a township *lingua franca*, which has occurred at the expense of their own linguistic and cultural diversity. Although this has meant inevitable decline in diversity, it has also brought unity to the people, nurturing resilience in the face of rapid cultural change. Language remains a critical expression of culture in Saint Fiacre, constituting and reaffirming key beliefs, concepts, and meanings, resulting in a distinct worldview. Vass, Mitchell and Dhurrkay (2011:33) suggest that the term *worldview* is the way in which a group of people ‘categorise and conceptualise their reality’, forming a ‘foundational philosophy that informs each group’s perception of their respective worlds’.

In Saint Fiacre, women’s sexual and reproductive abilities are situated within a worldview that uses a life-cycle approach constructed through age-grades. Age-
grades are a resilient feature in the post-contact worldview of Saint Fiacre residents, with ethnographic records confirming they were in use before and after the mission started (Falkenberg 1962; Stanner 1936a). Compared with earlier records, a female age-grade that described the period between *kardu mardinpuy* and *kardu palngun* (Falkenberg 1962) appears to have dropped from vernacular use. This period coincided with the time that a young girl would traditionally relocate to her husband’s country for marriage. As this practice no longer occurs due to Catholic beliefs and Western laws, it may be that the term has no further cultural significance. Despite minor variances to the reported childhood age-grades, these also remain very similar to earlier records (MS 3752, 1932).

Women explain the functioning of the female body through language that is not English. Many anatomical and physiological explanations of the reproductive cycle do not reflect Western medical knowledge. The names of female genitalia remain sacred, and, despite colonisation, participants wish to maintain the sanctity of these words. Cultural reproductive and sexual terminology has survived the prohibition during the mission times but appears to be undergoing some blending of terms/meanings and, overall, is not as well known by younger women. With an increasing population and high adult mortality rates, this lessening of reproductive knowledge is expected to exacerbate as many of the older, knowledgeable women pass away before they are able to enculturate the younger generation. Young women, due to their pressing sexual and reproductive health needs, increasingly face the confusing task of amalgamating this fractured cultural reproductive knowledge with Western medicine when they seek health care. Overall, this worldview affects the provision and effectiveness of Western health care in Saint Fiacre.
Unlike people from Saint Fiacre, health practitioners trained in Western biomedical discourse believe that the structure and function of the human body is universal. This belief is substantiated by knowledge gained through the long-term cultural educational practice of cadaver dissection, with these findings and techniques passed on to subsequent practitioners through written texts and drawings. With the rise of anatomy and physiology as a subbranch of medicine, this knowledge has been used to understand the trajectory of many diseases and forms the foundation of many of medicines healing and curative techniques (Gray & Carter 1996; Hayes 2008). Practising within this authoritative and dominant system, many health practitioners forget that people under their care may hold different beliefs and knowledge about their bodies. This is not through an outward rejection of Western medical knowledge but due to a historical legacy that has shaped their current worldview. This is especially true for Aboriginal women in Saint Fiacre, who along with other Indigenous groups in northern Australia, do not share in their history a ‘biomedical worldview’ (Vass et al. 2011:34). Instead, the women who participated in this research rely on concepts and terms embedded in their own language and culture to understand their body and health. It is not that they are incapable or unmotivated to comprehend Western medical concepts—rather, for effective cross-cultural communication to occur, special attention is needed in the construction and communication of key health messages.

Such differences in worldviews affect a gamut of women’s health issues. These issues include the overall effectiveness of interpersonal health communication, the acceptability of and compliance with medical treatments, the willingness to undertake health screening, and the ability to give informed consent. For example, these research findings have documented how women in Saint Fiacre do not believe
in the Western equivalent of a uterus and have no knowledge of the internal anatomical structures of the cervix or fallopian tubes; hence, no terminology exists in relation to these structures. It is not clear how a health practitioner can encourage a woman who does not believe in the existence of a cervix to undertake a PAP smear screening, or how to encourage a young woman to protect herself from sexually transmitted infections when she does not know there is a uterus and fallopian tubes, which may be harmed. It is also unclear how women in labour can give informed consent for vaginal examinations, if they do not know what is being checked. These examples are common clinical situations that health practitioners and women from Saint Fiacre encounter, and they highlight some of the ethical and legal tensions that occur when medical concepts without cultural meanings are unwittingly used in health care. These tensions need to be better understood through further research and need to be addressed in both the microcosm of clinical practice and in the broad design of health policy and intervention if Aboriginal women’s health inequity is to be addressed.

Research with other Australian Indigenous people confirms similar communication barriers when Aboriginal people attempt to access Western scientific knowledge (Cass et al. 2002; Trudgen 2000; Vass et al. 2011). For example, Vass et al. (2011:34–35) note many instances where biomedical Western concepts, such as ‘pain’, ‘muscle’(as in contractile tissue), ‘cell’, and ‘infection’, cannot be accurately translated into the Aboriginal Yolnu Matha language. Similarly, there are Yolnu Matha terms that are not easily translated into English, such as nir’yun, which is often glossed in English as ‘breathing’ but actually has broader non-biomedical meanings. This research, along with our findings, suggests that effective health communication across languages and cultures requires more than just the translation
of words. As Vass et al. (2011) articulate, an exploration of the ‘areas of meaning’ of common health-related words is also required.

If we accept this proposition, then it is likely each community has its own cultural and language-based understanding of physiology and health-related matters. Therefore, there is an ethical and organisational challenge in articulating the value of such knowledge and in how each community can collect and store it, making it accessible for health practitioners and Aboriginal people to pursue in the meaningful customisation of health care. The Aboriginal Resource and Development Services (2014) and the Batchelor Press (2014), the publishing arm of the Batchelor Institute of Indigenous Tertiary Education, Northern Territory, provide two models of provision of culturally congruent health messages and Indigenous knowledge and language resources. As an example of meeting specific local health needs, the online and hard-copy Dictionary of anatomy: Dhäruk mala ga mayali’ rumbalpuy provides translations and explanations of anatomical and medical terms from English into the Aboriginal language Yolnu Matha. However, until such resources become widespread, we believe it is important to openly explore and acknowledge factors affecting communication and to contend with the paucity of accurate information that many Aboriginal women are forced to rely on when making critical decisions regarding their sexual and reproductive health.

**Conclusion**

This research has explored women’s beliefs, knowledge and language surrounding their sexual and reproductive bodies in one remote northern Australian Aboriginal community. Documenting Aboriginal language and exploring the areas of meaning of health-related words is a powerful method for unearthing cultural meanings that
affect women’s health care. Women in Saint Fiacre deserve to better understand and make informed decisions about the Western health care provided to them. This can only be achieved through health care providers gaining a better understanding of their client’s worldview and its implication for their sexual and reproductive experiences. It is no longer acceptable for Western health care practitioners to simply assume that Aboriginal women believe in the ‘biomedical body’. This research clearly demonstrates a currently unfulfilled obligation to culturally inform and localise health care approaches.

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Chapter 8:

‘Jumping Around’: Exploring Young Women’s Behaviour and Knowledge in Relation to Sexual Health in a Remote Aboriginal Community

Figure 8.1. Statement of Authorship for publication: “Jumping around”: Exploring young women’s behaviour and knowledge in relation to sexual health in a remote Aboriginal community"
‘Jumping around’: Exploring Young Women’s Behaviour and Knowledge in Relation to Sexual Health in a Remote Aboriginal Community

Authors: Sarah Ireland, Concepta Wulili Narjic, Suzanne Belton, Sherry Saggers and Ann McGrath

Abstract

Background: Sexual health indicators for young remote living Aboriginal women are the worst of all of Australian women. The purpose of this research is to describe and explore young women’s behaviour and knowledge in relation to sexual health, as well as to provide health professionals with cross-cultural insights to assist with health practice.

Methods: This research is a descriptive ethnography that includes: extended ethnographic field work in one remote community over a six year period; community observation and participation; field notes; semi-structured interviews; group reproductive ethno-physiology drawing and language sessions; focus group sessions; the training and employment of Aboriginal Research Assistants; and the consultation and advice from a local reference group and a Cultural Mentor.

Outcomes and Results: Young women in this remote community have a very poor biomedical understanding of sexually transmitted infections and contraception. This is further compounded by not speaking English as a first language, low literacy levels and different beliefs in relation to their body functions. In their sexual relationships, young women often report experiences involving multiple casual partners, marijuana use and violence.
Conclusion: This research contributes to a better understanding of the factors underlying sexual health inequity among young Aboriginal women.

**Keywords:** Sexual and Reproductive health, medical anthropology, Aboriginal women, health promotion

**Introduction**

In Australia, Aboriginal and Torres Strait Islander people experience sexual health inequalities when compared to the rest of the population. They are over-represented in notifications of sexually transmissible infections and viral hepatitis (The Kirby Institute 2012), and have higher rates of teenage pregnancy (Li, Hilder, and Sullivan 2012). The notification rates for chlamydia and gonorrhoea in the Aboriginal and Torres Strait Islander population in 2011 were, respectively three and 30 times higher than in the non-Indigenous Australian population, and 80 percent of the chlamydia cases occurred in young people aged 15-29 years. If left untreated, these infections may have lasting negative effects on young people’s health and fertility. For Aboriginal women, these negative consequences manifest with high rates of Pelvic Inflammatory Disease (Skov, Murrary, and Latif 2008; Silver et al. 2012), infertility (Kildea and Bowden 2000) and premature childbirth (Li, Hilder, and Sullivan 2012). The disparity in these sexual health indicators increases with geographical remoteness, with rates of chlamydia, gonorrhoea and infectious syphilis substantially higher than those encountered in regional or urban areas (The Kirby Institute 2012).

There is limited evidence examining the effectiveness of sexual health education programmes in Australian Indigenous settings (Willis, Anderson, and Morris 2005), though recent evaluations suggest that approaches combining clinical best practice with a coordinated sexual health program can reduce the incidence of sexually
transmissible diseases (Guy et al. 2012). International evidence also suggests that sexual health outcomes can be positively impacted without causing harm, when young people’s sexual knowledge is increased (UNESCO 2009). Education programmes often employ social, clinical and behavioural interventions, but as Willis et al. (2005, 6) caution, they need to be based on the ‘sound knowledge of the behaviours, knowledge, beliefs or practices that they are trying to influence’. Despite the urgent need for this background information, there is a knowledge gap in the documentation of Aboriginal and Torres Strait Islander people’s beliefs, practices and behaviours that may be perpetuating sexual health inequalities (Willis, Anderson, and Morris 2005; Strobel and Ward 2012). In addition to the work of other researchers often using qualitative methods (Senior and Chenhall 2012; Senior and Chenhall 2008; Chenhall et al. 2013; Willis 2003; Stark and Hope 2007; Mooney-Somers et al. 2012; Fagan and McDonell 2010), this research addresses the knowledge gap by describing young Aboriginal women’s sexual health behaviour and knowledge in one remote Aboriginal community.

**Research site**

Saint Fiacre (pseudonym) is a large northern Australian remote Aboriginal community, which was once a religious mission. It has a youthful demographic profile with nearly half the population less than 15 years of age. The lingua franca of the community is an Aboriginal language, with almost no one speaking English as their first language. A Catholic primary and secondary school provide bilingual education in the community’s first language. The curriculum is underscored by Catholic values and beliefs and includes religious instruction that may conflict with secular public health messages around contraception and safe sex practices. All Catholic education schools in the Northern Territory incorporate teachings from the
human sexuality program ‘Made in the Image of God’ which attempts to address the ‘complexities of relationships today’ through the ‘lens of faith’ (Catholic Education, Northern Territory Diocese of Darwin 2014). As is the case in many remote Northern Territory schools (Northern Territory Government, Department of Education 2014), poor attendance has led to generational disengagement with western education in Saint Fiacre. Many young people now have limited pre-vocational literacy and numeracy skills, struggling to read and write in English and perform basic arithmetic. For young women, their attendance is further complicated by high rates of teenage pregnancy in the Northern Territory (Thompson 2013).

This isolated town has road access for approximately six months of the year due to flooding in the monsoonal season. There is a regular aeroplane service, with the nearest regional centre around one hour flight away. There are limited services and infrastructure in the community. There are permanently stationed police officers and a women’s Safe House. The health needs of the people are serviced by a government-run Community Health Centre. The Health Centre provides limited sexual health screening and counselling, PAP smear screening and access to free condoms.

Gaining Permission

This research is part of a doctoral study investigating the social, cultural and historical factors underlying women’s sexual and reproductive health in the town of Saint Fiacre, worked in partnership and with permission from Aboriginal women. Ethical approval was granted by the Menzies School of Health Research Ethics Committee and a sub-committee dealing specifically with Aboriginal research (Application #HR-10-1429). Letters of written support were obtained from the
community and other key stakeholders. A local reference group comprised of senior women, female community leaders, Aboriginal Health Workers and other interested individuals. The reference group gave support, advice and direction throughout the research process, including research objectives and methodologies.

Concepta Wulili Narjic (author #2) was the Cultural Mentor for the project and provided leadership and valuable advice on all aspects of Aboriginal research methodology and recruitment. Several Aboriginal Research Assistants who live permanently in the community were recruited, trained and paid to assist with data collection. Due to the sensitive nature of the project, it was their request to remain anonymous, although the project’s Cultural Mentor gave permission for her name to be publically identified.

Methods

This ethnographic study was completed over a six year period (2007-13) and involved iterative cycles of data collection. Research rigour was ensured by collaboration with Indigenous women, prolonged community engagement, triangulation of research methods, and participant validation (Liamputtong 2009, 23–29). Data collection methods included: extended ethnographic field work in the community; community observation and participation; written field notes, semi-structured interviews (n=9); group reproductive ethno-physiology drawing (MacCormack and Draper 1987; Shedlin 1979; Sobo 1993; Brewis 1994) and language recording sessions (n=10); and focus group sessions (n=10). During the interview and focus group sessions a theme guide was used covering the domains of gaining consent, participant demographics, women’s health, contraception options, recreation and family group structures. During the group ethno-physiology sessions
an exploratory life-cycle narrative approach was used, with participants asked to
discuss, comment and make drawings on the journey a new-born baby girl makes
through life. Participants were asked to draw their ‘words’ for anatomical structures,
rather than the approach of filling the internal structures of a female body outlined on
paper (Shedlin 1979; MacCormack and Draper 1987).

To purposively recruit participant’s author # 2, Aboriginal Research Assistants and
the local reference group used the ‘message stick’ method to verbally invite potential
respondents. This technique has been successfully used in previous research in a
remote Aboriginal community (Ireland et al. 2010). If the potential participant
responds to the message stick and agrees, then the non-Indigenous researcher is
introduced and consent is gained. The inclusion criteria were all women in the
community from 16 years of age upward. As a result, the number of women invited
and who declined invitation to participate was unable to be determined.

An audio recording of the project information sheet and consent form was played
aloud in the participant’s first Aboriginal language. Depending on the participant’s
literacy levels and personal preference, written or verbal consent was gained. The
consent process was witnessed by author # 1 and/or an Aboriginal Research
Assistant, and then documented in writing on a consent form.

**Data Collection**

Women formed two groups; those aged 16 to 33 years and those aged 49 years and
older. Data collection sessions occurred in a combination of Aboriginal languages
and English. Some sessions involved participants’ drawing pictures on paper. As the
primary researcher is not fluent in any Aboriginal language, translations were made
in real time either by author #2 or an Aboriginal Research Assistant. In addition, with
participant permission, the sessions were audio recorded for later translation and validation. Author #1 made written notes during all sessions, kept a written fieldwork diary, retained participant’s drawings, took photographs and made audio-visual recordings.

Interviews and focus groups were co-facilitated by both a female Aboriginal and non-Aboriginal researcher. Participants chose the location of the sessions, which occurred in private homes and also in the non-Aboriginal researcher’s accommodation. In all locations privacy was essential and participants were made comfortable with refreshments.

After initial collection, data was typed and printed out. The printed work was then read aloud and checked by the participants for mistakes. If any changes were made, the information was re-typed and once again reviewed by the participants. This cycle continued until the participants agreed on accuracy. This participant validated data was then re-checked against the translated audio recordings. The data was further triangulated between the different sources, linguistic literature, professional translators, extreme and similar findings, participant observations, local reference group discussions and notes made in fieldwork diaries.

Analysis

The data underwent the process of thematic analysis. As Green et al. (2007) describe, this involves the four step process of data immersion, coding, creation of categories and identification of themes. Written transcripts, drawings, photographs, field work diaries, audio recordings and participant observations were read, watched, viewed and listened to numerous times, leading to the identification of codes of descriptive labels. These were applied throughout the data material until a sense of broader
analytical categories could be identified; the coded data were then clustered around these categories. The final step of analysis was the creation of explanatory and interpretive thematic domains, allowing women’s experiences to be understood from a local sexual health perspective.

For example, codes of descriptive labels emerged from the data such as: ‘physical symptoms’, ‘causation’ and ‘treatment’. These codes were then commonly clustered around the broader analytical category of ‘sexually transmissible infections and blood borne viruses’. This category was then assigned to the thematic domain of ‘sexual health literacy’, allowing the data to demonstrate significance and meaning to young women’s sexual health.

**Findings**

A total of twelve woman aged 16-33 years responded to message sticks and participated in the research and their responses were augmented by data obtained from older women (n=19) aged 49-90 years. All participants have been given pseudonyms. The three major themes of ‘Sexual Health Literacy’, ‘Cultural Impacts on Sexual Scripting’ and ‘Behaviours Contributing to Risk’ were identified in the process of thematic analysis, which is described below.

**Theme 1: Sexual Health Literacy**

Women shared their knowledge of western medicine and techniques that could be used to prevent pregnancy and sexually transmissible infections, and the types of sickness that affected young women’s bodies. Participants’ access to dominant culture resources on sexual health topics is significantly limited due to poor English literacy and numeracy. Young people in this community are therefore drawn to audio-visual materials to compensate for their poor literacy. Though internet-based
written resources can be accessed through mobile phones and computers in the local library, observations and interviews found that low literacy prevents women using them as information resources. Similarly, any written health promotion material at the Community Health Centre, was unable to be adequately comprehended by young women.

**Contraception**

Women reported that there were three types of medicine available to them at the ‘clinic’ that can stop pregnancy. These were the contraceptive implant Implanon TM, known as ‘Spaghetti’, ‘Long Medicine’ or ‘Implim’; the depot medroxyprogesterone acetate injection- known as ‘Depo’ or ‘Injection’; and condoms. Some but not all participants were able to correctly describe the length of contraceptive effect as three months for the depot medroxyprogesterone acetate injection and three years for the contraceptive implant. In general the older, more experienced contraceptive users were more likely to know this information. No participant, however, was able to explain how the hormonal contraceptives worked, and the contraceptive effect was merely attributed to it being ‘whitefella medicine’. Participants were not able to identify any other hormonal or non-hormonal contraceptive method such as the oral contraceptive pill, diaphragm, vaginal hormonal ring or inter-uterine device. No participant reported being aware of or having had experience of taking emergency contraceptive.

Women readily admitted that they rarely used condoms, and the younger women said that the young men show a preference for having sex ‘Fay Go’, that is Fair Go style. This means they prefer sex without a condom. One woman said she used condoms but remained unsure if any other women she knew used them. It is known that
condoms can be collected in the clinic, but even if they wished to try them out, many young women felt ashamed and too shy to pick them up.

The hormonal contraceptive implant and depot medroxyprogesterone acetate injection methods were seen to be associated with many undesired physical side effects. These included: feeling weak, sleepy and lazy; unwanted weight gain; excessive appetite; reduced and concentrated urine production, menstruation cessation or changes in menstruation colour and consistency; and painful abdominal cramping. Alterations to the menstruation cycle caused much concern. A 31 year-old, palngun participant named Selina, described her experience with a contraceptive implant:

The bleeding [menstruation] gets stuck inside and clots- this is not good for your health and gives you big cramps like labour pains.

The contraceptive implant was also linked to unwanted physical sensations at the site of insertion such as itching, skin tightness, general discomfort and stinging. One woman said that holding her mobile phone to her ear for speaking, made the implant site ‘burn’. Participants suggested that switching the implant site to the opposite arm can sometimes relieve these unpleasant sensations. Many women also complained that young children and infants played with their implant under the skin which was very annoying. During fieldwork, author #1 often experienced young children expertly palpating her arm to ascertain the presence or absence of an implant.

Young women rarely sought preventative contraception to delay the onset of parity and most often it was commenced only after a first pregnancy. The impetus for contraception use after birth was not clear and appeared to mainly be at the instigation or suggestion of medical staff involved in postnatal care. Pregnancy
remained an acceptable, natural and often desired consequence of sexual relationships and was believed to rarely require management.

Unlike western societies, in Saint Fiacre the perceived economic and social cost of childrearing is of low impact on young women’s lives. There was a plethora of childcare and even longer-term adoption options, made available to young women through their extended kinship networks and communal-style living arrangements. Small children were reared in a peer-supervised model which required less individual adult effort with the tasks of supervision and intervention being shared. Young mothers did not subscribe to formal career paths that a child could negatively interrupt, and in a welfare-based economy, children were perceived to provide more, rather than less access to money. Children may also have added authenticity and legitimacy to a young woman’s claim to a male relationship.

Older women were very cautious about contraceptive use. One kungunu woman, aged 68 years and named Helen, who had grown up in the Saint Fiacre Catholic mission dormitory said, ‘God made our bodies that way to have babies’. Many of these older women expressed concern and were not supportive of young family members using contraception, especially methods that stopped menstruation. Though young women did not cite religious beliefs as impacting their contraceptive use, they may have been affected by the opinions of older Catholic women close to them. Abortion was not spontaneously mentioned by any woman.

**Sexually transmissible infections and blood borne viruses**

Sexually transmissible infections and blood borne viruses otherwise known more simply by the women as “Sex Infections” are attributed to either excessive sexual intercourse or sexual intercourse with too many partners. This was described by
participants as ‘having too much sex’ and ‘jumping around’ with multiple sexual partners. One incident was also described where a young local woman developed a sex infection as a result of malicious black magic sorcery. It was deemed a sex infection because there was evidence that sorcery had targeted her genitals, and her physical symptoms included hair loss. Despite this perception, one of the non-Aboriginal researchers knew this woman to be suffering from cancer and was recovering from chemotherapy treatment. These beliefs make young women vulnerable to sexually transmissible infections, because without knowing that infections are caught through sexual intercourse without a condom, they are unable to protect themselves.

A diverse range of symptoms were deemed as being signs of sex infections. This included: painful urination; abdominal cramping; lower back pain; weight loss; sunken eyes; hair, eyebrow or eyelash loss; and yellowing of the whites of the eyes. There was consensus that the most common health problem for young women was dysuria (‘hot urine’) and abdominal pain (‘tummy pain’). These symptoms were known as treatable with ‘whitefella medicine’ at the local Community Health Centre. This suggested a degree of acceptability at seeking treatment for symptoms.

The women stated that there was no clear way of preventing sex infections but some participants thought that having a contraceptive implant could assist. An older keke woman, aged 33 years and named Madonna, when overhearing our discussion offered her advice that ‘condoms can save your body from sex infections’. When participants were asked if this was true, they remained uncertain. No causal link between sex infections and fertility problems was reported.
Theme 2: Cultural Impacts on Sexual Scripting

Women described certain cultural beliefs that shaped their sexual perceptions and practices. Some of these cultural beliefs may compound communication problems with health professionals when discussing western medical terms and concepts.

Age-grades

Women in Saint Fiacre reported identifying with traditional Aboriginal social structures such as clan and language groups, kinship categories and cycles, totem affiliation and paternal country inheritance. In addition women also identified as belonging to a particular ‘age-grade’. Age-grades are a set of gendered concepts reflective of the human lifecycle from childhood, through adolescence, to middle and then old age. A specific set of terms applied to males and females. Women explained that the age-grades were differentiated through sentinel physical events including: breast development; pubic hair growth; menstruation; fecundity; and cessation of menstruation. In the public domain, the shape and development of a woman’s breasts was an important factor in allocating her an age-grade.

There were five age grades progressing from Mardinhbuy, Palngun, Keke, Kunugunu and then to Muthinga. Approximate western age groupings and terms can be applied but this was not always an adequate or accurate representation of the age-grade. Participants represented in this research identified as either Mardinhbuy the age grade ranging from around 12-16 years, or Palngun ranging from around 17-30 years. And women in the older group included Palngun, Keke, Kunugunu and Muthinga participants.

The socially acceptable time for females to commence sexual activity was governed by their age-grade and not merely years of age since birth. Sexual experimentation
could start around a girl’s first menstruation during the Mardinbuy phase and though pregnancy is possible at this time, women thought it better to have your first child when you are Palngun with large breasts and a regular menstrual cycle. It was perceived that a woman’s libido and enjoyment of sexual intercourse peaks during the Mardinbuy and Palngun phases, slowly lessening and then ceasing with old age.

The belief in age-grades should encourage health professionals to adopt more culturally based sexual health promotion to target Aboriginal women. For example, many health initiatives, like the Saint Fiacre program advertised here in photograph 1, target women through age based screening and adopt a communication style based on written English. The very low levels of English literacy and the preference of women to relate to their cultural age-grade, makes a written and age based approach of limited impact in attracting participants to a screening program.

Photograph 1: Poorly Designed Sexual Health Screening Poster

Language and the female body

The dominant Aboriginal language in Saint Fiacre had a rich sexual and reproductive vocabulary which included terms applied to the female body and bodily functions
including pregnancy, birth and lactation. Distinct nouns described the female external genitalia including the western medical equivalent terms for the groin, pubic hair, vulva, labia majora, urethra, vagina and clitoris. In this Aboriginal language, female genital nouns were unique in that a different noun classifier was used which is not applied to all other human body part names. Young women experimented with noun classifier protocols and chose to not follow orthodox traditional rules when naming female genitalia. In what appeared to be a bastardised version of their traditional language, they opted to use the classifier reserved for vegetable foods rather than the correct one, or the likely alternative of the classifier reserved for all other parts of the body. The words for female genitals were used by both little girls and women to swear, call out and curse at others.

The dominant western understanding of internal reproductive organs consists of uterus, fallopian tubes, ovaries and vagina. However this notion of fixed organs was not shared by the Indigenous women. Ethno-physiological discussions, drawings and language recording with older women revealed a more ephemeral concept of body organs. The naming of each part of female internal anatomy showed that there was only a permanent single ovary, with an absence of any noun to describe the western medical equivalent of uterus, fallopian tubes, uterus or cervix. This absence was explained by the ephemeral nature of an organ known as the whanpanh.

Though whanpanh has been glossed by linguists as the English word for womb and identified as such in one piece of health promotion literature, this is incorrect as participants understood that only a pregnant woman can have one. The whanpanh was more accurately ascribed as the equivalent of the ‘foetal ammonic sac’ which grew during pregnancy and was expelled from the body during childbirth. The nuances of whanpanh as a term only became apparent, when physiological
explanations were explored. Conception occurred, according to respondents during sexual intercourse, when a man’s ejaculate met the ovary and induced it to begin growing a whanpanh. These explanations were a fusion of Catholic teachings and Aboriginal word-views.

Menstruation was believed to be the body’s way of self-cleansing. The menstrual blood was seen to be ‘no good blood’ full of accumulated poisons and toxins. The bleeding was positive because it ‘cleans out the body’. Menstruation was marked by the moon and followed by monthly cycles. The menstrual blood did not accumulate but simply flowed out from the body through the vaginal opening.

**Desire dreaming 1**

Young people of both sexes reported popular use of a traditional aphrodisiac to tempt sexual partners. A substance from a gendered distant Dreaming location was collected and brought into town to attract a desired boyfriend. The substance is not further identified at the request of participants, but was used to create a material that was applied over the body whilst citing incantations and naming the desired person. Young women said the substance was very strong and powerful in effect and was favoured for use at local discos, where young people gathered. People belonging to the country where this Dreaming site is located often collected and sold the substance at great profits. During fieldwork, author #1 visited this Dreaming site and witnessed evidence of current and frequent harvesting of the substance. It was unclear if the use of this substance elicited unwanted sexual advances, but confidence in its effectiveness was certainly maintained by all participants and more broadly throughout the community.
Theme 3: Behaviours Contributing to Risk

Women described experiences that revealed behaviours contributing to sexual health risks. Many women’s sexual experiences were negotiated around complex social situations, leading to accentuated stress but also enjoyment in the tensions.

Playing around at night

Women reported that most young people have sex at night in outdoor locations. Outdoor locations are seen to provide a sense of privacy and ownership for young people. With over-crowded housing the norm, there are very few options available should a couple wish to stay indoors. Five precincts spread across the community were identified as preferred nocturnal venues for meeting with boys and ‘playing around’. Participants said that evidence of these sexual encounters was observable in discarded underwear and blood stains. Mobile phones and texting were used to organise and coordinate these meetings. Young women explained that it was common to have more than one partner and it was up to the girl to decide if the boys knew about each other. As one mardinhbuy participant, named Anastasia said:

…..honest people just have one but in the background lots of people swap around and have secret boyfriends and girlfriends.

In this group of young research participants, male partners were all of a similar age broadly suggesting one feature of an equal power dynamic within their personal relationships. However, community observational material and information shared from other young women indicated many young people’s sexual relationships feature at times non-peer aged partners, sexual coercion, harassment for money or substances, condom-use refusal, violence, and substance use. Senior et al. (2014) has reported similar findings with young women in other remote areas, as having had
gendered difficulties in negotiating the terms of their sexual relationships. Although the concept of homosexual, lesbian or bisexual relationships were known by participants, they stated they occurred only in urban centres associated with binge drinking. Some participants linked these concepts of sexual partner preference to the transgender Aboriginal *sista girls* from the Tiwi Islands in the Northern Territory, but denied any similar traditions in their own community. Participants named some young men in the community that they thought were ‘a bit like the sista girls’, in that they had a feminine disposition but they were not known to cross dress or have same-sex relationships. The concept of sista girls proved a culturally congruent and useful starting point for discussing sexual attraction with young women who did not relate to the western concepts such as bisexuality or lesbianism.

Two of the participants also explained oral sex as a new sexual technique whereby the ‘boys are eating out’ the girls. They had seen this technique from ‘Blue Movies’ on some of the young men’s mobile phones (the use of mobile phones will be further explored in a separate journal article). The acquisition of this apparently new technique illustrated how young people’s sexual practices underwent change. It also demonstrated how sexually explicit audio-visual material played and shared via mobile phones, was used as a novel and significant information source for young people to explore different sexual techniques and practices.

Sexual encounters, current and expired relationships, family affiliations and fighting were all savoured topics for hushed discussion, which made young women’s management of their sexuality at times stressful but also very exciting.
Smoking

All participants smoked tobacco and some also reported *mi kuntje*- gunja/marijuana use. ‘Gunja’ as a term has been appropriated into the local language and assigned the same noun classification as all vegetable foodstuffs, fruit and faeces. If within hearing distance of ‘whitefellas’ the conversation topic was disguised by substituting the term for *mi parnu*, which simply means grass. All participants described incidents where they had to negotiate or accommodate marijuana use with their sexual partners. Marijuana was most commonly smoked using a “bucket bong” made from powdered milk tins and a small length of garden hose. The women explained that some houses in the community were known to be a ‘gunja house’ where young people gathered and smoked together. Susan, a *kunugunu* woman aged 60 years, lamented that the young women ‘find pregnancy in the gunja’ because the boys sexually exploited their vulnerability when under the effects of marijuana. Participants described some young women as using transactional sex to secure personal supplies of marijuana from ‘dealers’ who were known to be older Aboriginal males. One *mardinhbuy* participant, aged 18 years and named Anastasia, said that young women, who are dependent on marijuana, use transactional sex to secure larger volumes which they then sell on, making large profits to buy more marijuana. Another *mardinhbuy* woman named Agnes, aged 21 years, had experienced a very violent long term relationship and spoke of ‘giving up on boys’ so she could now spend her time just smoking marijuana. Young women did not report any use of alcohol whilst in their dry community. Two participants said they sometimes drank but only on infrequent visits to urban centres.
Violence

Violence from sexual partners was encountered by young women in their relationships, and in some circumstances women were also the perpetrator of violence towards other females who were engaged in sexual relations with their own partner. Violence was reported both in monogamous and polygamous relationships. Participants considered violence as an expected and often acceptable form of communication between partners in sexual relationships. One young women felt ‘very sorry’ for her father who was in prison due to domestic violence but was accepting and apparently not regretful of her mother’s facial scarring from the incident.

Young women had limited skills for negotiating emotionally taxing and complex social situations, which often involved multiple partners and vested interests. Changing social norms that would otherwise inform who would be an appropriate partner, lead to very confusing situations where young women often had conflicting choices. For example, should I tolerate my partner having a second partner at the same time as me; or should I demand his monogamy? If so, how do I achieve this? Social support and retreat from violence was often sought from women’s mothers, placing significant stress on older women and their already burdened role as extended family carers.

Discussion

Qualitative research collects rich, specific and detailed information from a small number of people and settings. Patton (1990) cautions that though this results in a deeper understanding of the people and setting being researched, it creates greater reduction in generalisability. This is a clear limitation of this study. Yet it is also
important to acknowledge that Saint Fiacre is one of the larger remote Aboriginal communities in northern Australia and shares a similar historical legacy with other colonised Indigenous people around the world. The relative size of Saint Fiacre to other comparable Australian Indigenous communities allows a diversity and depth of data to be collected which would not be possible in a smaller place. This enhances the social but not statistical generalisability.

Participants in this small cohort highlighted clear deficits in their sexual health knowledge and participation in risky behaviours that are known to perpetuate poor sexual health outcomes. In this community, young women typically do not know about safe sex practices and frequently do not use condoms during casual sex with multiple partners. Knowledge of sexually transmissible infections in this group was restricted to a range of symptoms and not understood to be caused by sexual intercourse without a condom or to be of any consequence to future fertility. Though other researchers have criticised the use of a ‘deficit model’ of health in understanding Indigenous young people’s sexual health knowledge (Mooney-Somers et al. 2012), in the very isolated town of Saint Fiacre, young women’s poor knowledge places them at significant risk of harm. Without openly and respectfully addressing these deficits, it is likely that women’s fertility and sexual health will continue to be negatively impacted upon.

Women felt burdened by the side effects of contraception but did not have comprehensive knowledge of other contraceptive methods available. This suggests that it is important for young women to be adequately counselled on the side effects and benefits of contraception. However the generalised chaotic and over-crowded conditions, in which the young women live, may make many other contraceptive options inappropriate. For example, it is unlikely that a young woman in Saint Fiacre
would be able to safely store and administer her daily contraceptive pill. With assumed frequent sexual activity and low contraceptive use, it is plausible that some young women in this community would benefit from the use of emergency contraception to prevent unintended pregnancies; however this technique was unknown to all women regardless of age. In this community, women’s limited knowledge of emergency contraception is in stark contrast with other Australian women, with one national survey reporting 96% of Australian women have heard of the emergency contraceptive pill and 26% have personally used it (Hobbs et al. 2011).

Significant cultural factors also impact young women’s sexual scripting and pose serious challenges to mainstream western sexual health approaches. Of most importance is the finding that there are no words to describe the uterus, cervix or fallopian tubes, and no perception of their existence. This emic construction of the female body means that it is difficult for many women to understand how untreated infections may harm a part of their body that does not exist and then lead on to infertility. It also makes it hard to comprehend how contraceptives work in their body and the reasons for experiencing side effects such as changes to menstruation patterns.

This is not an unusual finding, with different ethnophysiological explanations of the female body and reproduction reported by women in research from other cultures around the world (Belton and Whittaker 2007; Brewis 1994; Castaneda, Garcia, and Langer 1996; Sobo 1993; de Bessa 2006; Obermeyer 2000; MacCormack and Draper 1987; Shedlin 1979). It is probable that other Aboriginal women in Australian communities, who speak languages other than English, will also perceive and understand their bodies in different ways to dominant western medicine. This
research result again cautions health professionals to be mindful in their assumed shared beliefs in western medical physiology and the unconsidered use of medical terms. A similar sense of ‘cultural and linguistic distance’ is reported in other settings as compounding communication problems between Aboriginal patients and non-Aboriginal health practitioners, and alarmingly this is often not recognised (Cass et al. 2002, 467–468).

Health professionals working in remote communities are urged to localise their clinical approaches taking into account the immense impact of language and cultural constructs of the body. This sort of information is rarely written down or presented to health professionals as part of their workplace orientation. Accessing such knowledge requires health professionals to relinquish their role as an ‘expert’ and invest time in relationship building with local people whilst demonstrating a genuine interest in understanding the people they are working with.

The aetiology of sexually transmissible infections and blood borne viruses, continue in this community to be influenced by cultural understandings of health and sickness. Traditional Aboriginal health models illuminate the importance of the spiritual and supernatural worlds that influence health, sickness and wellbeing (Maher 1999; Mobbs 1997). Senior and Chenhall (2013) describe how in one remote Aboriginal community, people still believe that sorcery is the cause of many unexpected or sudden illness and deaths, and is often involved in serious mishaps. Certainly in this research, the health of one woman’s genitals and sexual function were thought to have been affected by malicious sorcery. It is likely that other aspects and experiences related to sexual health are also understood to be influenced by supernatural interventions, ceremonial ritual and/or the work of a sorcerer. These beliefs are often in opposition to a scientific paradigm of cause and effect that
explains aetiology through the crossing and mixing of infected bodily fluids during sexual intercourse without a condom. This obviously poses significant cross-cultural problems in communicating the logic behind the need to adapt sexual behaviour and adhere to condom use. Further examples of cross-cultural barriers to condom use have been explored by Willis (2003) in his work with Pitjantjatjara Aboriginal men.

Young women also reported behaviours that made them vulnerable to sexually transmissible infections and blood borne viruses. Substance dependency has previously been reported as risk factor in contracting sexually transmissible infections (Miller et al. 2001; Saggers, Gray, and Strempel 2006). In this community young women’s vulnerability was accentuated by complex social situations which involved marijuana use and dependency, and also violence. Young Aboriginal women’s acceptance of male violence as a normal part of intimate relationships has been reported in other remote settings (Senior and Chenhall 2012) and was a common experience in Saint Fiacre. Previous research has highlighted a strong association between sexually transmissible infections in young Aboriginal women and physical assault (Fairbairn et al. 2010), and in broader mainstream populations, women who experience intimate partner violence are already known to experience poorer sexual and reproductive health outcomes (Coker 2007; Taft, Watson, and Lee 2004). However, in this research, women’s role in violence was complicated by often being both perpetrator and victim. Although this has previously been documented in other research with Aboriginal women (Burbank 1994) and challenges victim stereotyping, the association with sexually transmissible infections is unknown.
Conclusion

Through describing and exploring young women’s behaviour and knowledge in relation to sexual health, this research makes important contributions to better understanding sexual health inequality in remote Aboriginal communities. It demonstrates young women’s poor knowledge and the situational vulnerability many encounter in their sexual relationships. Due to a lack of western biomedical knowledge, many young women remain unable to protect themselves from the immediate risks and long-term harm of sexually transmissible infections and blood borne viruses. School-based opportunities to impart sexual health knowledge are problematic due to chronic poor attendance and a Catholic-based curriculum. Furthermore, remote-area health professionals who are responsible for providing secular sexual health counselling and screening are disadvantaged by not sharing with their clients a common language or construct of the body on which to base clinical consultations and public health messages. This research suggests that sexual health outcomes in remote Aboriginal communities may only be improved through the provision of better culturally-situated sexual health services and information.

Acknowledgments

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1. Dreaming is a deeply philosophical Aboriginal term with complex nuances and inherent challenges when attempting to define it. It is a concept linked to a “sacred and heroic” time when human beings and nature came to be, but can also be used to refer to the present time. It can further serve as explanatory “narrative” to the past, a “character” of events still happening
and also be a “logis or principle of order transcending everything significant” for Aboriginal people (Stanner 2009, 57–58). The Dreaming when used to refer to a physical place in the country, often will mean the place from whence an ancestral spirit being came forth.

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Chapter 9: Conclusion

This final chapter concludes the thesis with an integrated discussion of the research findings. The implications and recommendations arising from the research are organised around women’s sexual and reproductive health rights, as defined by the World Health Organization.

Summation of Objectives and Aims

This research was undertaken during a six-year period (2008–2014) in a large, remote, disadvantaged northern-Australian Aboriginal town. Working with permission and alongside Aboriginal women from Saint Fiacre, I fulfilled the research objectives of documenting women’s cultural and linguistic constructions of reproduction and historically contextualising women’s reproductive experiences. The research specifically explored women’s emic perspectives and uses of language to describe their female body’s reproductive life cycle, anatomy and physiology. The thesis has also provided a historical account of how women have been locally cared for during pregnancy and childbirth.

These objectives were achieved through four journal papers. In summation, the first of these papers historically contextualises how women were locally cared for during pregnancy and childbirth in Saint Fiacre and documents dramatic cultural change in midwifery care, along with the resulting implications for the community. The second paper builds on the theme of the first paper, using critical discourse analysis to deconstruct and understand the impact of widely used health practice manuals on remote Aboriginal women’s choices in planning for place of birth. The third paper documents the language and ethnophysiology used to describe female reproduction in Saint Fiacre. The fourth and final paper examines the current
behaviour and knowledge of young women that has affected their sexual health disadvantage.

My research also had several specific aims. In summing up, I aimed to develop research partnerships with the women in the community and to increase community capacity by recruiting and training Aboriginal researchers. I have now successfully engaged and worked with Aboriginal women in Saint Fiacre. Our research partnership allowed us to document the ethnophysiology and language of fertility and reproduction and to produce together a local historical account of changes in midwifery care. In historically contextualising maternity care, I also critiqued influential maternity health practice manuals. Dissemination of the research findings has been undertaken by submitting the four research papers for publication in peer-reviewed health journals.

Finally, in meeting my remaining research aims, I successfully returned the research findings and language recordings to the town museum and language centre for the community’s future use and safekeeping. The process of returning the research findings included the community dissemination of a participant feedback booklet (See Appendix 12). The booklet content was negotiated, agreed upon and approved by the research’s local reference group and cultural mentor. It includes detailed information of local significance and is co-authored by Mrs Narjic.

**Sexual and Reproductive Rights**

To better understand the implications of these four paper’s findings, it is necessary to revisit the World Health Organization’s definition and agenda for improving women’s sexual and reproductive health. Sexual and reproductive health is defined as:
A state of complete physical, mental and social well-being and not merely the absence of disease and infirmity, in all matters relating to the reproductive systems and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how to do so. (World Health Organization, 2006, p. 5)

It is timely to also recall that the aims of reproductive and sexual health care are twofold in that they aim to support not only the normal physiological functions of human reproduction such as pregnancy but also to reduce the impact of adverse health associated with reproduction and sexual activity (Glasier et al., 2006). This approach embraces a human-rights based approach to health, whereby women have a universal right to be informed of and to have access to choose safe, effective and affordable methods of family planning, along with other methods of fertility regulation, such as legal safe abortion. These reproductive health rights extend to accessing appropriate health care through experiences of pregnancy and childbirth (World Health Organization, 2006). The attainment of such rights can be used as a yardstick for measuring women’s sexual and reproductive health. A selection of these rights will now be used as a framework to integrate the results and organise recommendations arising from the research.

**Right to a safe and satisfying sex life.**

Women in Saint Fiacre struggle in the realisation of safe and satisfying sex lives. As documented in the literature review, many Aboriginal women in the Northern Territory, especially younger remote-living girls and women, encounter situational vulnerability in their sexual negotiations. Findings from my research support this by demonstrating that young women lack both the background
knowledge and the agency to safely negotiate their sexual encounters. Their vulnerability is extenuated by situations that commonly involve violence and drug use. Young women’s sexual satisfaction is often overshadowed by emotionally taxing and complex social situations, frequently involving multiple partners and vested interests. Sometimes, sex is used as a commodity for transaction rather than for the purposes of procreation, enjoyment or pleasure. In Saint Fiacre, women’s knowledge about sexually transmitted infections and bloodborne viruses is poor and incomplete. This means women are unable to take behavioural precautions that might otherwise protect or reduce their risk of harm from sexual activity. Cultural interpretations of sexually transmitted infections are fraught and sometimes reasoned through supernatural beliefs and the use of sorcery. Although there is limited free access to male condoms in the community, they are infrequently used, and young women reported that most male partners prefer sex without them.

In this gendered social milieu, infrequent use of condoms remains a significant barrier to improving sexual health outcomes in Saint Fiacre. Although not 100% effective, the correct and consistent use of condoms during vaginal intercourse is statistically associated with reduced rates of transmission and acquisition of most sexually transmitted infections and viruses in males and females (Holmes, Levine, & Weaver, 2004). Protective sexual behavioural changes are very complex, and as yet there is limited evidence to prove a direct correlation between condom promotion and a reduction in sexual/reproductive morbidity (Holmes et al., 2004). Despite this lack of empirical evidence, condom promotion remains an essential strategy in addressing the risks and harm from high rates of sexually transmitted infections and viruses.
A culturally targeted marketing campaign of condom use to youth in Saint Fiacre may be beneficial in shifting condom use and acceptability. Although no longer in production, the Indigenous youth-friendly male ‘snake condom’ brand and associated social marketing campaign is an example of such a tailored approach, and it was positively reviewed in a small-scale marketing evaluation (Gregory, Phillipson, Barrie, Jones, & Validas, 2008). The marketing slogans in the campaign involved masked sexual references to the ‘trouser snake’ and ‘snake in the grass’. This humorous approach appears to be particularly congruent with Saint Fiacre, where the Murrinh Patha word for ‘penis’ is the same the word for ‘poisonous snake’.

Use of the female condom also remains almost unexplored in this at-risk Northern Territory population. My research documented that for many young women sexual activity required coordinated planning and communication to meet up with male partners. For young women in this context, the female condom appears to offer some practical advantages, in that, unlike the male condom, it can be inserted (hours) before sexual activity begins and does not require immediate removal after male ejaculation (UNFPA & IPPF, 2007). Although there are mixed international evaluations regarding user acceptability and affordability of the female condom (Hoffman, Mantell, Exner, & Stein, 2004), it remains the only female-initiated method of barrier protection with high efficacy against sexually transmitted infections (and pregnancy). Due to growing evidence on the impacts of gendered inequality on sexual health outcomes, Mantell et al. (2006) note that it is hoped female-initiated methods of protection will offer alternatives for the many women who are unable to successfully negotiate male condom use. However, they caution that this alternative is based on ‘monolithic assumptions of female choice, autonomy,
control and empowerment’ (Mantell et al., 2006, p. 2000) that ironically are not encountered in settings where women struggle with agency in their sexual negotiations. Using international examples, Mantell et al. (2006) suggest that in different settings, female-initiated methods of protection against sexually transmitted infections have the possibilities of either reinforcing or challenging gender inequality. It is too presumptive to assume that because a method of protection is female-initiated that a woman will negotiate successful use of it.

Based on interviews with 12 Aboriginal women in the Northern Territory, Roberts and Cahill (1997) suggest that research participants generally had negative attitudes towards male condoms but appeared to be more positive about female condoms. Participants also aligned the female-initiated use of female condoms within the cultural domain of women’s business. This may indicate that use of the female condom is culturally acceptable for and congruent with Aboriginal couples who respect this gendered divide. These insights alongside international experiences cited in the literature (Hoffman et al., 2004; Mantell et al., 2006) suggest that female condom use in remote Aboriginal populations, such as Saint Fiacre, is worthy of further consideration.

Safe and satisfying sexual experiences can also be enhanced through the provision of quality sexual and reproductive health information. As Glasier et al. (2006) report, the burden of sexual and reproductive morbidity disproportionately affects adolescents and thus they should be targeted for educational interventions. In Saint Fiacre’s context of poor sexual health outcomes and a rapidly growing youthful population, strategic investments into increasing young people’s knowledge about sexual health matters are urgently required. This investment is time critical because
adolescents only remain the ‘target population’ for a short period and are then rapidly replaced by a new cohort of younger people (Savage, 2009).

While international evidence suggests that the provision of school-based sexuality education can positively affect health outcomes without causing harm (UNESCO, 2009), this school-based approach is highly problematic in Saint Fiacre. With very low rates of regular school attendance in Saint Fiacre, poor English literacy and a preference for nocturnal recreation activities, alternative and novel ways of engaging young people for the sole purpose of conveying sexual education is urgently required. Strobel and Ward (2012) suggest that other possible approaches to sexual education include community-based or combined clinical- and behavioural-based programs. Savage (2009, pp. 24–26) has compiled a review of community programs that target Indigenous youth (e.g. ‘Moodijt’ and ‘Core of Life’), which could inform local approaches in Saint Fiacre, but she cautions that most have not been rigorously evaluated against key determinants, such as behavioural changes or teenage pregnancy rates. The Central Australian Aboriginal Congress (2015) has also developed the Young Women’s Community Health Education Program, but this also suffers from a lack of rigorous evaluation.

Although many of these targeted programs have not been adequately evaluated, this may simply be circumstantial and does not necessarily mean the content and delivery is without effect. In absence of high-level evidence, it is suggested that successful sexual and reproductive health programs for Indigenous youth should be based on community consultation and engagement (AIHW, 2013b; Savage, 2009), should require a good understanding of adolescent’s sexual ‘behaviours, knowledge belief or practices’ (Willis et al., 2005, p. 6) and should be culturally appropriate in their design and implementation (AIHW, 2013b). An
international example of a culturally responsive well-designed and well-evaluated sexual health program for Indigenous youth is demonstrated in the work of Rink et al. (2014, 2015) in Greenland. Their research, known as ‘Inuulluataarneq’ (having the good life), implemented a successful sexual health educational intervention for Greenlandic youth and their parents/guardians. Their research also demonstrated the importance of the youth–parent/guardian relationship, finding that for adolescents having an adult/guardian to talk with about sexual matters was a protective factor against the acquisition of sexually transmitted infections (Rink et al., 2015).

Promotion of sexual health information through programs is further hindered by culturally and linguistically bound constructions of reproductive physiology and anatomy, which do not translate well into Western biomedical models. These implications are far reaching and pose significant philosophical and ethical questions concerning what constitutes the ‘best’ educational approach to health literacy. Of particular concern is how to impart Western biomedical knowledge without colonising, marginalising or devaluing Indigenous ways of knowing and understanding.

These issues appear to parallel similar and still unresolved debates that started in the 1980s around the pedagogy and politics of bilingual and bicultural schooling in remote Aboriginal communities (Grimes, 2009; Harris, 1990; McConvell, 1991; Wilson, 2014). One of the crucial issues debated in this context and relevant to cross-cultural health education has been around the virtues and drawbacks of pedagogical practice that ‘compartmentalises’ and separates Western and Aboriginal languages and cultural domains to preserve and strengthen a student’s primary Aboriginal identity (Harris, 1990) versus a pedagogical model of ‘two-way learning’, where Western and Aboriginal languages and cultural domains converge, interact and
exchange (McConvell, 1991). Although a detailed critique of bicultural pedagogy is outside the scope of this chapter, the execution and implications of bicultural health education for Indigenous people who speak minority languages in remote locations is worthy of further intellectual scrutiny and requires cross-discipline exchanges between health practitioners, linguists and educators.

This doctorate research has also highlighted women’s common experiences of violence, both as victims and perpetrators in Saint Fiacre. Violent encounters were often normalised within both monogamous and polygamous relationships. In the Northern Territory, Indigenous people experience assault victimisation at a rate that is six times higher than for non-Indigenous people, and, across the nation, the rate of Indigenous females being hospitalised due to assault is 31 times higher than for non-Indigenous females (AIHW, 2015, pp. 44–45).

Research indicates a strong correlation between experiences of violence and women’s poor sexual and reproductive health outcomes. Research by Fairbairn, Tyler, Su, and Tilley (2010) in the Alice Springs hospital documented a strong association between sexually transmitted infections in young Aboriginal women and presentations for physical assault. In broader mainstream populations, women who experience intimate partner violence are also known to experience poorer sexual and reproductive health outcomes (Coker, 2007; Taft, Watson, & Lee, 2004). This correlation has significant implications and opportunities for health service providers and criminal-justice service providers to co-operate in improving sexual and reproductive health outcomes.
Recommendations.

Women’s right to safe and satisfying sex lives in Saint Fiacre could therefore be improved through a raft of locally based and system-based recommendations as well as through further research.

Locally based interventions.

- Investigate the feasibility of designing and implementing an Aboriginal youth-friendly condom marketing campaign in Saint Fiacre.
- Consult widely with men and women to consider the viability of introducing the female condom to Saint Fiacre.
- Consult with young people to increase conveniently located and discreetly obtainable supplies of condoms in Saint Fiacre.
- Increase young people’s agency through the provision of sexual and reproductive health education that uses novel methods and does not rely on school attendance.
- Consult with the community about culturally congruent and acceptable adaptations and translations of Western biomedical reproductive anatomy and physiology.
- Raise the community profile of intimate partner violence in Saint Fiacre, and provide access to appropriate family-violence referral and support services for men and women.
System-based interventions.

- Investigate innovative and novel low-literacy approaches to the promotion of youth-friendly sexual health education, available outside of school-settings and normal business hours.

- Educate health clinicians and police officers on the increased sexual health vulnerability of women involved in violent relationships. Encourage police officers to offer clinical referrals to all perpetrators and victims of violent crimes. Encourage clinicians to always consider offering opportunistic sexual health screening to patients who report assault or incidences of violence.

- Through the development of referral pathways and liaison with staff at the women’s safe house, counselling services and the local police station, provide targeted sexual health screening and information to young women known to experience violence.

- Target young people for sexual health screening outside of clinical areas.

Further research.

- Investigate the barriers, myths and misconceptions surrounding remote dwelling Aboriginal youth’s use of condoms.

- Investigate and evaluate the efficacy of different models of bicultural/lingual health education with cross-collaboration between experts from the fields of linguistics, health and education.
Right to reproduce when and if you wish.

In Saint Fiacre, women’s freedom to decide if, when and how they reproduce is affected by positive cultural endorsement of motherhood and by women’s limited knowledge of Western biomedical contraceptive techniques and information. Although becoming a mother is acknowledged in Saint Fiacre as an important and often positive social milestone for many young women, it is likely that numerous young women experience unplanned and perhaps unwanted pregnancies. Unplanned teenage pregnancies have serious public health implications and are associated with poorer outcomes for young women and their babies (Williams & Davidson, 2004). Unplanned pregnancies in Saint Fiacre could be better managed by improving the promotion, access, knowledge and use of long-acting reversible contraceptives (LARCs) and emergency contraception medication and by providing timely referral to abortion services.

One of the most effective strategies to reduce unplanned pregnancy rates is to increase women’s access to and use of LARCs (Black, Bateson, & Harvey, 2013), which require administration less frequently than once a month (Sexual Health and Family Planning Association of Australia [SH&FPA], 2012). LARCs include 3-monthly depot medroxyprogesterone acetate injection, 3-yearly etonogestrel subdermal implant, 5-yearly hormonal levonorgestrel intrauterine devices and 10-yearly copper intrauterine devices (Black et al., 2013). LARCs have very few clinical contradictions, have high efficacy and require little ongoing motivation on the part of women beyond the initial fitting/administration (SH&FPA, 2012). In one piece of research, women reported high rates of continuation and satisfaction with LARCs (Peipert et al., 2011).
There are no reliable and routinely kept data on Australian women’s contraception use (SH&FPA, 2012), and neither are there publicly available records on contraceptive use among women in Saint Fiacre. While nationally the uptake of LARCs by Australian women has been variously described as lacking, low and less than 10% (SH&FPA, 2012), one survey has indicated a higher uptake by remote Indigenous women, with 14% of women indicating use of contraceptive injections and 13% indicating use of contraceptive implants (Pink & Allbon, 2008). Although the data is scant, it indicates an encouragingly higher uptake of LARCs by remote Indigenous women, and it should remain a key priority for all health clinicians to promote their use, especially to adolescent girls. Contraceptive implants and intrauterine devices can be safely inserted and used by adolescent and nulliparous women (SH&FPA, 2012).

However, many young women in Saint Fiacre felt burdened by the side-effect profile of LARCs such as the etonogestrel subdermal implant. Progestin-only LARCs are most commonly used by the girls and women in Saint Fiacre, and all disrupt the normal menstruation cycle. Progestin-only LARCs can be associated with different patterns of vaginal bleeding, with amenorrhea or infrequent bleeding or with frequent, heavy or prolonged bleeding (Read, Harvey, Bateson, McNamee, & Foran, 2010). Frequent, heavy or prolonged vaginal bleeding are the most common reasons for the discontinuation of this contraceptive, and although there are short-term pharmacological treatments available, there is no evidence that these provide long-term relief from this inconvenient bleeding pattern or increase the rates of continuation (Read et al., 2010). Other side effects, such as decreased dysmenorrhoea or decreased rate of anaemia may be advantageous to women (SH&FPA, 2012). The
barriers to the promotion of and women’s use of these highly effective contraceptive methods in remote Aboriginal towns needs to be better established.

Young female research participants displayed very limited knowledge in how unplanned pregnancies could be managed. Women had no knowledge concerning the access, safety and efficiency of emergency contraception. The prescription rate of emergency contraception at the local health centre is not available to the public. During my two years of clinical practice at the centre, I never saw it prescribed, nor experienced a woman asking for it. In Saint Fiacre, women’s limited knowledge of emergency contraception is in stark contrast with that of other Australian women, with one national survey reporting 96% of Australian women have heard of the emergency contraceptive pill and 26% have used it (Hobbs et al., 2011). According to the World Health Organization (2012), the emergency contraceptive pill is very safe and can be used up to five days after unprotected sexual intercourse. Its effectiveness ranges between 52% and 94% depending on how soon after intercourse it is used (World Health Organization, 2012). In regional areas of the Northern Territory, the emergency contraceptive pill can be obtained without a prescription, over-the-counter at pharmacies, but in Saint Fiacre it is only obtainable via the clinic. A copper-bearing intrauterine device may also be used as emergency contraceptive if inserted within five days of intercourse, and although this requires access to a skilled clinician for insertion, it is 99% effective and can then serve as LARC (World Health Organization, 2012). Although not explicitly discussed as a discrete topic, no participants spontaneously spoke about abortion as a way of managing an unplanned pregnancy. This finding suggests further research is required to better understand women’s beliefs, knowledge and current access to services, which may be of assistance in managing unplanned pregnancies.
Women’s linguistic and culturally bound constructions of their bodies also affect their reproductive freedoms and are often not taken into account in the provision of sexual and reproductive health care. The infertility rate in Saint Fiacre is unknown, but it is likely many couples do experience difficulty in conceiving. Research in one remote Northern Territory Aboriginal town demonstrated an infertility rate of 26.3% (8.2% primary infertility and 18.1% secondary infertility) (Kildea & Bowden, 2000, p. 382). Although infertility is attributed to a range of lifestyle and biomedical factors, in Saint Fiacre cultural constructions of the female body are important to consider because they appear to not relate the menstrual cycle to periods of fertility. Basic management of fertility by the timing of sexual intercourse (to either promote or limit the chances of conception) is negatively affected by this belief. This belief structure makes the clinical assessment and counselling about fertility both challenging and open to miscommunication. Clinicians may require alternative visual resources, such as the commercially marketed CycleBeads (CycleBeads, 2015), a colour-coded string of beads that represents a normal menstruation cycle, as important tools to assist with bridging communication gaps about fertility and menstruation cycles. Constructs of fertility and the reproductive system additionally complicate how women perceive the actions of Western biomedical contraception. Situations were reported in my research where Aboriginal women had not been adequately counselled and had not understood the permanency of tubal ligation contraception.

These cultural constructions also have serious implications for Aboriginal women’s consent for and participation in clinical reproductive and sexual health screening. Although the older women who participated in my research demonstrated language to describe their external genitalia, the naming of the internal female
reproductive system was limited to a single ovary and an ephemeral organ known as the ‘wanhpanh’. Younger women also displayed a loss of reproductive language terminology and often did not identify or recognise an ovary. Without careful cross-cultural communication, this emic construct makes it very difficult for women to comprehend the pathology and common screening rationale for sexual and reproductive health disorders. I argue that many women appear to undertake sexual and reproductive health screening or care in ‘good faith’, without adequate background knowledge. Willingness to participate or give consent is often about the relationship with and trustworthiness of the actual person requesting. More importance should be placed on empowering women’s participation in health screening through better knowledge sharing and communication. Although outside the scope of this research, I suggest that cultural constructions of the human body’s structure and function affects peoples’ understanding of other health issues and chronic disease pathology.

**Recommendations.**

Women’s right to decide if, when and how they reproduce could be improved through a raft of locally based and system-based recommendations and through further research.

**Locally based interventions.**

- Consult and develop a resource to assist health practitioners with counselling women about the effects of LARCs.
- Raise community awareness and reduce misconceptions about LARCs.
- Instigate a public health campaign to increase young people’s knowledge about the safety and access to emergency contraception.
• Invest in documenting and understanding the implications of cultural and linguistic constructions of the human body on health.

• Encourage clinicians to use visual resources when discussing fertility and menstruation with women.

**System-based interventions.**

• Educate healthcare professionals on promoting the benefits of and offering LARCs to all women of reproductive age, especially adolescent girls.

• Collect community data on emergency and non-emergency contraceptive use and continuation for the purpose of improving access and clinical services.

• Promote training for all remote-area Aboriginal health workers, midwives, nurses and doctors in the use and insertion/administration of LARCs.

• Encourage the use of trained translators and of language resources when requesting consent for medical procedures and treatments with Aboriginal women who do not speak English as a first language.

**Further research.**

• Investigate the acceptability and continuation rates of LARCs for remote-living Aboriginal women.

• Investigate remote-living Aboriginal women’s knowledge and beliefs regarding the management of unplanned pregnancies.
• Investigate the impact of cultural body constructions on communication with Aboriginal women in reproductive and sexual health encounters.

• Investigate the options and efficacy of various visual communication tools for use in the provision of sexual and reproductive health care.

**Right to appropriate health care during pregnancy and childbirth.**

Aboriginal women’s right to what they deem appropriate health care during pregnancy and childbirth in the Northern Territory has been marginalised by the logics of Western biomedicine. A system of obligatory evacuation of remote women to regional centres for hospital-based childbirth has reduced some medical perinatal risk factors but amplified others. As discussed in the literature review (see Chapter 2), the cultural and social costs of removing childbirth from Aboriginal communities have been significant and well documented over the past 30 years. Australian mainstream maternity care has undergone significant reform led by the consumer lobbying of wealthy, educated Caucasian and urban-based women (Reiger, 2001), while Aboriginal women’s maternity care preferences continue to be muted and marginalised in the redesign of maternity care (Wilson, 2014). Successful consumer-led reform often utilises a political approach based on the tenet of informed choice, but it can be argued that this is a fraught concept for remote Aboriginal women, who are already socially disadvantaged with relative political powerlessness.

It is possible to draw parallels with the propositions put forward by Daviss-Putt and Akaloyok (1993) who examined the more recent history of childbirth for remote Inuit women. In this Canadian setting, birth places for Inuit women rapidly changed from solitary birth huts to Western nursing stations, and then to obligatory
evacuation for regional-based hospital childbirth. Daviss-Putt and Akaloyok (1993) suggest that although Inuit women traditionally had minimal childbirth choices limited by survival and cultural traditions, women’s childbirth choices as a result of obligatory evacuation are now limited by the cultural traditions of biomedical medicine. Here, as in many parts of the developed world, childbirth has become a biomedical act, bounded by the legally enforced concept of informed choice. In this setting, it is assumed that an Inuit woman can be offered an obstetrical intervention that she will either accept or reject; there is no acknowledgement that she may wish to choose something entirely different. Daviss-Putt and Akaloyok explain that, where, in the past, birthing women had no access to or knowledge of Western obstetrical technology and interventions, today they have no choice to refuse it. Daviss-Putt and Akaloyok question whether informed choice is just another ethnocentric construct imposed on an already colonised Inuit community. They state that traditional societies, such as the Inuit people, do not function within the ‘ethics’ of informed choice and have no historical experience in its execution. The exempting clause of ‘informed choice’ is that colonising nations appear to reserve the right for their own people only and not for those whom they have colonised.

In a shared legacy with the Inuit people, Aboriginal women in the Northern Territory also have no historical experience of informed choice in their social organisation and political structure. Their community has been colonised, and the locations for childbirth rapidly changed in quick succession from bush camp ancestral estates to community clinics to obligatory evacuation for a regionally based hospital childbirth. Throughout this sequel, informed choice has never been offered to women, but it is now being positioned as a reproductive ‘right’ in the debate to return childbirth back to remote communities. Without careful consideration, the
ongoing campaigning for informed choice for Aboriginal women may well become just another Eurocentric outsider construct that further diminishes and demeans Aboriginal women. Successful attainment of the right to informed reproductive choice requires Aboriginal women and their families to have the knowledge and information about all of the alternatives and options. As Daviss-Putt and Akaloyok (1993) state, it equates to abuse when women are not educated about their choices.

In the social isolation of Saint Fiacre, women continue to know very little about the common standards and expectations that ‘outsider’ women take for granted during their reproductive experiences. They also know very little about the international experiences of other indigenous women and their shared history of childbirth being removed from their home communities. With a limited scope of experiential and information resources to draw upon, women have no cause to question the absence of their loved ones when they give birth alone in hospital or their separation for prolonged periods from their other children while waiting in Darwin for labour to commence. Without a greater knowledge base, informed choice remains an alien, culturally bound concept in Saint Fiacre. In partnership with women in Saint Fiacre, the concept of informed choice requires careful cross-cultural translation and unpacking.

Without doubt, the introduction of Western midwifery to Saint Fiacre resulted in the colonisation and disruption of many centuries of ancestral reproductive practices. Yet, overtime, the colonising features of local Western midwifery were mitigated by Aboriginal women’s involvement as maternity carers. With the passage of time, Western midwifery transformed into an important instrument of care that nurtured Aboriginal women’s resilience. Historical review suggests that remote childbirth services in Saint Fiacre were both well regarded and accepted by local
women and appear to have had the benefits of being both physically and culturally safe. One of the key factors in the success of community childbirth services was the pioneering role and contributions made by Aboriginal health workers in the care of their own women during pregnancy and birth.

Alarmingly, there is now an absence of any Aboriginal health workers clinically practising in Saint Fiacre. The demise of their clinical role appears to be linked with professionalisation and expectations of higher education and literacy standards. Once childbirth was removed, the career pathways of Aboriginal health workers’ skilled and passionate in the provision of maternity care were abruptly terminated. In northern Canada, Epoo, Stonier, Van Wagner and Harney (2012) describe how community activism to abolish obligatory evacuation for childbirth, coupled with the need to reclaim Inuit-led midwifery practice, resulted in the establishment and ongoing success of an Indigenous midwifery education program in 1986. However, without this sort of coordinated political advocacy, childbirth continues to be removed from Saint Fiacre, and this makes it unlikely that young Aboriginal women will be inspired to become midwives. In the unlikely event that they are inspired, these young women’s educational disadvantage makes further Western-styled study untenable. If we value the involvement of Aboriginal women in the midwifery care of Aboriginal women, we may need to radically reconceive the terms of their participation. In Saint Fiacre, this means the health system has a short-term obligation to accommodate the employment of Aboriginal women who have the appropriate attributes and interest to be involved in the provision midwifery care but who may be unable to meet certificate-level Western educational standards. In the longer term, it will mean investment in, and promotion of, education for Aboriginal
girls, along with pre-vocational opportunities, such as work experience with midwives and Aboriginal maternity care workers.

**Recommendations.**

Women’s right to appropriate health care during pregnancy and childbirth could be improved through a raft of locally based and system-based recommendations and through further research.

**Locally based interventions.**

- Give women and their families access to information about a broad range of maternity care alternatives and options, not just current practice in Saint Fiacre.

- Instigate a primary maternity care service in Saint Fiacre that supports childbirth in the existing, resourced birthing room in the community health centre.

- Apprentice local Aboriginal women, on their own terms and conditions, to assist in providing community-based care for women during pregnancy, childbirth and the postpartum period.

- Strategically invest in girls’ school education and provide opportunities for work experience with midwives providing maternity care in Saint Fiacre.

**System-based interventions.**

- Prioritise, support and value the involvement of Aboriginal women in all aspects of maternity care.
• Support primary maternity services as a basic health requirement for all women in remote Aboriginal towns.

**Further research.**

• Investigate midwifery care models for publicly funded private-practice midwives to work in remote Aboriginal towns.

**Conclusion**

In conclusion, this final chapter has synthesised and integrated the research results, using a sexual and reproductive health rights framework. The research was undertaken using an ethnographic design, which relied on iterative cycles of data collection over a six-year relationship with the Saint Fiacre community. Alongside ethnography, complementary qualitative research methods and historiography were used to rigorously explore matters of importance in better understanding Aboriginal women’s sexual and reproductive health. This achievement is due to the generous collaboration of, and assistance from, women in Saint Fiacre and from the support offered from a diverse range of professionals, such as linguists and archivists. Although the attainment of Aboriginal women’s sexual and reproductive health rights are impeded by a complex set of social, historical and cultural determinants, this research importantly highlights opportunities to positively affect and reverse remote Aboriginal women’s current health disadvantage in the Northern Territory. The cultural domain of women’s business involves many sensitive and confronting issues for Aboriginal and non-Aboriginal women alike, but the personal discomfort in discussing these matters cannot be used as a reason to ignore them. As Glasier and Gülmezoglu (2006, p. 1551) note, ‘to tackle sexual and reproductive ill health requires courage’. For too many remote Aboriginal women, the sacredness of their
reproductive function is overshadowed by unacceptably poor sexual and reproductive health. Now is the time for Aboriginal women, health practitioners, policymakers and researchers to collaborate and act with courage in addressing this gendered health inequity.
Acknowledgement of Assistance

Acknowledgement of Editor’s Contribution

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www.wendymonaghan.com.au
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Appendices

Appendix 1: Ethics Approval Letter

17th January 2011

Ms Sarah Ireland
PhD Candidate
Menzies School of Health Research
PO Box 391
KATOOMBA NSW 2780

Dear Ms Ireland,

Re: HR-10-1429 - Reproducing History: Aboriginal women in a remote community in the Northern Territory

Thank you for email communication of 18 January 2011.

The Human Research Ethics Committee of the NT Department of Health and Menzies School of Health Research thanks you for taking the time to respond to the issues of concern identified by the Committee at the meeting held December 2010.

Full approval is now granted. The Committee is satisfied that the research proposal meets the requirements of the NH&MRC National Statement on Ethical Conduct In Human Research, 2nd Ed., 2007.

This approval will be ratified at the next meeting of the Human Research Ethics Committee to be held 16/2/2011. Please note that HREC approval applies only to research conducted after the date of this letter.

Approved Project timeline: 17/1/2011 to 30/7/2013. This approval is for a period of twelve (12) months. A final project report is required on or before 17/1/2012.

Please note the terms under which ethical approval is granted:

1. The safe and ethical conduct of this project is entirely the responsibility of the investigators and their institution(s).
2. Researchers should report immediately anything which might affect continuing ethical acceptance of the project, including:
   a) adverse effects of the project on subjects and the steps taken to deal with these,
   b) other unforeseen events,
   c) new information that may invalidate the ethical integrity of the study,
   d) Proposed Changes in the project
3. Approval for a further twelve months will be granted if the HREC is satisfied that the conduct of the project has been consistent with the original protocol.
4. Confidentiality of research participants should be maintained at all times as required by law.
5. The Patient Information Sheet and the Consent Form shall be printed on the relevant site letterhead with full contact details.
6. The Patient Information Sheet must provide a brief outline of the research activity including, risks and benefits, withdrawal options, contact details of the researchers and must also state that the Human Research Ethics Secretary can be contacted (telephone and email) for information.

The Human Research Ethics Committee of NT Department of Health and Families and Menzies School of Health Research (HREC) is constituted and operates in accordance with the NH&MRC National Statement on Ethical Conduct in Human Research (2007).
concerning policies, rights of participants, concerns or complaints regarding the ethical conduct of
the study.

7. The Committee must also be notified at the completion of the project.

Yours sincerely

[Signature]

Dr Michael Nixon
Chair
Human Research Ethics Committee
of NT Dept of Health and Menzies School of Health Research
Appendix 2: Sample Interview Theme Guide for Non-Aboriginal Participant

Sample Interview Theme Guide – Retired Clinic Staff

<table>
<thead>
<tr>
<th></th>
<th>Introduction and consent process</th>
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<tbody>
<tr>
<td>2</td>
<td>Collect participant demographics:</td>
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<tr>
<td></td>
<td>Age</td>
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<tr>
<td></td>
<td>Role</td>
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<tr>
<td></td>
<td>Years of Saint Fiacre experience</td>
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<td>3</td>
<td>Tell me about working in Saint Fiacre</td>
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<td></td>
<td>Probe for:</td>
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<td></td>
<td>Where was the old hospital you worked in?</td>
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<td></td>
<td>How did the labour ward in the hospital work?</td>
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<td></td>
<td>What equipment did you have?</td>
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<td></td>
<td>Who provided antenatal care?</td>
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<td></td>
<td>Did you work alongside Aboriginal health workers?</td>
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<td></td>
<td>What do you remember of the birth outcomes?</td>
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<td></td>
<td>What where the common birth and pregnancy complications?</td>
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<td></td>
<td>Did you provide postnatal care?</td>
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<td></td>
<td>What sort of contraception was available during this time?</td>
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<td></td>
<td>How did women manage their fertility?</td>
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<td></td>
<td>Did any women or babies die during childbirth while you worked there?</td>
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<td></td>
<td>Do you know when birth in the community stopped being offered?</td>
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<td></td>
<td>What medical support did you have?</td>
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<td></td>
<td>What was the condition of the airstrip?</td>
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<td></td>
<td>Was the radio reliable communication?</td>
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<td>4</td>
<td>Tell me about a birth that happened in Saint Fiacre</td>
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<td></td>
<td>Probe for:</td>
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<td></td>
<td>What happened?</td>
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<td></td>
<td>What was your role?</td>
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<td></td>
<td>Who was present?</td>
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<td></td>
<td>Describe the first stage of labour.</td>
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<td></td>
<td>Did the women have antenatal care?</td>
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<td></td>
<td>Were you professionally satisfied with the birth?</td>
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<td></td>
<td>What were the good things about this experience?</td>
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<td></td>
<td>What were the bad things about this experience?</td>
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<td></td>
<td>Would this woman have been able to be evacuated to Darwin?</td>
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<td>5</td>
<td>Anything else you would like to add?</td>
</tr>
<tr>
<td>6</td>
<td>Conclusion and wrap-up</td>
</tr>
</tbody>
</table>
Appendix 3: Sample Interview Theme Guide for Aboriginal Participant

<table>
<thead>
<tr>
<th>Sample Interview Theme Guide – Aboriginal Health Worker</th>
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<tbody>
<tr>
<td><strong>1</strong> Introduction and consent process</td>
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<tr>
<td><strong>2</strong> Collect participant demographics:</td>
</tr>
<tr>
<td>Age</td>
</tr>
<tr>
<td>Traditional Country</td>
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<tr>
<td>Languages spoken</td>
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<tr>
<td>Training/Work Experience</td>
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<tr>
<td><strong>3</strong> Tell me about working in Saint Fiacre at the old hospital</td>
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<tr>
<td>Probe for:</td>
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<tr>
<td>Where was the old hospital?</td>
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<tr>
<td>How did the labour ward in the hospital work?</td>
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<tr>
<td>What equipment did you have?</td>
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<tr>
<td>Who provided antenatal care?</td>
</tr>
<tr>
<td>Did you work alongside nurses, nuns or doctors?</td>
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<tr>
<td>What do you remember of the birth outcomes?</td>
</tr>
<tr>
<td>What where the common birth and pregnancy complications?</td>
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<tr>
<td>Did you provide postnatal care?</td>
</tr>
<tr>
<td>What sort of contraception was available during this time?</td>
</tr>
<tr>
<td>How did women manage their fertility?</td>
</tr>
<tr>
<td>Did any women or babies die during childbirth while you worked?</td>
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<tr>
<td>Do you know when birth in the community stopped being offered?</td>
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<tr>
<td>What medical support did you have?</td>
</tr>
<tr>
<td>What was the condition of the airstrip?</td>
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<tr>
<td>Was the radio reliable communication?</td>
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<tr>
<td>Can you compare this to how you work now?</td>
</tr>
<tr>
<td>Can you tell me about any special ceremonies that were used to help women in labour or newborn babies?</td>
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<tr>
<td><strong>4</strong> Tell me about a birth that happened in Saint Fiacre in the old hospital</td>
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<tr>
<td>Probe for:</td>
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<tr>
<td>What happened?</td>
</tr>
<tr>
<td>What was your role?</td>
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<tr>
<td>Who was present?</td>
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<tr>
<td>Did the women have antenatal care?</td>
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<tr>
<td>What were the good things about this experience?</td>
</tr>
<tr>
<td>What were the bad things about this experience?</td>
</tr>
<tr>
<td><strong>5</strong> Anything else you would like to add?</td>
</tr>
<tr>
<td>How did you begin doing this type of work?</td>
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<tr>
<td>Did you have any traditional training?</td>
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<tr>
<td><strong>6</strong> Conclusion and wrap-up</td>
</tr>
</tbody>
</table>

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Appendix 4: Sample Focus Group Theme Guide

<table>
<thead>
<tr>
<th></th>
<th>Sample Focus-Group Theme Guide</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction and consent process</td>
</tr>
</tbody>
</table>
| 2 | Collect participant demographics:  
   Number of participants  
   Ages  
   Clan Groups  
   Languages |
| 3a | So much has changed since your parents grew up in the dormitory, tell me about being a young woman in Saint Fiacre  
   Probe for:  
   - What do young women do for fun here?  
   - Where do you go if you want to have fun?  
   - How do young women choose their husbands or boyfriends?  
   - What kinship terms do girls use to describe their families? |
| 3b | Tell me more about young women’s business.  
   Probe for:  
   - What sort of sickness do young women get here?  
   - How is sickness caused?  
   - How can sickness be treated?  
   - Do young women like getting pregnant?  
   - How can you stop getting pregnant?  
   - How does contraception work?  
   - Does contraception affect young women’s bodies?  
   - If a young woman is pregnant but does not want to have the baby, is there anything she can do about it? |
| 5 | Anything else to add? |
| 4 | Conclusion and wrap-up |
Appendix 5: Community Letter of Support

Kanamke Yile Ngala Museum
c/o Post Office
via Winnellie
NT 0822
11/05/10

To Whom It May Concern:

RE: Letter of Community Support

We represent the local Kanamke Yile Ngala Museum and the traditional land owning women of

We would like to provide in principle community support to the research project titled: "Rosaries, Ovaries and The Rainbow Serpent: Aboriginal women's experiences of reproduction and fertility in Wadeye, Northern Territory". We know Sarah Ireland and are happy to welcome her back to the community for the purpose of undertaking this research.

Our support is provisional on ethics committee approval and the ongoing support of the community. We believe this research can be a valuable opportunity to document and understand Women’s Business in We will support Sarah; provide her cultural mentoring and make available community based storage facilities for the research results.

Yours Sincerely,

[Signatures]

M. Crocombe
Mr Mark Crocombe
Curator
Kanamke Yile Ngala Museum
NT

Ms Theodora Narndu
Senior Kardu Diminun Female Leader
Traditional Land Owner
NT
Appendix 6: Letter of Support from Cultural Mentor

Ms Concepta Wulili Narjic
c/o Christian Outreach Hostel
10 Crecar Road
Berrimah NT 0828
19/05/10

To Whom It May Concern:

RE: Letter of Support

I am a senior woman from [Community] and work as a traditional midwife in Darwin with the Northern Territory Department of Health and Families. I have known Sarah Ireland and Suzanne Belton for some years now. I have worked with them in the past doing health business research.

I would like to provide in principle support to the research project titled: "Rosaries, Ovaries and The Rainbow Serpent: Aboriginal women’s experiences of reproduction and fertility in [Northern Territory]". My support is provisional on ethics committee approval and the ongoing support of the community.

I will support Sarah in this research by providing her cultural mentoring, advice and consultation.

Yours Sincerely,
Concepta Narjic
30-7-2010

Ms Concepta Wulili Narjic
Kardu marra wunthirri-yu: traditional midwife
[Community], NT
Appendix 7: Participant Consent Form

This means that you can say NO

Consent Form
This form asks for your consent to participate in this study. If you provide consent you can still withdraw from the study at any time without any negative consequences.

Study Title: Reproducing history: Aboriginal women in a remote community in the Northern Territory
Researcher: Sarah Ireland, Menzies School of Health Research

Aboriginal Research Assistant:

Interpreter:

Project Summary:
I consent to being in this study. I have read the information sheet and had a chance to ask questions about participating in this study. I understand that the purpose of this study is to investigate women’s business in Saint Fiacre. This will include collecting stories, memories, drawings, explanations, experiences and language about fertility and reproduction.

I understand that the ownership of Aboriginal knowledge and cultural heritage is retained by the informant and this will be acknowledged in research findings and in the dissemination of the research. After the research is finished, the information not contained in the book will be destroyed. I have the choice to donate the information I share to the Kanamkek-Yile Ngala Museum.

Statement of Participant:
I would like to not be identified in the research. This means I will share my information with you, the researcher, but my name should remain confidential so that other people cannot know who I am. Yes □ No □

I would prefer to be identified in the research. This means other people will know who I am from looking at the research. Yes □ No □

I understand that I will be asked about my views and experiences regarding past and present maternal and women’s health services and I consent to this. Yes □ No □

I consent to my voice being recorded on a tape recorder for the interviews. The researchers can then listen again to what I have told them at a later time. Yes □ No □

I consent to being recorded on a digital video. The researcher can then look over what I have shown them at a later time. Yes □ No □

I consent to my photograph being taken to record information and this will be put in a book called a ‘thesis’. Yes □ No □

I consent to photographs/recordings/stories from me to be publicly displayed after I have passed away. Yes □ No □

I consent to copies of my drawings to be kept and used. I will not be identifiable from the drawings. Yes □ No □

I consent that the information I provide in the interview may be published in research reports, journals or presented at conferences. Yes □ No □
I understand that I may withdraw from the study at any time with no effect to me or my family.

Yes □ No □

I would like copies of my voice/video/photograph recordings to be put in the Kanamkek-Yile Ngala Museum. This means the information will be kept safe and owned by the Saint Fiacre community.

Yes □ No □

If YES :
I would like my name to be recorded with the information when it is stored in the Kanamkek-Yile Ngala Museum.

Yes □ No □

The people who may access my donated material are:

Any member of the public
Yes □ No □

Only by Saint Fiacre community, family and descendants
Yes □ No □

Only by women
Yes □ No □

Do you have any other special instructions for access to the donated material?

... ...

Name of participant: _____________________________________________________

Participant signature: ___________________________

Date: ___________________

Interpreter name: ________________________________________________________

Interpreter signature: ____________________________

Date:___________________

Witness name: ___________________________________________________________

Witness signature: _________________________________________________________
Appendix 8: Participant Information Sheet for Aboriginal Participants

Reproducing history: Aboriginal women in a remote community in the Northern Territory

This is for you to keep

Information sheet for Saint Fiacre participants

Hello. My name is Sarah Ireland. I am a midwife, nurse and researcher from Menzies School of Health Research. I would like to invite you to be part of a study that I am conducting called ‘Reproducing history: Aboriginal women in a remote community in the Northern Territory’.

The Aboriginal community of Saint Fiacre has changed since the mission started 75 years ago. This project would like to explore how women’s lives have changed since the mission started, examine women’s relationship with maternity health services and document women’s beliefs and practices regarding fertility and reproduction. As part of this research, I would like to hear your stories, memories, language and experiences about women’s business in Saint Fiacre. An Aboriginal research assistant and I would like to work with you and other women in the community to record and understand these stories.

If you agree to this study, I will be in contact with you. The Aboriginal research assistant and I will visit you over a four-month period to collect your stories or ask you to participate in a group session. We may write notes about the stories, ask you to draw pictures, record your voice on tape, video or photograph you.

The results of this study will be kept safe and confidential at Menzies School of Health Research. We will examine the information that is collected from you and other women and will write regular reports about our findings for you to keep. Your name will not be recorded in the reports, unless you request it to be.

With permission, copies of your stories will also be kept safe at Kanamkek-Yile Ngala Museum. You will have the choice if you would like to be identified and who will access the material stored in the museum.

At the end of the research, all the information will be put together to create a book for the university called a ‘thesis’. Copies of this will also be given to the Kanamkek-Yile Ngala Museum.

If you are interested, either the Aboriginal researcher or I will provide you with a consent form to sign that you agree to be in the study. Please ask us any questions you like, and if you want an interpreter then one will be provided.

You can choose to not participate in this study, and that is fine. Even if you do agree to participate, you can still withdraw from the study at any time, and the information that has been collected from you will not be used.

If you have any worries about the study, please feel free to discuss these either with myself (0410 328 797), the Aboriginal researcher assistant (Ph); or my supervisors, Dr Suzanne Belton (Ph 08 8922 7953) or Professor Sherry Saggers (Ph). If you have any concerns or complaints about the ethical conduct of this study, you may contact the secretary of the Human Research Ethics Committee on 08 8922 7977 or email: ethics@menzies.edu.au

Thank you very much

Sarah Ireland
Appendix 9: Participant Information Sheet for Non-Aboriginal Participants

Reproducing history: Aboriginal women in a remote community in the Northern Territory
This is for you to keep

Information sheet for retired health workers

Hello. My name is Sarah Ireland. I am a midwife, nurse and researcher from Menzies School of Health Research. I would like to invite you to be part of a study that I am conducting called ‘Reproducing history: Aboriginal women in a remote community in the Northern Territory’.

The Aboriginal community of Saint Fiacre has changed since the establishment of a Catholic mission 75 years ago. This research will explore the impact of social change on women’s roles, critically examine women’s relationship with maternity health services and document women’s beliefs and practices regarding fertility and reproduction. I would like to work with you to understand how maternity and women’s health services were delivered in Saint Fiacre in the past.

If you agree to this study, I will be in contact with you over a four-month period to collect your stories, experiences and memories of working in Saint Fiacre. I may write notes about the stories, record your voice on tape, video or photograph you.

The results of this study will be kept safe and confidential at Menzies School of Health Research. We will examine the information that is collected from you and other participants and will write regular reports about our findings for you to keep. Your name will not be recorded in the reports, unless you request it to be.

With permission, copies of your stories will also be kept safe at Kanamkek-Yile Ngala Museum, Saint Fiacre. You will have the choice if you would like to be identified and who will access the material stored in the museum.

If you are interested, I will provide you with a consent form to sign that you agree to be in the study. Please ask us any questions you like.

You can choose to not participate in this study, and that is fine. Even if you do agree to participate, you can still withdraw from the study at any time, and the information that has been collected from you will not be used.

If you have any worries about the study, please feel free to discuss these either with myself (0410 328 797) or my supervisor Dr Suzanne Belton (Ph 08 8922 7953) or Professor Sherry Saggers (Ph). If you have any concerns or complaints about the ethical conduct of this study, you may contact the secretary of the Human Research Ethics Committee on 08 8922 7977 or email: 
ethics@menzies.edu.au

Thank you very much

Sarah Ireland
Appendix 10: Floor Layout of the Sacred Heart Hospital as Recorded During Fieldwork

The Sacred Heart Hospital Floor Plan

Hospital Floor Plan Key

A: Women and children’s ward with ten beds and assorted baby cots; B: Women and children’s bathroom with toilet and showers; C: Labour ward with one bed, cupboard, oxygen and statue of Saint Gerard Majella; D: Nursing sister’s office with desk, bed, radio, toilet and shower; E: Entrance foyer with a floor mosaic saying ‘Sacred Heart Hospital’; F: Store-room for medicines, food and supplies; G: Hospital kitchen, dining room and laundry; H: Mother’s ward for postnatal recovery with two beds and baby cots, toilet and shower; I: Men’s ward with five beds; J: Men’s toilet and shower; K: Men’s outdoor recreation area for sitting down, talking and playing cards; L: Pharmacy and treatment bay with examination table; M: Patient waiting room; N: Pharmacy dispensary window; O: Out-of-hours emergency doorbell to call for hospital staff.
**Appendix 11: List of Aboriginal Language Words Recorded During Fieldwork**

Please note that the spelling protocols used in this list may vary from those in the submitted publication chapters or other sources. The spelling in this list was established by the project’s employed Aboriginal research assistant and has not been changed. It is based on the oral recordings of the terms.

<table>
<thead>
<tr>
<th>Record #</th>
<th>English</th>
<th>Comments</th>
<th>Murrinh Patha</th>
<th>Marri Ngarr</th>
<th>Marri Ngarr</th>
</tr>
</thead>
<tbody>
<tr>
<td>835</td>
<td>Rectum</td>
<td>This internal anatomy not identified, only anus</td>
<td>weyi ngukin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>921</td>
<td>Womb</td>
<td>No equivalent word, although it has been previously glossed as <strong>manhpanh</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>922</td>
<td>Afterbirth</td>
<td>The same as placenta and membranes [924]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>923</td>
<td>Amniotic fluid</td>
<td>Baby lying in the baby water</td>
<td>kardu wakal yibim nagarra kura</td>
<td>ma yiper na wurdhi the</td>
<td>ma yiperi the na wurdhi</td>
</tr>
<tr>
<td>924</td>
<td>Placenta</td>
<td>Includes membranes, no discrete word for placenta</td>
<td>nanhthi manhpanh</td>
<td>nanhthi malawurr</td>
<td></td>
</tr>
<tr>
<td>925</td>
<td>Umbilical cord</td>
<td>Also refers to navel/belly button</td>
<td>nanhthi thirrimeme</td>
<td>nanhthi therdirr</td>
<td>nanhthi therdirr ma piperi nang</td>
</tr>
<tr>
<td>926</td>
<td>Anus</td>
<td></td>
<td>nugukin karmal</td>
<td>yeri mi wen</td>
<td></td>
</tr>
<tr>
<td>927</td>
<td>Pubic hair</td>
<td>Further refined term</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>928</td>
<td>Pubic mound</td>
<td>No word identified, included in <strong>nanhthi parnta[2598]</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Record #</td>
<td>English</td>
<td>Comments</td>
<td>Murrinh Patha</td>
<td>Marri Ngarr</td>
<td>Marri Ngarr Itich</td>
</tr>
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<td>----------</td>
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<td>---------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>929</td>
<td>Penis</td>
<td>Same as the death-adder snake and resembles shape</td>
<td>nanhthi ngi</td>
<td>thawurr ngu</td>
<td></td>
</tr>
<tr>
<td>931</td>
<td>Testicles</td>
<td></td>
<td>nanhthi karnkart</td>
<td>thawurr marrangi</td>
<td></td>
</tr>
<tr>
<td>934</td>
<td>Breast</td>
<td>See further refined terms [2503;2504;2505;2506]</td>
<td>nanhthi ngapulu</td>
<td></td>
<td></td>
</tr>
<tr>
<td>935</td>
<td>Nipple</td>
<td></td>
<td>ngapulu karmal</td>
<td>yengi mi</td>
<td></td>
</tr>
<tr>
<td>937</td>
<td><em>Labia majora</em></td>
<td>No word identified, included in nanhthi midhut</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>940</td>
<td>Menstruation</td>
<td></td>
<td>nanhthi mamurr warda</td>
<td>muli thirirdig amburra pingi</td>
<td></td>
</tr>
<tr>
<td>1223</td>
<td>Midwife</td>
<td>Only able to record MP</td>
<td>wakal manhthirriyegarl</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2500</td>
<td>Pain</td>
<td>Generalised term</td>
<td>yidingurr</td>
<td>yiderr</td>
<td></td>
</tr>
<tr>
<td>2501</td>
<td>Genital pubic hair</td>
<td></td>
<td>kardu kurlpurruwran</td>
<td>themi yithiwuni kang</td>
<td></td>
</tr>
<tr>
<td>2502</td>
<td>Underarm hair</td>
<td></td>
<td>kardu kurlpurru wanthay</td>
<td>them wantirr kang</td>
<td></td>
</tr>
<tr>
<td>2503</td>
<td>Breasts start developing</td>
<td></td>
<td>ngapulu pirrinurduyi</td>
<td>yengi karnirdurdumi</td>
<td></td>
</tr>
<tr>
<td>2504</td>
<td>Breasts pointing</td>
<td>Refers also to thumpith tree, whose thorns resemble adolescent breasts</td>
<td>ngapulu thumpith</td>
<td>yengi kalan</td>
<td></td>
</tr>
<tr>
<td>2505</td>
<td>Large developed breast</td>
<td></td>
<td>ngapulu ngalla</td>
<td>yengi kilinga</td>
<td></td>
</tr>
<tr>
<td>Record #</td>
<td>English</td>
<td>Comments</td>
<td>Murrinh Patha</td>
<td>Marri Ngarr</td>
<td>Marri Ngarr Itich</td>
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</tr>
<tr>
<td>2506</td>
<td>Engorged breasts</td>
<td>Lumpy sore breasts from poor feeding attachment, previously glossed as meaning ‘breast cancer’ but denied by participants</td>
<td>ngapulu kampauk</td>
<td>yengi kampuk</td>
<td></td>
</tr>
<tr>
<td>2507</td>
<td>Breasts hanging/falling down</td>
<td></td>
<td>ngapulu bamat</td>
<td>yengi kanigubak</td>
<td></td>
</tr>
<tr>
<td>2508</td>
<td>Groin (male and female inclusive)</td>
<td>Refers to inguinal folds and rise of the pubic bone, not genitals</td>
<td>nanththi parnta</td>
<td>awu memingu</td>
<td></td>
</tr>
<tr>
<td>2509</td>
<td>Baby turning for childbirth</td>
<td></td>
<td>wakal wurdamperduuy buybatnu wanda kardu yurrutthurrut warda</td>
<td>ye kitikibigurr kitbatning</td>
<td></td>
</tr>
<tr>
<td>2510</td>
<td>Baby engaged</td>
<td>Baby dropping down headfirst</td>
<td>kardu damludut warda</td>
<td>multi yidirr pingi</td>
<td>yurrutthurrut</td>
</tr>
<tr>
<td>2511</td>
<td>Contraction s</td>
<td></td>
<td>multi yidirr pingi</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2512</td>
<td>Sex</td>
<td>Darnitbay</td>
<td>dhibap kani</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2513</td>
<td>Breastmilk</td>
<td>Same as breast</td>
<td>nanththi ngapulu</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2514</td>
<td>Female virgin</td>
<td>mere puyngkawerrdhakani</td>
<td>multi ampokimwerrkani</td>
<td>multi ampukinmi-werr kani</td>
<td></td>
</tr>
<tr>
<td>2515</td>
<td>Shame</td>
<td>kardu yidiwewe</td>
<td>Yidingpikani</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2516</td>
<td>Menopause</td>
<td>kumulung dinnhetar'I warda</td>
<td>wurrkirim kinigatpingi</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2517</td>
<td>Miscarriage</td>
<td>wakal manthak</td>
<td>ye ngarrithakka</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2518</td>
<td>Abortion</td>
<td>Punching the stomach</td>
<td>wakal mampelip</td>
<td>ye ngerritherrkka</td>
<td></td>
</tr>
<tr>
<td>2519</td>
<td>Premature baby</td>
<td></td>
<td>wakal demngewerr</td>
<td>ye yiperi</td>
<td>kumunmimerra</td>
</tr>
<tr>
<td>Record #</td>
<td>English</td>
<td>Comments</td>
<td>Murrinh Patha</td>
<td>Marri Ngarr</td>
<td>Marri Ngarr</td>
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</tr>
<tr>
<td>2520</td>
<td>Stillborn baby</td>
<td>Death of baby inside body or as the baby is born</td>
<td>wakal thirlminh</td>
<td>ye yiperi</td>
<td>danthirakka</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ye yiperi</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>nanthirakka</td>
</tr>
<tr>
<td>2521</td>
<td>Midwife to many women</td>
<td>kardu mampunthirriyim purr kanam</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2522</td>
<td>Childbirth</td>
<td>wakal dimpak</td>
<td></td>
<td></td>
<td>ye attibatta</td>
</tr>
<tr>
<td>2523</td>
<td>Sperm</td>
<td>Refers to the white fluid of ejaculation</td>
<td>nanhthi ngimpitharl</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>nanhthi ditmi</td>
</tr>
<tr>
<td>2524</td>
<td>Maternal death from childbirth</td>
<td>Death during or after childbirth</td>
<td>wakal bammat kalekale yibimpup</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ye atibatta kila nathirakka</td>
</tr>
<tr>
<td>2525</td>
<td>Maternal postpartum haemorrhage</td>
<td>wakal bammat kalekale kumulung ngalla kanthin dim</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ye atibatta kila wurkirim killia karrbath kani</td>
</tr>
<tr>
<td>2526</td>
<td>Spirit baby</td>
<td>wakal ngepan</td>
<td></td>
<td></td>
<td>ye ngepan</td>
</tr>
<tr>
<td>2527</td>
<td>orgasm</td>
<td>The pleasure of sex</td>
<td>Mandinhinhinh</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2528</td>
<td>Sanitary products</td>
<td>Sanitary pads and tampons</td>
<td>nanhthi mayerung thawurr purtung purtung</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2529</td>
<td>Baby shell ceremony</td>
<td>wakal puninthebat ngarra ku ke ngarra the</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2530</td>
<td>Baby smoking ceremony</td>
<td>wakal pankuma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2531</td>
<td>frank breech baby</td>
<td>wakal lumpu-re bammat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2532</td>
<td>Footling breech baby</td>
<td>wakal me-re bammat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2533</td>
<td>Ovary</td>
<td>nanhthi kaminherrrkmminh yerrk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2534</td>
<td>Child before puberty</td>
<td>kardu mamay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Record #</td>
<td>English</td>
<td>Comments</td>
<td>Murrinh Patha</td>
<td>Marri Ngarr</td>
<td>Marri Ngarr Itich</td>
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<td>-------------</td>
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</tr>
<tr>
<td>2535</td>
<td>Female teenager and young girl</td>
<td></td>
<td>kardu mardinhpuy</td>
<td>muli dhirridi</td>
<td></td>
</tr>
<tr>
<td>2536</td>
<td>Women</td>
<td></td>
<td>kardu palngun</td>
<td>muli mungu kila kani</td>
<td></td>
</tr>
<tr>
<td>2537</td>
<td>Woman who has birthed a child Also refers to motherhood</td>
<td></td>
<td>kardu purlma warda dim</td>
<td>muli mugu pulma pingi kani</td>
<td></td>
</tr>
<tr>
<td>2538</td>
<td>Mother to a Deceased baby</td>
<td></td>
<td>kardu wakal manthak i ngurrgirr warda wurran kalekale-yu</td>
<td>kila kanipirr ye muli ngurryirr pingi kani</td>
<td></td>
</tr>
<tr>
<td>2539</td>
<td>Father to a deceased baby</td>
<td></td>
<td>yileyile pana wakal methak-ka kurlli wadu wurran</td>
<td>ma yitha kanipirr nan yenang nanga ma kurli pingi kani yah</td>
<td></td>
</tr>
<tr>
<td>2540</td>
<td>Menopausal woman Dim means sitting down or pointing at</td>
<td></td>
<td>kardu kunugunu dim</td>
<td>muli kunugunu pingi kani</td>
<td></td>
</tr>
<tr>
<td>2541</td>
<td>Elderly woman</td>
<td></td>
<td>kardu mutchinga</td>
<td>muli pindi</td>
<td></td>
</tr>
<tr>
<td>2542</td>
<td>Attractive woman or man Middle-aged</td>
<td></td>
<td>kardu keke</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2543</td>
<td>Premature deceased baby</td>
<td></td>
<td>wakal thilminh</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2544</td>
<td>Young girl sitting on the menstruation grass bed</td>
<td></td>
<td>kardu mardinhpuy pana nanhthi merburr ka dininganamarda</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2545</td>
<td>Erect penis Hard penis</td>
<td></td>
<td>nanhthi ngi tetemam</td>
<td>nanthi ngu dakin pingi kani</td>
<td></td>
</tr>
<tr>
<td>2546</td>
<td>Baby water breaking</td>
<td></td>
<td>kura nunga lurita</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2548</td>
<td>Vaginal tear from childbirth</td>
<td></td>
<td>kardu pana ngarra wakal thangaru bambat-ka banganganngurrud uk warda</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 12: Participant Feedback Booklet

This appendix has been removed for electronic dissemination but is available in a hard copy of the thesis held in the Charles Darwin University library.
Appendix 13: Audio Recordings of Aboriginal Language Words

This appendix has been removed for electronic dissemination but is available in a hard copy of the thesis held in the Charles Darwin University library.
Appendices for Female-Only Readers

The appendices contained in this next section are restricted to female readers only. If you are male, please refrain from reading the section. This protocol requires self-regulation, and we urge you to respect the wishes of the female cultural custodians who participated in this research.
Female-Only Appendix 1: List of Sacred Aboriginal Language Words Recorded During Fieldwork

Please note that the spelling protocols used in this list may vary from those in the submitted publication chapters or other sources. The spelling in this list was established by the project’s employed Aboriginal research assistant and has not been changed. It is based on the oral recordings of the terms.

This appendix has been removed for electronic dissemination but is available in a hard copy of the thesis held in the Charles Darwin University library.
Closed Appendices

The appendices contained in this next section are not accessible to the general public. They have been recorded only for the preservation and use of the Yek Yederr and the people of other relevant clans. They will be removed from the final thesis and deposited only in the Kanamkek-Yile Ngala Museum in Saint Fiacre.
Closed Appendix 1: Gendered Dreaming Sites

This appendix has been removed for public dissemination. A copy is located in Kanamkek-Yile Ngala Museum in Saint Fiacre.