BORNING

AMPE MBWAREKE PMERE ALALTYE

The Congress Alukura By The Grandmother's Law,

A Report Prepared by the C.A.A.C., AUGUST 1985

The immediate purpose of this research report is to document the nee for the Congress Alukura. The case as documented is impressive and it is to be hoped that the proposal is proceeded with swiftly. Clearly the need is urgent. The research report bears some signs of the urgency of the enterprise but these are "honourable scars" on a book with a purpose. It is clearly not an academic treatise. With a bit more time, prior to formal publication, I am sure these minor impairments will be resolved.

The immediate purpose of this research report is to document the need for the proposed Congress Alukura. This purpose is set within a broader and more complex movement, the assertion by the Aboriginal communities of Australia of their right to determine their own health care; to determine their own destiny. The research described in this report makes a most significant contribution to the ongoing controversy between the proponents of simple mechanical solutions to Aboriginal ill health (more doctors, more nurses, more hospitals, more dietery supplements) as opposed to strategies which are conceived with a view to the broader cultural, economical and political context. Within the Aboriginal community the need to understand Aboriginal mortality and morbidity within this broader context is widely appreciated. Likewise, the need to ensure that health strategies are part of and are compatible with broader strategies aimed at achieving cultural, economic and political goals is well illustrated by this research report. At the very least health strategies should not be antagonistic to the achievemen of those broader goals. Among the things which follow from an appreciation of health within the broader context are the critical importance of respect for the Law, the importance of community controlled services and the importance of "two-way borning".

Some white readers may be disturbed by Pam Nathan's vigorous critici of Western obstetric practices, and of the Northern Territory Health Department, notwithstanding the acknowledgement within the report of the power of Western obstetrics and the need for Aboriginal people to get adequate access (but on their own terms) to it. If one appreciates the degree to which the Aboriginal health struggle is embedded within the broader cultural, economic and political struggle then one will appreciate that the polemical style of this research report is an absolutely essential component of the report itself. A critical task within the health strategy which has been adopted by C.A.A.C. focuses on what Nathan has referred to as "two-way borning", defending and promoting the Law whilst exploring and adopting Western knowledge and skills,

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but from a position of strength. This area of "two-way health care" is characterised by some very difficult contradictions and apparent inconsistencies. Nathan has steered a difficult course through these difficulties and in doing so has made a major contribution to the process itself.

Understanding health within a cultural, economic and political context is of great importance to the health of Australians generally if the preventive challenges of the so called "life-style diseases" are to be met. In the Aboriginal situation the need to see health within its broader context is much more stark. Through the work of Aboriginal controlled medical services such as C.A.A.C., through projects such as the Congress Alukura Aboriginal people are leading the way in identifying the relationshi between individual health and broader cultural, economic and politic factors. Pam Nathan, in this and her previous works, is playing a most important role in documenting and clarifying the Aboriginal experience and perspective and in making them accessible to the broader Australian society.

I have no doubt that this research report will prove to be a significant contribution to improved Aboriginal health care. In due course a slightly more polished version should be published more widely. Such a publication would constitute a major contribution to Australian thinking about the relation between health and society, both with respect to Aborigines and more generally.

DAVID LEGGE
Health Department, Victoria

BORNING

AMPE MBWAREKE PMERE ALALTYE

The report is on a subject of the greatest significance. CAAC is to be congratulated for initiating and sponsoring research of this kind. The research is of fundamental cultural importance, and at the same time it deals with practical matters. The process of coming into the world is an everyday happening, in one sense a commonplace matter. In another sense it is the most important and mysterious of events, linking and renewing the generations, just as it links our past, our present, and our future. In medical terms, in technology oriented societies, the process has two stages after conception - monitoring the medical health of the woman, and delivery of the baby. That practice has its division of labour, between those who monitor and deliver, and the mother. Having babies is an individual act of the mother, and a collective act of the medical profession. This research has lighlighted the deep contrast which exists between these beliefs and practices, and those desired by Aboriginal people. Here the process is tied to the traditions of the people, and in the time of birth is an act shared and supported by other women.

The report of this research is worthy of the subject. In its preparation, and in the report, the Aboriginal women have made known their views, and made clear their understanding of the contrast and the oppositions between their way and the technical-medical way. To these words of the women are added the accounts of long-standing methods, and the account of modern medical practice. The theoretical material complements the directly made statements of the women, sharpening the contrast and contradictions. By drawing on European knowledge and practices, these contrasts become clear to the non-Aboriginal reader. In a sense the report is an example of two-way writing; it is convincing in its portrayal to the non-Aboriginal reader, just as the report indicates that Aboriginal women are well aware of the contrast.

We have no common English language word which characterises the process. We could, I suppose, say "coming-into-being" but then we would use a phrase common in philosophy and not used by others. "Borning", the term

used in the report seem appropriate. It is a word in use by Aboriginal people, apparently, and unfamiliar to most English speakers; its unfamiliarity is an advantage in this case, forcing the reader to rethink his other normal categories.

The report is clearly written, and moves forward in clear and logical fashion. The conclusion, that the people need their own Alukara, is in keeping with the presentation, and follows inevitably from it. The author of the report has shown clearly that certain modern techinques can be incorporated into the Aboriginal way, without the whole control and ideology within which western techniques are embedded in the dominant medical system. The report should be very helpful in bringing about the establishment of the Alukara, and its wider publication will make better known the meaning of two-way medicine under Aboriginal control. It is a very useful addition to the previous work for Congress which Pam Nathan has been involved, and in my opinion it is an advance and development of that work.

Dr D White

Reader's Comment on 'Borning...', Ampe Mbwareke Pmere Alaltye: The Congress Alukura By The Grandmother's Law

Report Prepared by C.A.A.C., August '85.

The most outstanding features of this report are the importance of the issues it raises and the honesty with which it considers them. Childbirth is a central feature of any culture and its significance has too often been ignored both by academics and by policy makers. This is so even within the western context, and it has had particularly ill effects in cross-cultural situations. A major advantage of this report is the extent to which it reveals the complex emotional and practical issues surrounding the organization of 'borning'. Childbirth encapsulates much of the essence of a society and this research has clearly revealed the gulf which separates traditional Aboriginal beliefs, values and attitudes from the modern scientific obstetrics of white society.

In giving voice to Aboriginal women's perceptions of the 'borning' problem, the research process itself has been an important development. It has encouraged Aboriginal women to move from passive resistance to alien practices to active articulation of their concerns and, still more importantly, to formulation of an exciting new development, the congress Alukura. As the author of the report notes, Aboriginal women have not in the past been consulted about their needs and desires and too frequently policies affecting them have been made by white men with little understanding of the issues involved. This clearly generates overwhelming problems in the area of childbirth, a major life event for women, and critical life experience for all of us. However, while the fears of discomfort with white obstetrical practice which these Aboriginal women have spelt out so clearly are particular to their circumstances and traditional culture, they are not entirely alone in their predicament. Not only have other non-white women expressed comparable reservations about the 'mechanized' male-dominated midwifery of white western society, but since World War 2 in particular a strong critique of obstetric practice has developed within white society. It has, as in the Aboriginal case reported here, been led by women themselves and has resulted in the modification of many practices. Nonetheless, western fascination with technology and dominant professional interests continue to make childbirth an excessively technical occasion rather than a natural, harmonious and profoundly social event.

The strengths of this report in my opinion then, are the clarity with which it addresses the problems and the understanding of the issues it reveals. The problems experienced by Aboriginal women with current medical provision are explained not in terms of particular people or resources, but as a direct result of quite different approaches to childbirth. These arise out of radically different attitudes to the natural processes of the body and to the social relationships surrounding them. For Aboriginal people, childbirth cannot be seen merely as a matter of technical problems to which there can be technical solutions. The report argues for 'two-way' understanding, and any genuine attempt to meet Aboriginal women's needs must be based on honest and sympathetic exploration of the potential for combining traditional and modern practices. The report stops short of fully exploring these issues, but I do not think this is a serious weakness, further clarification of 'two-way' 'borning' should arise out of 'two-way' practice. Until that is implemented in the congress Alukura, its advantages and dilemmas

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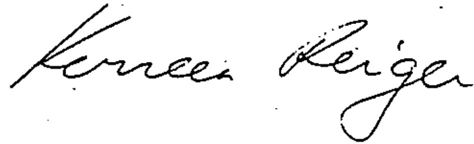
cannot be adequately specified in advance. Moreoever, 'two-way' practice should not be confined only to the Alukura; it is important that efforts be made to modify mainstream obstetric practice in order to meet Aboriginal needs even within the hospital setting.

In conclusion, I commend this report as charting a new course in attempting to meet Aboriginal health needs more effectively than in the past.



Dr. Kerreen Reiger,
Sociology Department,
PHILLIP INSTITUTE OF TECHNOLOGY.

BORNING

Ampe Mbwareke Pmere Alaltye

The Congress *Alukura* by
the Grandmother's Law

Report prepared by the Central Australian Aboriginal Congress

August, 1985

Betty Carter
Chief Investigator

Dr Mary Wighton
Senior Research Officer

Maureen McCormack
Research Co-worker

Susan Satour
Recent Research Co-worker

Pip Duncan
Conference and Interim Co-ordinator

Pamela Nathan
Author and Relieving Senior Research Officer

Prepared for the Central Australian Aboriginal Congress

Funded by the Policy and Planning Division,
Commonwealth Department of Health

CONTENTS

Author's note		i
Acknowledgements		iii
Preface		v
INTRODUCTION		1
1	The Borning Problem	6
2	Two-way Borning	21
3	Passive Resistance: 'The Whitefellah Way is Shame, Proper Shame'	42
4	Active Resolution: Congress Alukura	67
5	'Let There Be No More Shame'	91
Appendix 1		102
Appendix 2		105
Appendix 3		112
Appendix 4 - Budgetary Statement		114
Glossary		121
References		122
Bibliography		128

AUTHOR'S NOTE

Many people contributed to the writing of this report. Betty Carter, a senior Aboriginal employee and advisor to many other Aboriginal organisations was the chief investigator. In this role, Betty was assisted by Eileen Hussen, a cabinet member of Congress and Lana Abbott, who is the senior Aboriginal health worker of the clinic at Congress. These three women, in convening the final women's Conference, also acted as senior research officers, conducting research the Aboriginal way.

Dr Mary Wighton, a medical practitioner who has worked in the Pitjantjatjara homelands and Congress for nearly six years, was the senior research officer. Mary submitted the research proposal on behalf of Central Australian Aboriginal Congress and developed the design and methodology of this research. She co-ordinated over fifty field trips, holding all the meetings and in this way, initiated and completed the groundwork. She also prepared a confidential submission for the founding of a Congress Alukura for the Aboriginal women.

Maureen McCormack, a senior tribal Aranda woman, was employed as the research co-worker. Maureen travelled with Mary on most of the bush trips, filling an essential role for the research project and the Aboriginal women.

Many Aboriginal women helped Maureen and many accompanied them on bush trips in the capacity of directors and interpreters. These women include Daisy Morgan, Margaret Mary Turner, Rosemary Miller, Monica Poulson, Nancy Lynch, Julie Cline, Daureen Lord and Jennifer Summerfield. Susan Satour, in the latter stages of the project, joined Maureen as co-worker. Susan is younger and has some useful whitefellah research skills.

Pip Duncan, a midwife who worked with the Urapuntja service for three years and the Alice Springs Hospital for one year, was employed as an interim co-ordinator for the last three months of this project. Among other things, Pip co-ordinated the final conference. She also completed some interviews with the Northern Territory Department of Health medical staff and helped Mary prepare the model of the Alukura and the budget.

In May, at the end of all the field trips and before the conference, Mary developed ill health. Mary has been on leave since this time.

Pip and I were replacement staff. I completed a field trip to four communities with Maureen, Monica and Sue. I started with interviews with the Northern Territory Department of Health medical staff and made a search for local statistical information. At the end of the conference, Congress asked if I would write the report. It was considered politically urgent to complete this report quickly. In addition, the research project had its own deadline. Because of her ill health, Mary did not think she could write the report in the time required.

Writing this report was difficult. I was writing in Melbourne and had only been comparatively briefly engaged

with this research project, which was also a new subject for me. Admittedly, my earlier work in Alice Springs stood me in good stead. But what was more important, throughout the conference the women made the borning problem and its resolution clear in an unqualified and unquestioned way. This clarity, however, made my position ambiguous. What was the sense in making the interpretation when the women could speak for themselves? Could I do justice to their powerful and moving words? On the other hand, I was required to communicate their knowledge and preferences to official bodies which is the purpose of this report.

The lack of continuity and brevity of time spent meant that the usual protracted research processes of digestion and reflection were compressed into a very short space of time. Thus, writing this report was an unfamiliar and yet familiar daunting task.

Despite these difficulties I am very grateful and very privileged to have been given this opportunity to be involved in working with the Aboriginal women living in Central Australia and to work for Congress again. I can only hope that the Grandmother's Law will be realised in the Congress Alukura so that Aboriginal women will no longer 'feel shame' and so that 'babies will no longer die in the mother's tummy'. May their sacred story so rarely told be heard.

Pamela Nathan
August 1985

ACKNOWLEDGEMENTS

There are many people who must be thanked for their assistance in completing the writing of this report.

I would like to thank Mr Bill Meggitt, from the Policy and Planning Division of the Commonwealth Department of Health, for his considerate advice and interest.

A number of people must be thanked for their prompt and careful reading of the manuscript in its final stages. Dr Doug White must be thanked for reading and correcting the manuscript in the capacity of an academic theoretician and in his experience working with Aboriginal people in Central Australia. Doug is specially thanked for his consistent advice and support throughout the project.

Dr Kereen Reiger is thanked for reading the manuscript in the capacity of an academic sociologist with theoretical experience in this area and for her clarifying contributions.

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Margaret Mary Turner, Wendy Leichleitner, Jenny Green and Dr Di Bell are thanked for their linguistic and anthropological clarifications and Christine Nathan is thanked for her useful questions.

Fran Coughlan and Philip Toyne are thanked for their friendship and generous hospitality during my stays in Alice Springs.

Anne Shuttleworth is warmly thanked for her prompt and careful typing of the draft manuscript, and Sandra Zurbo is thanked for her speedy word processing of the final manuscript. Jane Arms is particularly thanked for her advice and careful copy editing.

Finally, I would like to thank the staff at Congress. Dr Mary Wighton is particularly thanked for her introduction to the project. It should be pointed out again that this report would not have been possible if she had not undertaken and completed the research groundwork.

Pip Duncan must be thanked for co-ordinating the delivery of the research material so promptly and her weekly, cheery, up-date phone calls were greatly appreciated.

Maureen McCormack, Sue Satour and Monica Poulson are greatly thanked for their teaching, enthusiasm and humour on our bush trip, and Monica's family must be thanked for their generous hospitality at Yuendumu. I hope they get that bush turkey one day!

Stephanie Bell, who bore the brunt of the panic, is thanked for her patience, kindness, typing and accounting skills.

Most importantly, I wish to thank the director of the Central Australian Aboriginal Congress, John Liddle, Betty Carter, the chief investigator, Eileen Hussen, a cabinet member, Lana Abbot and Margaret Liddle, the senior welfare

officer. They provided the direction for writing this report with hours of discussion, crucial advice and enormous support. I have learnt much from them and particularly during the final conference.

I am very grateful to Congress for allowing me to work in such a challenging, demanding and rewarding environment once again. I sincerely hope that their commitment to resolving the borning problem will be recompensed.

Pamela Nathan
August 1985

PREFACE

We have lived by our strong Grandmother's Law for a long time now. Our Law has been violated since the white man came. Our babies die. Our women are shamed.

We have no choice but to tell our story. We regret making known to all our sacred women's business. We talk in whispers about this Law. Now it is in bold print.

When you have read this story, you will know our shame and our sadness. And you will know why we want our Congress Alukura for our children's children.

We appeal to the funding bodies and the Australian public to read our story and help us implement the recommendations which have been strongly voiced by many hundreds of Aboriginal women in Central Australia. We want healthy babies and we want our Law.

We thank Dr Neal Blewett for his consistent support throughout this research program. We also thank Janet Layton and Andrea Larkins, from the Commonwealth Department of Health, and Pat Turner from the Department of Aboriginal Affairs (Alice Springs) for their advice and support. We remind you that the United Nations has declared 1975-1985 the International Decade for Women.

The women are waiting for this Congress Alukura.

Signed by

Lana Abbott
Betty Carter
Eileen Hussen
Margaret Liddle

Maureen McCormack

MINISTERIAL STATEMENTS

Your submission (draft) raises the specific problems associated with the inclusion of Aboriginal women in western obstetrics procedures, and establishes the necessity for the creation of a women's place. The importance of culturally specific obstetric practice has, I understand, been well established internationally, as has the need for the creation of a women's space within cultures, including that of white Australia.

After reading your submission (draft), I find myself in general sympathy with your proposal as a policy initiative, and with your agreement I will seek to have the document fully assessed by my Department.

Letter, Hon. Dr Neal Blewett, MHR, Minister for Health, to Mr J. Liddle, Director of CAAC, June 1985.

I am extremely concerned about the maternal and neonatal mortality and morbidity rates among Aboriginal women and infants. I hope that the research you propose will uncover the underlying reasons for any non-compliance or rejection by Aboriginal women in their own health care. The research is in an area of high priority for the Government and is in accord with our policy of delegating control of Aboriginal services to the Aboriginal communities.

Letter, Hon. Clyde Holding, MHR, Minister for Aboriginal Affairs, to Mr J. Liddle, Director of CAAC, April 1984.

INTRODUCTION

> Congress asked the government for money so they could do this review. They wrote a submission saying 'We wanted to ask all the Aboriginal women about what they wanted to do, about how they wanted to have their babies and how they wanted to be treated.'
>
> Anyway it took three months to get their money, and finally Dr Blewett said we could have the money.
>
> So this is how we've started, by having meetings with all the people to ask them how we should go about starting this program. Now it's up to you to tell us how you want it done...
>
> White people have never asked us where we want to have our babies. They've always said, 'You've got to go to the hospital.' The old time way people have babies at the places where they are born in their country with the old people.
>
> This is the first time that Aboriginal women in Central Australia all come together from different countries and sit down and talk like this. We've got Pitjantjatjara women, Warlpiri, Waramunga, Aranda, all mixed up, all sitting down and talking together, and that's a really good thing. How many times this happen? Must be the first time here in Alice Springs?
>
> This thing Congress is trying to do is a really important thing. That's why we gotta talk together as one, all black women, as all Aboriginal women. We got to talk together. Doesn't matter that we're from this country or that country.
>
> This thing Congress wants to do is for all Aboriginal women, and we've got to stand strong and talk together about it, but we've got to give Congress ideas so Congress can do how Aboriginal people wants it.

This project documents the beliefs, practices and preferences of the Aboriginal women in Central Australia about what is referred to in Aboriginal English as 'childbirth business' or 'borning' or in Aranda as ampe kweke mbwareke pmere alaltye (being found in country). Borning is primarily 'women's business', and the Aboriginal way is asserted in the single women's camp or the Alukura.* Widowed, single and old women camp in the Alukura, and they are the custodians for Aboriginal women's Law.

* The Loritja term is used here because Alukura is perhaps better known and is more easily read. In Anmatjirra, the language used throughout this text, the term is rlwekwere.

The past, the present and the ancestors of the Dreamtime (Altjerre) are interwoven in the women's Alukura. Borning and 'growing up' children are anchored in the Law and the Dreamtime, which link the land and the people. Women have the major responsibility for maintaining harmony and nurturance among relations and for country.

This project was initiated by the Central Australian Aboriginal Congress (CAAC), a large health organisation, which was established in 1974 and is based in Alice Springs. In 1983, the women in Central Australia had begun to describe their reasons for delaying antenatal check-ups, their 'lonely', 'frightened' and shaming' experiences during confinement in the Alice Springs Hospital, and the disruption that hospital confinement brought to traditional midwifery and related ceremonial practices. The women at Congress strongly advocated the establishment of a 'birthing centre' that would assure comfort and ease through a continuation of their traditional practices.

In 1984, CAAC approached the Policy and Planning Division of the Commonwealth Department of Health, and funds were provided in May 1984 to start a project on matters of borning. The first public meeting of tribal and non-tribal Aboriginal women was held in June 1984, providing the first opportunity for the women of Central Australia to talk deeply and honestly about borning matters, including the old-time way, the whitefellah way, Aboriginal resistance and their preferences in health practices.

The primary aim was to achieve a redefinition of Aboriginal borning and to clarify the processes required to improve Aboriginal childbirth in the Centre. This involved helping Aboriginal women to understand the problems of borning, to look critically at the present form of health care and to define a culturally relevant and non-invasive form of care of their choice.

The attempt to understand how Aboriginal women think about childbirth business and perceive their health needs and priorities was central. Consequently, the nature and extent of traditional borning beliefs and practices were explored at the point where they meet western obstetric beliefs, practices and available services. These services were analysed in this context.

The interaction of the two now is associated with shame and degradation. The question the women ask, and this report attempts to echo, is, How can a point of contact be developed in which the Aboriginal way and the mothers and children, become, and remain, happy and healthy?

This report is intended to be of value to those planning, providing and receiving services at Congress and in other Aboriginal communities involved in this project. It is also intended for use by those at the federal and state levels involved in the funding and provision of borning services for Aboriginal people.

A large part of this project was carried out in the ancestral lands belonging to the women in Central Australia. Women at nine different types of communities of Central Australia were involved. Borning was usually discussed in informal meetings called by the older women, under trees or

by camp fires. A number of Aboriginal women, young and old, representing different language groups, led the discussions. In the bush communities, periods of a day to a week were spent talking to the Aboriginal women in their camps. Progress was regularly reviewed by senior women, and the staff and cabinet of Congress. These research meetings culminated in a final conference where many Aboriginal women clarified the problem and their preferences and made recommendations.

The infant mortality and morbidity rates of Aboriginal people in Central Australia are much higher than for non-Aboriginal people. The realities of a high infant mortality rate are grim and compelling. From a medical perspective, the problem has been narrowly defined in terms of Aboriginal women not presenting on a regular basis for antenatal check-ups, their practice of bush births and their high absconsion rate from the hospital immediately after delivery. The solution advocated by the mainstream medical practitioners has rested with attempting to make antenatal check-ups available to everyone, increasing the transport of women from remote communities for hospital delivery. These interventionist strategies provide, at best, only crisis and interim relief. There has been a decrease in the rate of infant mortality that has been linked with the increasing rate of hospital births. Aboriginal women in Central Australia, however, continue to reject the mainstream antenatal and obstetric services. A redefinition of the borning problem requires a new perspective that takes into account these considerations.

Aboriginal people have traditional borning beliefs anchored in the Dreamtime and the Law that are radically different from western beliefs and practices, and to talk about borning requires a careful and respectful understanding of traditional Aboriginal beliefs and practices.

Borning, the Aboriginal way, is not equivalent to western birthing. The term 'borning', used loosely, does not refer to the act of birth or labour and in Arrente, the verb inteke (to lie, birth, labour) is used. Today, the answer to the question, 'Where were you born?', using the verb inteke, will usually be 'on the ground' or 'in the Alice Springs Hospital'. Borning in the strict sense, however, is primarily used to refer to the fact that the baby was 'found' or conceived in his or her own country: ampe mbwareke pmere alaltye. Thus, borning is used to refer to a much wider and more symbolic process. Where one is 'found' refers to the rebirth of a 'spirit child' from the Dreamtime ancestors who belong to a particular area of country which may be the grandmother's or grandfather's country. The child has strong traditional affiliations to the country where he or she was found and will later assume rights and responsibilities for it. Borning, then, is inseparable from the Dreamtime, the Law, the land and its people.

The act of borning is a process which is integral to kin, country and the Dreamtime. Women with particular familial and traditional affiliations, usually the

grandmothers and aunties, are in attendance during birthing in a <u>alukura pmere alaltye</u> (in a single women's camp in country). In the aftermath of borning, special ceremonies (<u>welye</u>) are performed by the appropriate women, which include the 'naming' of the child by the grandmother as <u>kirda</u> (owner) or <u>kurdungurlu</u> (manager) for his or her country. Part of this process is also later carried out if Aboriginal babies are born in hospital.

The coming of the white man has led to the widespread dispossession of country, the depletion of 'bush tucker' and the introduction of disease and 'rubbish' food. In the old times, Aboriginal women had lower infant mortality patterns. With the 'coming of white man', the fertility and childbirth rate declined and the infant mortality rate rose dramatically. Many people have been forced off their country to live in missions and settlements and 'all mixed up', although many people are now returning to and reclaiming their traditional lands. Access to natural resources, however, has been severely disrupted by the cattle polluting waterholes and altering the balance of flora and fauna, and the movement of the people has been impeded through their country.

Today, many of these natural and material resources have not been replaced on many Aboriginal communities. The abscence of adequate water supplies, housing, hygienic facilities, nutritional food, transport and communications has led to high morbidity and mortality rates. The social problems, such as alcoholism and petrol sniffing, products of the assimilationist policies, have served to compound the health problems. Under these circumstances, and needless to say, Aboriginal women having babies in the bush are at some risk, and so are their babies.

The benefits of universal public health measures that have reduced morbidity and mortality rates, including infant mortality, in the west, have been denied to Aboriginal people. In the past fifty years, western society has witnessed the enormous growth of technological intervention in childbirth during which 'obstetrics', 'antenatal care' and 'hospital delivery' have become key words. In the 1980s, childbirth is medically managed, technologically administered and male dominated: reproduction is the medical specialty of obstetrics. In the past ten years, in western countries, in reaction to the medical intervention, there has been a trend away from the hospital deliveries and a return to more 'natural' deliveries and home births. The two are intimately related.

Western medicine, including obstetrics, belongs to a belief system developed by Europeans. Aborigines have been forced to cope with and attempt to understand western practice and, as a result, most Aboriginal women have been compelled to use the Alice Springs Hospital for the delivery of their babies and, in the process, to accept a foreign and unknown form of obstetric care.

Aboriginal people are reoccupying their lands, they, too, are reasserting more culturally 'natural' birth practices. Today, Aboriginal women have a belief about where and how their babies will be born, but the decision to follow

it is fraught with the changes that modern circumstances have imposed on them. Bush births, the Aboriginal way, may be preferred but may place the women and babies at a great risk. For Aboriginal people, there is an absence of public health facilities, and most are living in Third World conditions. There is also an absence of knowledge, staffing and resources under Aboriginal jurisdiction to help at bush births. The only alternative is that Aboriginal women have a western hospital delivery, which may produce a healthy baby, at least in the interim, at the cost of undermining their traditional practices and producing widespread shame and fear. Neither of the options affords Aboriginal women choice or control.

Aboriginal women living in Central Australia are faced with limited service options. For antenatal care and delivery, Aboriginal women are encouraged to use the Alice Springs Hospital, which is directed by the Northern Territory Department of Health (NTDH). The department also has satellite clinics on remote communities that are served by the Royal Flying Doctor Service. The beliefs and practices about childbirth in the hospital and the clinics are European: medical safety is equated with western obstetrics. Aboriginal women, who may be at high risk, have their babies on the ground, in the Alukura, by their Grandmother's Law, and medical safety cannot be guaranteed.

A redefinition of borning demands that consideration to be given to the traditional Aboriginal way, and the interaction between traditional borning beliefs and practices, the technological advances of obstetric care and the material conditions of Aboriginal people. Aboriginal borning is not equivalent to birthing or obstetrics and the solution does not solely rest with increased use of hospitals and improved antenatal care. Aboriginal consultation and control is fundamental to a successful outcome.

The first section of this report provides an account of the 'problem' and the issues that determined the appropriate methodology. The second explores the interaction between indigenous borning beliefs and practices and western obstetrics. The third focuses on the satisfaction of Aboriginal women and the medical caretakers with available health service delivery. In the fourth section, the Aboriginal women talk about their preferences for future initiatives. Finally, the main points of the project are drawn together and recommendations for future government initiatives presented.

1 THE BORNING PROBLEM

> ... today lots of babies are dying inside the mother's tummy, and hospital doctors don't explain to young women and tell them why babies die inside the tummy. The doctors don't tell them when they go for check-up.

The Problem

Aboriginal women living in Central Australia are sorry and worried by the high number of sick babies and the number of babies who die. They want to help to try and stop this problem which is bewildering and devastating in its impact. Aboriginal women have never been systematically consulted about where and how they want to have their babies born or why they think there is a problem about childbirth business today.

Until recently, Aboriginal women in Central Australia have not talked about borning problems. They have been left to feel shamed, engaged in persistent sorry business for the death of their children who have become statistics and a source of international disgrace. In their shame, sorrow and confusion, Aboriginal women have been left to the mercy of white doctors and sisters with their aeroplanes, ambulances, clinics, hospitals, machines and operations. The Aboriginal women have been made to feel that this is their disgrace.

Aboriginal women know that they care about their babies but feel that they must be doing something wrong because, as they put it, 'Today lots of babies are dying inside the mother's tummy' and 'In the old time, babies were fat and happy.' They wonder if it is their dishevelled appearance and bare feet or the food they eat, or the way they live. They wonder if they should be seeing that white doctor who pokes and prods, or taking tablets or being screened, all of which they fear.

Until recently, Aboriginal women have been left alone in silence with their shame and sorrow, and their guilt has been mistakenly coined as their well-known 'shyness' or a 'lack of caring'. It has been well documented, however, that motherhood for Aboriginal women means valued nurturance, where babies are constantly adored, cuddled and indulged. Why is it, then, that Aboriginal women should be made to feel guilty, sorry, useless and negligent?

Until now, well-intentioned, non-Aboriginal medical and government caretakers have defined borning in narrow medical terms. Aboriginal women, it is said, are at high risk because they are susceptible to an exhaustive list of diseases such as hypertension, diabetes mellitus, obesity, anaemia and venereal disease, which can lead to complications in pregnancy and labour and require close medical attention. Medical monitoring, in the form of antenatal check-ups and hospital deliveries, ensured by the oversight of sisters who have ambulances and the Royal Flying Doctor Service on call, is pursued with missionary zeal.

These interventionist and clinical strategies are used by non-Aboriginal medical workers to intercept the failure of Aboriginal women to adhere to the western notions of conception and time, to recognise their pregnancies openly, to comply with antenatal care, to use hospitals willingly and to stay in them. Western obstetric beliefs and practices have predominated in Central Australia not only for the reason that Aboriginal women are regarded as a high-risk population. They also dominate because non-Aboriginal caretakers believe that western obstetrics is safe and saves lives. In their view, western obstetrics are is and right. This certitude is confirmed by the repeated success of the Royal Flying Doctor Service and by the falling mortality rates, which leave the doctors proud of the results shown on 'their colour charts'.(1)

No attention is given by these medical caretakers to why Aboriginal women are a high-risk population and why they do not fully participate in this form of medical care. To ask these questions may lead to 'changes in the system which might lead to problems'.(2)

A senior obstetrician from the Alice Springs Hospital, for example, was reported in the Age as saying: 'At this stage, if you try to give them [Aboriginal women] a choice, it will simply cause troubles in the long run. It is too early to give them a choice.'(3)

Although medical caretakers in Central Australia are confronted by the borning problem and their problems of service delivery every day, any nagging 'apprehension' is justified by the belief that 'hospitals offering the highest obstetric standards are the best and safest places for babies to be born.'(4)

The solution is simple: 'If Aborigines want an infant mortality rate the same as white people, they need the same sort of medical standards.'(5)

Aboriginal women, however, are still bewildered. In short, they do not understand why so many of their babies die. But, Aboriginal women living in Central Australia do know many things. They know about their timeless Grandmother's Law, which goes back over thousands of years and is still strong today. They do know they want a Congress Alukura, an Aboriginal women's place where they can have their babies by their Grandmother's Law. They will know and understand when white ways have to be used and they will no longer have to 'feel shame, proper shamed by these white ways'. The women 'talk strong' for a Congress Alukura and this is where they want to have their babies born. And Aboriginal women know strongly, in a general way, why their babies die, which started to happen 'when the white man came'.

Aboriginal women's definitions of borning and their preferences for borning services, once stated, may herald changes to the system of western obstetrics. The changes, by definition, will involve a recognition of a two-way borning process (the Aboriginal and the non-Aboriginal), a two-way service delivery, and the passing of control to Aboriginal women who are the custodians of their Law and practice. These practices cannot be controlled by non-Aboriginal medical

workers because they are not the caretakers of this knowledge. This is amply demonstrated by the confusion about the Grandmother's Law of an NTDH medical practitioner, who was reported in the Centralian Advocate as saying: 'If we carted all the bush seeds into the obstetric rooms it would be a disaster.'(6)

Little consideration has been given by the official caretakers to the cultural dimensions of borning. Can there be any doubt that if services are developed in a more culturally appropriate way, including the most elementary aspect of any culture, which is language, that Aboriginal women will be able to participate and learn the two-way care necessary for the survival of their babies? Put more simply, this is their right.

Little attention has also been given to the basic public health measures and environmental conditions that assure the health of a population. These include nutritious food, water supplies, shelter, sewerage, washing facilities, heating and transport. Once Aboriginal women leave the hospital in Alice Springs, many return to camps that do not have running water and stores that stock, as their main items, flour, sugar and cool drinks. Is it any wonder that the infant mortality rates are so high?

Traditional Society

In the past, according to some authorities, it appears that Aboriginal women had comparatively high fertility rates, well-spaced families and a stable population.

Before European occupation, Aboriginal groups lived and moved through their country in small family groups. Their movements followed the seasons, which determined the availability of food and water supplies. People from local kinship groups usually formed smaller, foraging groups. A division of labour was observed according to which the men hunted large game, such as emu and kangaroo, and the women and children gathered fruits, seeds and roots and caught goanna and smaller game. The men hunted and the women foraged daily to secure a consistent and regular supply of nutritious food.

The hunter/gatherer way of life, social organisation and the physical environment shaped the family size, birth rate and mortality rate among Aboriginal people. In Central Australia, Aboriginal people maintained a stable and stationary population size, in aggregate, through a balance between a high death rate and a high birth rate.(7) The view that the birth rate was high has been challenged on the basis that the family size of children under fourteen was low.(8) But small family size was by no means incompatible with high fertility in Aboriginal society. Children were well spaced and few, if any, intentional contraceptive or abortive methods were used. Infanticide was practised occasionally.

High-fertility patterns were maintained by a nourishing and abundant diet. Children were breast-fed and weaned late. The contraceptive significance of late weaning accounts for long birth intervals,(9) and the restrictions placed on women in a hunter/gatherer society accounts for the well-spaced children and the occasional practice of infanticide.

No factors which would have produced a high infant mortality rate have been found to exist, and few ethnographers refer to infant mortality in their observations.(10) In traditional society, there was a nutritious diet and an absence of infectious diseases.

European Settlement

The impact of European settlement on the fertility rate, population growth and infant mortality rates was catastrophic. As the demographer Alan Gray says, violent dispossession, subjugation, murder and rape were only the more visible signs of the catastrophe.(11) Almost all the early counts of Aborigines in settled districts revealed a large disproportion between the numbers of adult men and women.(12) The settlers also brought sterility to many women through the effects of the previously unknown disease gonorrhoea.(13) The introduction of many other infectious diseases, such as smallpox, measles, whooping cough, venereal disease and in the north, leprosy and malaria, had a devastating effect on the Aboriginal population. The legacies of post-European settlement, namely dispossession and assimilation, are still being witnessed today by the high incidence of diseases such as hypertension, diabetes mellitus, anaemia and alcoholism.

In Central Australia, the arrival of the pastoralists compelled Aborigines to live a sedentary life because their ancestral lands and waterholes had been stolen. The arrival of the pastoralists heralded the unequal competition for scarce resources (good land and water), the upset of the delicate ecological balance and the depletion of rich nutritional stores. The introduction of cattle to the area altered the ecological balance by making excessive demands on the plant and water resources. It also affected the composition of native fauna. Many native animals either disappeared or were substantially reduced in number with the introduction of cattle.

With the expropriation of their hunting grounds, Aborigines became increasingly dependent on their expropriators. Many Aborigines congregated in camps at the stations where a sporadic source of food could be secured. This food consisted of white flour, white sugar, tea and, on occasions, bullock meat.

At this time censuses show that there were few Aboriginal women in proportion to adult men in settled areas and that women had fewer children.(14) In the Northern Territory, in 1911, there were only 157 children recorded between the ages of 0 and 4.(15) Though no doubt an incomplete record, this ratio of the numbers of children to the numbers of women of reproductive age was less than half the ratio recorded fifty-five years later and indicate fertility rates lower than those necessary to sustain positive population growth.(16)

With the advent of the assimilation policies, which started unofficially at the turn of the century, Aboriginal people living in Central Australia were herded onto missions and settlements. They became refugees, 'all mixed up'. All

aspects of Aboriginal life, including health, marriage, adoption of half-caste children, supervised feeding in dining halls and movement (which was circumscribed by curfews and permits), were subject to the control of non-Aborigines. These ghettos became breeding grounds for the high incidence of disease caused by social dislocation, poverty and powerlessness, which have continued today.

As late as 1964, of seventy-two people who were brought into Papunya in the space of one year, twenty-nine had died: six people died from malnutrition, four aged between twenty-four and sixty four and two babies; four died from unknown causes; six died from pneumonia; and eleven from chest and gastro infections, heart failure, tumours and injuries.(17) The general living standard of people on missions and settlements can be equated to Third World conditions.

In recent times, many people in Central Australia have returned to their traditional lands in the country camp movement. Many people are living without the basic facilities of running water, housing, electricity, sewerage facilities, radios, stores and transport. The provision of transport is necessary given that hunting and foraging around one vicinity may exhaust food supplies. The government policy, at present, requires communities to show permanency for three years before a bore will be provided. There is no medical evidence yet available to show that people are healthier on their own lands, but the people and local observers believe this to be the case.

Today, there is a lower fertility rate than in the past among Aboriginal women and high infant mortality rates. These rates cannot be viewed independently from the socio-economic, political and environmental conditions of Aboriginal people.

Morbidity, Mortality and Infant Mortality

The following Northern Territory definitions were used in dealing with these statistics:

Stillbirths are foetuses of at least twenty weeks gestation or of a birth weight of at least 400 grams which died before birth. The rate is expressed per 1,000 total (live and stillbirths).

Neonatal deaths are live-born infants who die within twenty-eight days of birth.

Perinatal mortality is the number of stillbirths plus the number of neonatal deaths per 1,000 live and stillbirths.

The infant mortality rate is the number of deaths of babies under one, per 1,000 total (live).

The crude fertility rate is the number of live births per 1,000 population of women between fifteen and forty-four years of age.

The following statistics are likely to be underestimated for they may not include all bush deliveries. In addition, it is difficult to obtain a fully comprehensive picture for there is a paucity of detailed statistical analyses.

The number of live births in the Northern Territory hospitals in 1983-84 was 825 for Aboriginal people and 2,023 for non-Aboriginal people.(18) In 1983-84, the infant mortality rate for Aboriginal people in the Northern

Territory was 38 compared to 5 for the non-Aboriginal population.(19) The rate of stillbirths for the Aboriginal population was 22 in 1983-84 compared to 10 for the non-Aboriginal population.(20) The rate of neonatal deaths in 1983-84 was 11 for Aboriginal people and 4 for non-Aboriginal people.(21) The total perinatal death rate for Aboriginal people in the Northern Territory in 1983-84 was 33 compared to 14 for non-Aboriginal people. That is, the infant mortality rate for Aboriginal people in the Northern Territory in 1983-84 was seven times greater for the Aboriginal population than the non-Aboriginal population and the rate of stillbirths and neonatal deaths twice as great. These high rates are in a context of a fertility rate for Aboriginal women of 142, which is twice as high as the fertility rate for non-Aboriginal women in the Northern Territory.(22) These 1983-84 rates are representative of recent years.

More information can be gleaned for the Aboriginal women who delivered their babies in the Alice Springs Hospital in 1980. A forthcoming report, compiled by a senior obstetrician at the Alice Springs Hospital, which included 1983-84 statistics, was deliberately withheld from this research. The 1980 report is not sufficiently comprehensive, its vagueness stemming from the paucity of causal correlations and standardised ratios on the determinants of morbidity and mortality.

The number of diseases shown in the 1980 report that cause complications during pregnancy and labour was high for Aboriginal women. Of the total number of deliveries in the Alice Springs Hospital, 616, 45 per cent were Aboriginal.(23) The overall incidence of diabetes mellitus was 1 per cent, and the rate for Aborigines was more than twice the non-Aboriginal rate.(24) Diabetes is one of the important medical diseases complicating pregnancy. The incidence of hypertensive complication was much higher for Aboriginal women, at 60 per cent, than for non-Aboriginal women, at 41 per cent.(25) Pre-eclampsia constituted 64 per cent of all hypertensive pregnancies, and the incidence for Aboriginal women was twice as great.(26) The perinatal rate of 7 per cent, considered high, illustrates the overall hazards to the foetus in such pregnancies.(27) Only Aboriginal women had cardiac disease constituting 0.8 per cent of all pregnancies.(28)

Of the 10 per cent of adolescent pregnancies, 76 per cent were young Aboriginal women.(29) Nearly one-quarter of these young Aboriginal women did not attend an antenatal clinic until mid-term, and a similar proportion had hypertension.(30) Sixty-one per cent of all adolescent pregnancies required delivery by surgery. Of 25 per cent of women who did not present for antenatal care, 96 per cent were Aboriginal.(31) Of these Aboriginal women, 85 per cent were admitted with various complications.(32) Of the women who failed to present for antenatal care, there was a total of 43 per cent of stillbirths and 37 per cent of neonatal deaths.(33)

The rate of caesarian section for Aboriginal women in 1980 in the Alice Springs Hospital was 23 per cent compared

to 10 per cent for non-Aboriginal women.(34) Twenty caesarians, 29 per cent, were performed on women with hypertension. The report shows that this figure is quite high when compared with the total number of caesarian sections performed in patients with all other indications combined, 17 per cent. This high incidence was partly caused by an increased trend towards delivering babies by caesarian section and partly by an increasing proportion of cases incidental to this problem.(35) Clearly some analysis is needed of the reasons for this high number of caesarian deliveries: is it the result of prejudice, fashion or specific complications?

The number of live babies of low birth weight born to Aboriginal women was high, 70 per cent, compared to 30 per cent born to non-Aboriginal women in the Alice Springs Hospital in 1980.(36) The rate of stillbirths for the Aboriginal population was equally high; three-quarters of these women had received no antenatal care or a minimal amount, and four Aboriginal stillbirths were caused by placental insufficiency.(37)

It would have been useful to have had more comprehensive correlations in order to determine the causes of morbidity and mortality.

These figures show that the types of complications that can lead to excessively high perinatal and infant mortality rates are the results of poor nutrition, poor living conditions, susceptibility to disease and illness and the inaccessibility of culturally appropriate services. Again, these figures are underestimated because despite the Northern Territory Department of Health stating that 82 per cent of deliveries of Aboriginal women in the Central region are in the Alice Springs Hospital, this is only an approximation.(38) Correlations between anaemia and growth retardation, the causes of neonatal deaths and the nature of residence by all these rates, among others, would no doubt provide an even more devastating picture. Such comparative population analyses are a testimony to the ill health of Aboriginal people and their Third World living conditions and a major indictment of the lack of provision of culturally appropriate health services. As the report by the National Health and Medical Research Council, 'Care of Pregnant Women in Remote Areas', states: 'There is a well-documented relationship between the socio-economic environment and higher perinatal mortality rates and increased incidence of low birth weight infants and pre-term births.'(39)

The report continued, saying: 'On this basis the working party formed the opinion that the needs of Aboriginal people and the recognition of their problems required to be given special consideration in any discussion relating to the provision of service to remote areas.'(40)

The realities of Aboriginal maternal and child health today are far from impressive and show the previous conceptions of borning and the solutions to be grossly inadequate.

Redefining the Borning Problem

> It has always been a sacred story. A story that has never been talked about often.

The beginnings

The Central Australian Aboriginal Congress was established in 1974. It is an organisation of Aboriginal people, for Aboriginal people and controlled by Aboriginal people. In 1980, Congress started research into health. A central part of this project was an attempt to understand how Aboriginal people think about health and illness, how they manage sickness and how they perceive their health needs and priorities. The nature and extent of traditional medical beliefs and practices were explored at the point where they meet western medical beliefs and practices and health care service. In the process of this research, the female health workers employed at Congress were keen to talk about women's business, and they suggested meetings with all the town camp people. Briefly, women described their reasons for delaying antenatal care, their 'lonely', 'frightened' and 'shaming' experiences during confinement which caused disruption to traditional midwifery and related ceremonial practices.(41) This part of the project began to be very time consuming, and it became apparent that the concern generated could not be met within the confines of this first research project.

Nonetheless, the meeting of Aboriginal women had started. In 1983, Dr G. Wheeler, a doctor employed at Congress on behalf of this organisation, wrote a detailed submission to the Northern Territory Department of Health asking for a 'birthing centre' for Aboriginal women. In his submission, Dr Wheeler referred to the medical and cultural needs of Aboriginal women and the inaccessibility of the present obstetric care. The submission contained a detailed outline of a two-way 'birthing centre', to be controlled by the Central Australian Aboriginal Congress.(42)

In the same year, the medical superintendent of the Alice Springs Hospital, Dr P. Bradford, wrote to Dr Wheeler in response to the submission. The letter claimed that the system delivered by the Northern Territory Department of Health had helped in decreasing Aboriginal maternal and perinatal mortality and morbidity over many years and that it was difficult to know at what stage a safe transition to an Aboriginal birthing centre could be made.(43)

Dr Bradford also said that some moves underway, such as the setting up of the maternal welfare committee, could allow the future establishment of a birthing centre.(44)

This research project started in May 1984 when it became clear that the Central Australian Aboriginal Congress was not going to receive a co-operative or meaningful response from the Northern Territory Department of Health, despite the preferences of Aboriginal women and the alarming dimensions of the borning problem. The Policy and Planning Division of the Commonwealth Department of Health generously financed this research project, providing funds for a four-wheel drive Toyota, a senior research officer and research co-workers.

For this exercise, the Central Australian Aboriginal Congress asked Aboriginal women living in Central Australia, for the first time, where and how they wanted to have their babies born. Betty Carter, a senior Aboriginal employee at Congress was the chief investigator. Dr Mary Wighton, a doctor employed by Congress, was the senior research officer and Maureen McCormack, a senior tribal woman, was the chief co-worker. Many other women worked as co-workers during the project.

Early Meetings

The formulation of this research design followed the research guidelines formally established by the Central Australian Aboriginal Congress in 1983, which were developed and crystallised in the completion of an earlier research project led by Congress. A comprehensive picture of this research methodology, which informed this research project, can be gained by reading Health Business and the Central Australian Aboriginal Congress research guidelines.(45)

During this former project many lessons were learnt, by trial and error, about the wisdom of using orthodox research methodologies in a cross-cultural situation. It became apparent that the success of a research project depends on using the sets of rules employed by the Aboriginal community, including their informal communication patterns, channels or authority, status and standards of credibility. It requires the support of a representative Aboriginal organisation, Aboriginal co-workers who are important in Aboriginal terms and are closely identified with the project and a researcher understanding the 'whitefellah' way and from their vantage point, attempting to know the Aboriginal way. In short, success depends on Aboriginal people giving it direction and taking control and the research taking place in an unintrusive and culturally appropriate way.

The project began with a series of open-ended, exploratory and explanatory meetings with large numbers of tribal and non-tribal Aboriginal women. To define the parameters of the research and the methods to be used a number of crucial questions had to be answered: How did Aboriginal women define borning? What options should be raised in the discussions on the resolution of the borning problem? Should Aboriginal men be involved in the research meetings or were borning matters strictly women's business? How many communities should be visited to ensure a representative sample? Would individual or group interviews be appropriate?

The first pilot meeting was held at Ayers Rock. There were thirty women representatives from all the Aboriginal-controlled health services, Central Australian Aboriginal Congress, Kintore, Urapuntja, Nganampa and the Pitjantjatjara/Nyaanyatjarra. This meeting proposed that a large meeting be held in June, consisting of representatives from all over Central Australia. The meeting at Ayers Rock was followed in quick succession by a meeting with the Tangentyere (Town Camp Organisation in Alice springs) Women's Council and one with the Pitjantjatjara Women's Council, a part of the Pitjantjatjara Land Council Inc. (see Appendix 1).

A tape was prepared and translated into the main languages spoken in Central Australia, namely Aranda, Warlpiri, Loritja, Pitjantjatjara, Waramunga and Anmatjirra. The tapes outlined the research proposal and summarised the views expressed by the Aboriginal women at the early meetings. They were sent to approximately sixty communities in Central Australia to act as a catalyst for future discussions and as an introduction to the mass meeting held in Alice Springs in June 1984. At this meeting, the parameters of the research and its design was finalised and the research was able to proceed.

Design

The research intention was to involve all the communities in Central Australia so that the voices of all the women living in Central Australia would be heard. These communities have a range of structural situations, cultural spectrums and service provisions. These communities can be classified into nine representative types: a settlement, a mission, a European-owned cattle station, an excision, an Aboriginal-owned cattle station, a country camp, a town camp with a lease, a town camp without a lease, and town proper.

These communities vary along a cultural continuum. At one end of the spectrum, the country camps and Aboriginal-owned cattle stations represent the more traditionally intact communities; at the other end, the town camps and town proper would be less traditional in their outlook and way of life. The determining factor in this spectrum is whether or not Aboriginal people are living on their ancestral lands under the authority of Aboriginal Law.

The health services vary in these communities. Most of the outlying areas that are serviced by Northern Territory Department of Health staff have their own medical supplies. At the larger communities, there is usually a resident sister; the others are visited once a month by non-resident sisters. A health department doctor visits these communities once a month. There are six Aboriginal-controlled health services that service the town area and many remote Aboriginal communities which provide resident doctors, sisters and Aboriginal health workers.

Most of the communities in Central Australia lack the basic service provisions essential for health and survival. Although the living conditions found in most communities are equivalent to those found in the Third World, some communities are serviced better than others. The living conditions of Aboriginal people living on Aboriginal-controlled cattle stations are probably the best. The country camps represent the communities that are the worst. In a study completed in 1983, it was found that only eight of the eighteen communities studied had access to comet mills, bores and tanks.(46) Ten of the communities did not have adequate water provisions; the majority relied on carting water.(47) None of the eighteen country camps was equipped with ablution, toilet and washing facilities.(48) None of the

people living on the eighteen country camps had permanent housing.(49) Only ten communities were provided with radios and, of the ten communities supplied with Toyotas,(50) only four had vehicles in working order.(51) Only one of the eighteen camps had a stove, and only two camps had educational facilities.(52) These camps were involved in this study.

Sixty communities in Central Australia were visited by the research team, and research meetings were held in all these places (see Map 1, Appendix 2). The communities involved in this project were as far north as Tennant Creek, as far west as Kiwikurra, as far south as Mimili and as far east as Lake Nash. Aboriginal people from at least ten different language groups, including the Pintupi, Loritja, Aranda and Anmatjirra, Pitjantjatjara, Nyaanyatjarra, Alyawarra and Kaytej, were involved in these research meetings.

In the field

The research workers, Mary and Maureen, travelled to all these places, staying from a couple of nights to a week or more in one place. They were often accompanied by other senior tribal women who were 'bosses for that country' and who could therefore perform a very useful role in leading and interpreting discussions. Some of these women included Monica Poulson, Daisy Morgan, Margaret Mary Turner, Julie Cline, Nancy Lynch and Rosemary Miller. On other trips, women volunteered to act as interpreters for their particular country. In any case, interpreting never presented a problem for Maureen is fluent in all the major languages. The research meetings were informal, held at sites selected by the women, near a fire, wiltja or creek bed. The site chosen had to be sheltered and above all, private. Often women had subsequent meetings a day or so later.

The women echoed each other: loud and proud, talking about the old-time Grandmother's Law, in whispers and shame talking about the hospital, and 'talking strong' about their preferences. In these meetings, the old-time borning beliefs and practices and the new were debated with lively repetition. Usually, the older women talked first, one following the other; the protocol held by the custodians of the Law. Then the women who are all 'finished up' called on the younger women to talk about borning the hospital way. During these meetings, physical demonstrations of borning the old-time way were often given. On one occasion, some Pitjantjatjara women simulated their practice of birth and it was recorded on video. This secret video provided valuable evidence about the differences between western obstetrics and the Aboriginal way and a demonstration of the power, strength and womanhood of their Grandmother's Law. Women frequently took the research team on 'bush tucker' expeditions, showing the bush medicines that are used during the birth of a baby. Late afternoons and nights were the times for welye and celebration, singing and dancing for country and their Alukura Law. Sacred women's business sites were also shown and stories of the Dreamtime told.

Some difficulties

Although Congress has conducted a number of big research projects in the past, this project was unique in its singular involvement of women. The different roles between Aboriginal men and women are marked in Aboriginal society, and these differences are respected and reinforced by Aboriginal men and women today. Borning traditionally is regarded strictly as women's business, and this responsibility was not to be compromised in this research.

This cultural requirement provided both difficulties and exciting eventualities. On the one hand, Aboriginal women are not used to being vocal in government-initiated meetings. Aboriginal men have been encouraged by non-Aboriginal officials to represent the business of their communities on behalf of the women and children. Similarly, until recently, the evidence of women in land claims as kirda (owner) and kurdungurlu (manager), for country, was not recognised or accepted. Again, the formation of Aboriginal women's councils reflects a new movement in Central Australia. Thus, many Aboriginal women have rarely actively participated in the whitefellah way of conducting meetings. In the past women routinely sat to one side of the men in a meeting. The women were onlookers. Unfamiliarity and shyness with 'whitefellah business' meetings did act as initial barriers to forthcoming responses from the women. These meetings were always conducted in the local languages of the relevant communities.

Similarly, few Aboriginal women have worked as co-workers on a research project on a continuous and intensive basis. Aside from the fact that women in general have been excluded from this type of work, women have full-time domestic and familial responsibilities. These responsibilities have curtailed the mobility and public whitefellah life of Aboriginal women. It was comparatively easy to find women who were happy to make short trips for these could be fitted into their daily routines. But it was difficult to find a women who could meet the criteria required of a co-worker. Maureen, a couple of months into the project, a mother, wife and grandmother, became the exception. She has established an important precedent for other Aboriginal women.

The women in most places became comfortable very quickly with the demands of the research project and the research meetings. The subject matter, by definition, had its own momentum. Once these meetings were established in a culturally appropriate manner, discussions about borning business assured the success of the meetings. The women regard childbirth business with unshaken conviction and unquestionable urgency. It was perhaps the intrinsic essence and fundamental humanism of the subject matter that culminated in such a successful final conference.

Once the field trips were completed, a large conference was proposed to finalise research findings and recommendations. In July 1985, the Minister for Health, Dr N. Blewett, provided funds to finance a conference on the grand scale planned. It was attended by over 200 tribal and non-tribal Aboriginal representatives from ninety-five communities in Central Australia (see Appendix 3). From a

research perspective, the women broke new ground. The research field trips paled to the status of preliminary meetings only in the successful aftermath of the final conference. The white researcher role became almost redundant. The Aboriginal women organised, convened and led the conference and participated in it on their own terms. They showed a complete disregard for English and its interpretation and, for most of the proceedings, the women spoke in their indigenous languages. It was a women's business meeting. The women spoke directly, and no interpreters were needed, either for literal translation or for comprehension and explanation. The women were consulted, and they talked.

There were also other difficulties, but they were extraneous to the difficulties encountered in the formulation and application of cross-cultural research. Sometimes, there were slight variations in the nature of information offered and the readiness to communicate during some of the preliminary research meetings.

In places where Aborigines experienced control over their own affairs, for example, on Aboriginal-owned cattle stations or country camps, people were happy to talk about old-time borning and childbirth business as we understand it. But childbirth business was not easily discussed in places where the people's basic needs and rights had not been met and where they were consciously seeking their rights, for example, on European-owned cattle stations. Sometimes the Aboriginal women were too frightened to talk because the station owner had refused the research team permission to visit the community. In other places, like the missions and settlements, women were sometimes reticent in talking about their shame in the hospital. Here, the women are dependent on the Northern Territory Department of Health staff and clinics and, recognising their dependant situation, did not want to be seen criticising the only available service. Overall, it was difficult to obtain a comprehensive picture of the practice of Aboriginal women and detailed notions about pregnancy, antenatal care, delivery and postnatal care. This is, in part, a function of the limited understanding that Aboriginal women have about western obstetrics and the limited understanding that white practitioners have of traditional Aboriginal practices.

The caretakers

Interviews were conducted with the medical staff employed with the Northern Territory Department of Health in the Alice Springs Hospital and clinics in the remote communities. Since non-Aborigines are the main administrators of health services in Central Australia, it was essential to determine their perceptions of childbirth business and obstetrics, the problems and the solutions, in order to gain an overall view of the health care available to Aboriginal women in the Centre. These medical caretakers are the medical experts and it was essential to obtain their perceptions of the borning problem. They are also the mediators operating in an unrecognised two-way health care system and could potentially

offer information about the when and why of the Law in relation to the use of services. Moreover, the policies endorsed by the department have helped to shape the prevailing health-care practices of Aboriginal people in Central Australia. It was also hoped that the department would be able to provide the relevant statistical information needed.

The Northern Territory Department of Health, in general, is imbued with a belief in medical dominance which, by definition, is ethnocentric.(53) The model of western obstetrics applied in a cross-cultural situation created problems. It gives rise to competition between the Northern Territory Department of Health and the Central Australian Aboriginal Congress over finances, resources and control, because they operate from radically different viewpoints, and the subordination of one and the supremacy of the other. Medical dominance has led to the invalidation of beliefs other than those of science. On this basis, caretakers neither think it is necessary or valuable to consider conflicting beliefs and practices nor desirable, in case it promotes an independent, challenging practice that is recognised in its own right.

Certainly other related factors inhibited the flow of information including the self-serving, vested interests of some government officials, who were unwilling to recognise or confront a problem or contribute to its resolution.

Interviews were conducted on a de facto and ad hoc basis despite official authorisation. On some occasions, interviews were refused or completed by uneasy, reticent respondents. Attitudes were generally defensive, and this in itself is an index of the degree to which the way health services are viewed and delivered in the Centre is more than technical. By and large, it is a political matter. The real problem appears to be the illicit recognition by the Northern Territory Department of Health medical staff that there are chinks in the armour of medicinal safety and that there are problems in the service delivery of western obstetrics. The very reluctance to openly co-operate and consider other positions and knowledge, despite their stated adherence to open scientific thought, provides a clear illustration.

Attempts were made to procure detailed statistical information from the resident sisters on remote communities and a summary of the information contained in the hospital records. No information was forthcoming, and no proposed alternative was accepted to overcome the constraints of time and staff and confidentiality of the Northern Territory Department of Health. No one, it was said, was in a position to authorise the release of this information. We did manage, however, to collect some statistical information that was willingly provided by non-Aboriginal sisters working with Aboriginal-controlled health services.

These difficulties have been aired at some length for a number of reasons. First of all, there are obvious gaps in the empirical material in this report; these gaps are not the result of sloppy research or a major oversight. Secondly, this account draws attention to the paucity of statistical information that exists, is not compiled and has not been

made available. Thirdly, these issues highlight the problems for powerless Aboriginal women, unknowing and vulnerable, without the language or concepts to interact with western obstetric staff on an equal basis. If these problems are encountered by skilled researchers who are able to meet non-Aboriginal medical staff on their terms, we may begin to understand the difficulties that face Aboriginal women in need of obstetric care in the Centre.

Conclusion

The following story belongs to the Aboriginal women and in the main is told by them. The women tell these stories so that they will no longer 'feel shame, proper shame' in the Alice springs Hospital. The women have been shamed by the white man for a long time now. The women are also happy and proud to talk about their Grandmother's Law and to listen to their old aunties and grandmothers tell their stories. At the end of the conference, the younger women thanked the older women 'for keeping strong our Grandmother's Law for our daughters and children who may get the chance through the Congress Alukura of using our Grandmother's Law'.

The women have told their stories 'strong' and 'straight'. In listening to these powerful words, you will hear the pride and the whispers, feel the shame, pain and anguish and see the vibrancy, warmth, conviction and resistance.

A Pitjantjatjara woman at the conference explained it in this way:

> The grandmothers and cousins takes care of these things. We Pitjantjatjara women used to keep it a secret. Now we feel unhappy about this, but we are going to talk and listen to you all. This story has always been separated, and the babies used to be taken back to the camp, after the cord has fallen off and after the baby has been put in the smoke. But now we are listening.
>
> It is truly sacred. It is a big story for the women. Now we are unhappy and listening. We used to see the baby and get unhappy for it. We were never told by our grandmother, mother or father or by anyone about how our babies were born. It has always been a sacred story. A story that has never been talked about often. Good. That all I can say.
>
> Thank you.

Now, it is your turn to listen to this sacred story.

> But you must look after your babies, and children, and the young girls - teach them both ways, our own way, and white way. Two. We've got two lines now; whitefellah's line and black people's line.
>
> These days we must live two ways like out people before us, and also the white way.

Aboriginal people today recognise and accept that borning matters are a two-way process and that women must be taught both the old-time way and the whitefellah way. Western obstetric care has been partly accepted on the basis of ignorance, the absence of options and the introduction of 'whitefellah sickness'. Acceptance has been virtually obligatory, however, because western obstetric care has predominated with the emphasis on whitefellah hospital delivery and antenatal care programmes. A similar recognition and acceptance by western medical practitioners of traditional borning beliefs and practices has not been reciprocated. More importantly, the Alice Springs Hospital has failed to recognise the recent changes in western obstetrics such as home births and birthing centres. In essence, borning matters in the Centre have been characterised by a somewhat antiquated one-way interaction.

Birthing and borning is a cultural process, at the heart of a culture, which has far-reaching consequences for the life of a society. Irrespective of the secret nature of some ceremonial matters in Aboriginal women's business, birthing and borning is a sacred process that must be considered with great care.

One solution to the problem of borning of Aboriginal women is the implementation of a two-way borning practice and health service delivery. But to implement this would entail establishing equality between western obstetrics and the indigenous beliefs and practices of Aboriginal women. A two-way borning practice involves working through rather than glossing over the differences in the belief systems and life conditions of Aboriginal and non-Aboriginal people.

This section provides a brief description of traditional borning and western obstetrics. European medical practice in an Aboriginal context will remain limited in its effectiveness if practitioners do not look at the foundations of western medicine or appreciate something of the beliefs and practices of the old time. And Aborigines, upon whom comparison and contrast between the two ways has been forced, need additional knowledge of western obstetrics so that their choices may be more effective.

Traditional Borning Matters

'Birth is a ceremony.'

The traditional Aboriginal world of borning is vastly different in philosophy and practice from western obstetrics. These differences reflect the essential differences between Aboriginal and western society. There are, however, some points of convergence.

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

Borning is primarily women's business and in particular the business of older women with matrilineal affiliations. Knowledge about borning is generalised, shared and a collective responsibility among women. Aspects of the Law that relate to borning are passed to the younger women who actively participate in the borning process. Beliefs about 'being sent', 'being found' and 'coming into being' are part of the common body of knowledge within the all-embracing mythology and social organisation.

Beliefs: borning, being found on country (ampe mpwareke pmere alaltye)

Aborigines in the Centre believe in the tradition that the spirit child is 'sent' from the ancestral spirits belonging to country. There are certain places known to Aboriginal women in which man spirit children live. Only a woman who wants a child or who is already with child deliberately goes near such a place. Spirit children may enter a woman directly or turn themselves into emu, kangaroo, and so on, and be eaten later by the woman.(1) A woman may be chasing small game that disappear inside her, or a husband may be out hunting game that may include a spirit child. Upon return, the husband may give his wife some of the game, which enters the woman. Often a child will bear a mark corresponding to the place where the father speared the animal. Usually, husbands have a 'dream' that announces the arrival of the spirit child.(2) Thus, the present and the Dreaming are linked by the spirit child, who is 'sent' from the ancestors in a particular patrilineal area of country.

The first recognition of the spirit child is with 'quickening', when the 'spirit child is found on country' (ampe mpwareke pmere alaltye), which may be the grandfather's or Grandmother's country. The newborn child will later have strong traditional affiliations to this country and rights

and responsibilities with where he or she was found. Once 'found', the spirit child is made to 'come up' and must be 'looked after' and 'built up'.

Thus, while non-Aborigines speak in biological terms of fertility, ovulation, conception, pregnancy and labour, Central Australian Aborigines speak of the process of borning, of babies being sent, found, coming up, and so on. It is a process in which the spirit of the land and the people come together, reproducing and continuing the people, the spirit, and the relations of people to nature and to culture.

Practices

The following accounts are just a few of the many stories told with great pride about borning the Aboriginal way, by the Grandmother's Law, in the old time. Only excerpts are told in the following pages in order to avoid repetition. It should be stressed, however, that these stories were repeatedly told and at great length. Although the past tense is used by the women, these accounts refer to current indigenous practices. Aborigines frequently use the past tense when describing traditional practices that are still living traditions.

Coming up - 'antenatal care'

'Being found' and 'coming up' are regarded as private matters. Special kinship women, usually the grandmother or aunty, may 'make straight' (arratyileme) or 'turn around' (akngartiweme) the spirit child from time to time. Many physical demonstrations were given showing the massage, rubbing and feeling movements that are made on the stomach of a pregnant woman. Certain food taboos may apply in the event of harming the spirit child in various ways:

> When you pregnant you not allowed to eat blue tongue lizard, or perenti, echidna, and also carpet snake. Not only everywhere too. They are not supposed to eat these when they are pregnant. They tell them carefully they might get sick and when they cooking they tell them to cook long away because of the smell of cooking. they might cook it for you or you might cook.

During this time, women are expected to carry on with their normal obligations and responsibilities.

Borning (Ampe inteke pmere alaltye) at the Alukura by the Grandmother's Law

Borning is a warm, supportive, familial, ancestral process directed by the Grandmother's Law. It is a carefully managed affair, which is guided by particular 'procedures' and 'techniques'. With the first onset of pain, the woman gets

ready. According to Warlpiri tradition, the husband performs some simple 'straightening' movements to assure the success of the woman's labour:

> The woman tells the husband she's getting pain. The man touches his nose on the right side of the nose and straight down the stomach. That straightens the baby here.

The women are not prepared for the birth of their child in an informed way. They learn the Grandmother's Law in their first labour:

> In the olden days, the young girls didn't know much about delivering babies but used to learn on the spot when they were pregnant. Like me, I didn't know anything. That was before, when I was a young woman. When I was pregnant I had my baby out bush. I learnt there.

At the beginning of labour, the aunties and grandmothers prepare a women's camp, Alukura, a long way from the main camp. Thus, the pregnant woman is assisted in the newly made Alukura in a private, warm place by special matrilineal kin for a couple of weeks. According to Aranda and Anmatjirra tradition, the father's mother, mother's mother and sisters attend the birth whereas in Pitjantjatjara country the aunties and sister-in-laws many attend. In most cases, the mother does not attend because 'she might get shamed when the baby is delivered.' Similarly, no children are allowed to attend the birth because they might get 'shamed' and they may go back and tell the men. The Alukura is a women's place only, separated by distance and windbreaks:

> In those days, kids and husbands weren't allowed near the camp where the mother and baby was - only the girls were allowed to see them. That way, if the girls were there they could also learn from the old ladies, because it's sacred Law for all the women, and it's best for them to learn because they will also be a mother some day.
>
> When the woman is ready to have the baby, the relatives or grandmother take the woman away from the main camp to make a windbreak and wait for the baby.
>
> This is how our grandmothers used to have their babies. Mother, aunty, grandmother, they used to take the pregnant woman when she was ready, make fire and make it warm for the mother.
>
> The woman stays with the other women for two or three weeks. Sister-in-law is not allowed to come near this place. If the sister-in-law

> comes, the aunty of the woman tells her to go back because they are looking after her sister-in-law.
>
> Grandmothers stay with her all the time. Not mothers; they are not allowed. They stay in another place.

During childbirth, the pregnant woman has total control over the process, and there is no interference by any woman unless there are difficulties. The woman 'sits down hungry with no meat or water' during the labour. No pain relief is used and the women are encouraged not 'to scream out' because 'men might hear them' and because they are not little babies anymore'. The pregnant woman, grandmother or aunties are naked in a bush birth. The pregnant woman adopts a squatting position and is closely supported from behind and sometimes the front.

> After that, one of the woman sat behind me and the other told me how to position myself. My granny told me how to push harder. She held me really tight just above my stomach and told me not to scream.
>
> They help the woman deliver her baby by pressing on her tummy and telling her to push on her bottom.

Two women help with the delivery. One woman at the back helps rub the labouring woman's stomach. She puts her knee at the back of the labouring woman and helps her to have her baby quickly. The other woman in the front catches the baby:

> Grandmother used to sit behind the pregnant woman; if not the grandmother, then big sister could help deliver the baby.

If there are complications during delivery, the grandmother may try and 'straighten' the baby:

> In the old days they knew how to deliver babies. In the old days, if the baby wasn't in the right position to be born, the grandmother used to try and straighten the baby. Sometimes, after trying to straighten the baby for five days and for five nights, they used to die.

Or the <u>ngangkari</u> (Aboriginal doctor) may be called:

> And if the sun came up and she was still paining and the baby was giving her trouble, they'd ask the <u>ngangkari</u> to come and see her and feel her tummy. When he'd finished he'd go and sit long way and wait.

> Old way, when two days or three days that baby not born, we go and pick that old man, and he do that secret way, you know, our way. He stand wind side. He don't go close to that woman. When she lying down for that baby, he singing secret way - and then that baby be born quick. That's our way, Law way.

Or the husband, if he has ngangkari, may be called:

> This is another story about if the baby is not in the right position to be born. If it takes two days and one night, the mother goes and gets the father and tells him she didn't have the baby. The father doesn't waste time. He just gets up and goes to the place where they are looking after the woman and sits down behind the humpy and sings, throws dirt towards the woman and takes all his clothes off, even hair string. And when the baby is born, the father goes back to camp.

The grandmother delivers the baby, and a shallow hole is dug 'for them to lay down when it is born'. The baby is born (inteke) 'on the ground'. The baby is not touched until he or she cries. The baby is then put to the breast. The cord (yepe) is cut with scissors, a stone or digging stick, warm sand is applied and then the cord is tied around the neck of the baby 'to make him grow strong' and 'to protect him from bad spirits'. The tied cord for a little girl is called a digging stick and for a boy, a boomerang. The cord is cut in a particular way to prevent the baby from becoming sick:

> And the cord was cut a little longer in a special way so that the baby doesn't get sick, so that he doesn't cry for his mother to feed him too much and so that he won't sulk.
>
> When there was no scissors they used to cut the cord with stone, and they used to tie it. They used to put hot sand on the tummy to close it. And they used to tie the cord with rags and then cover it with hot sand in a cloth and also with a little string, and when it's dry that's when they break it.
>
> The things that our elders did to our newborn child was cut their navel not too short. Also tie the cord, keep it warm so baby would not feel sore. They got some clean sand or clean dirt, warmed it in the fire and put it in the bag. Then rest it on the baby's navel to stop it from aching, to stop the soreness as well. The mother has it done as well on her stomach because after birth she is very sore. They also use a lot of bush medicine. The women also gather food and meat. Woman not allowed to eat lizards.

The mother and baby are rubbed with warm sand to relieve 'paining' and sometimes other bush medicines are used:

> They used to wrap the baby in material while they worked on the mother - they used to lie her down in hot sand back and front and when the mother had no pain they would put her in ashes and then the baby. They used to make them strong this way when there was no medicine.

> When he's born they'd cover him with warm sand. They would cut the cord and carefully attend to the baby and leave him in the warm sand. The grandmother would make fire and put warm sand on the mother's back, her backside and her tummy. They put warm sand for the afterpains.

> And they made the woman lie down, and the grandmother put warm sand from the fire on top of the woman's stomach, between her legs and on the breast, and they did the same for the baby.

> And we make fire, hot heat. We put in for that baby and for mother on the tummy and on the back and her leg. Stop that pain, that's why we do it, Aboriginal way. Hot heat, and put baby on the ground, put some sand on it, hot heat.

The afterbirth (yakwethe) is buried. Sometimes the stomach is massaged to help the removal of the placenta:

> And the grandmother put warm sand on top of the stomach and put her foot on the stomach, and the placenta would fall out. They buried the placenta next to the fire.

> After that, the placenta had to come out. They stepped on my stomach and sort of massaged it with their foot and the placenta came out.

After a rest, the mother and baby are smoked (ure ulpurelileme/kwetelileme) with special bushes, antbed, to make them both strong, to stop bleeding, and to make sure the baby has plenty of milk. Smoking may be accompanied by the 'singing of borning songs', aywewayekenhe welye, from the country. Smoking is carried out for preventative and ceremonial purposes.

> When you smoke little babies and mothers, you are part of a special ceremony - like men have special law, women have special law and ways too for smoking young babies.

> The grandmother smokes the woman on her stomach and breast and also the baby. They smoke the breast so that she can have plenty of milk. If no smoking then there is no milk. But if they are smoked, the mother and baby is strong.

> When smoking, the grandmother puts the child near the smoke, so that the smoke gets in the mouth so that the child won't swear and is not cheeky and so that the child don't cry in the night.
>
> And we dig that hole, put that medicine leaf, put fire, put that leaf, that smell, then we put baby there, with baby lying down and smoke coming up through the baby - baby can't get sick. After baby we put mother, lying down. First she heat her back, then her tummy and her leg. She can't bleed much now. Smoke stops that bleeding and makes strong. Law way we doing it.
>
> In the early days they used to put a black ochre across the forehead and cook them with antpit, sisters or grandmothers allowed to do this.
> After that they would smoke her and the baby - first the mother she would sleep in the smoke on her back and then her front side; she'd lie flat on her stomach so the hot fire would burn her tummy. Then they'd smoke the baby, everywhere, on the mouth so that he would not swear at any man and also on the backside.

Sometimes, when the smoking ceremony is completed, other rites are performed and other precautions taken for preventative and ceremonial purposes:

> When baby was born, they used to burn his head a little bit with a small stick so that his hair could grow. And also they would get hair of another little baby and put it on the soft spot of his head so that the devil would be frightened of the smell. Then the mother would put some of her milk on the head of the baby so that he wouldn't get sick. That's how they used to look after babies; they used to be very careful. And also the mother would burn her hair a bit so she would not get sick after having the baby. And she was not allowed to cook meat near the baby, because if the baby smelled the meat he would get sick from smelling the fat. If she wanted to cook meat, she'd go a long way from the baby.
>
> But in these early days the old people they used to burn themselves in the front, and the baby would be born okay. The mother would not get sick.

The husband supplies the <u>Alukura</u> with food, and the mothers and sisters bring presents for the baby:

> When the husband gets kangaroo, he leaves some meat for the woman long way - not close to where the woman and baby is. Husband always stay with the other men. the baby was secret when the baby was born in the bush.
>
> When the baby is two weeks old, the sister-in-law gives presents to the baby and mother, and the mother gives her presents too.

After a few weeks, the woman returns to her own camp, and the borning process is completed:

> The grandmother and mother tells the woman that she can go to her husband now. The woman goes to the camp where her husband is sleeping, and she puts the baby in a coolaman. The father brings presents for the mother and baby, and the woman gives tea, damper and blankets. She can sleep with her husband now.
>
> My mother used to tell us not to go back to our husbands too soon. If we did we could not be called women, and also we would get skinny and really sick. We used to stay in a separate place for one or two weeks, then go home after that. That was the Law.

Conclusion

Borning by the Grandmother's Law is a process guided by rites and skills, an oral tradition passed down through successive generations by experience. The Aboriginal women have control over their own lives, bodies, and babies in this borning process. Few tools are needed and helping hands only for support and massage. The women are helped by kin women relations, the familiar and wise, in spiritual solidarity. The women are not shy here or shamed, or alone, or scared. They have their babies 'on the ground', 'their camp, hearth, country, everlasting home token place, life source, spirit and centre and much else all in one'.(3) They encourage, reassure and support. There are immemorial rites and rituals that have been proven by time and refined. They have skills to look after their mothers and babies: sand and heat for pain and for healing wounds; massage for relaxation and afterbirth; smoke for healing, cleansing and suturing wounds. The women are nourished with kangaroo meat.

The Aboriginal women in Central Australia are proud of their bush babies and single them out for congratulation, and they are also proud of their grandmothers and aunties.

The Grandmother's Alukura Law is a living tradition; it is a life source and the base for future generations.

Western Obstetrics

Since many books and articles have been written on the growth of 'scientific medicine' and 'western obstetrics', it is beyond the scope of this report to do other than draw

attention to these features that characterise the contrast between western and Aboriginal beliefs and practices. Specifically, the issues are of effectiveness, cultural specificity and the role of women in childbirth.

It must be said that the following review, although critical of many assumptions of western orthodox obstetric care, does not deny intrinsic value. There are many occasions of medical necessity in which the welfare of the mother and baby is enhanced by antenatal and postnatal care or medical intervention.

The present practice of western obstetrics represents a long period of social and political conflict over the birthing process and access to medical knowledge. But it is true that the practice is subject to some abuse whereby unnecessary interventions have become routine, leading women to perceive the birthing process primarily as a medical event.

The Aboriginal community is not alone in challenging the existing hegemony of western obstetrics. This hegemony, however, is largely based on political and technical processes rather than on questions of objective, technical and scientific assessments. Conflict about western obstetric care continues within the medical profession and the lay public, exemplified in the home birth and birthing centre movements.

Aboriginal women, until recently, have not been party to this conflict. Western obstetric care, itself, largely remains opaque and mysterious and by definition, so has the critique. The Northern Territory Department of Health, moreover, has given no credence to this conflict. It has neither provided forums for discussion nor made concerted efforts to make western obstetric care comprehensible and accessible.

The development of obstetrics must be viewed against the backdrop of the central concepts of western medicine. Western medicine is 'scientific' in that it is based on a belief in the inanimate causes of disease. Being scientific, it searches for universal factors, not those specific to actual forms of life. Its expert knowledge became distant from local and experiential knowledge. Its definition of health is defined in pathological terms. It is the opinion of the 'experts' that defines and controls health and illness. Illness is perceived as the malfunctioning of a mechanical system, the body, and this perception is object-oriented and not person-oriented. Treatment consists of surgical and chemical intervention administered by the specialists, usually male, who are representatives of the upper middle class.

These caretakers are agents of these beliefs, who live a life of affluence that limits their knowledge and sympathy for Aboriginal people. The medicalisation of life processes has reached the point where birth, old age and death are controlled and presided over by the medical caretaker and his equipment. Health is defined negatively, for a healthy person is one who shows no signs of pathology. Health is usually defined in a functional sense, excluding the impact of culture and material life conditions.

Birth has become a medical and technological event, excluding control by those excluded from science and technology. While Aboriginal women have drawn heavily on their pasts and traditions, western culture has actively

rejected its past traditions in favour of new technologies developed by experts to control the emerging pathology of birth. Birth was once considered a natural process, and the female midwifery tradition was once considered a natural practice:

> Medicine in particular has retained the characteristics of belief, ritual and dogma that are ordinarily associated with religion. Organised medicine, obstetrics and gynaecology, in particular, has correctly interpreted its mandate to define and control women's reproductive functions, a mandate endorsed not only by government but by the people as well.(4)

The very word 'obstetric', which is derived from the Latin 'ob' plus 'stare', 'to stand before', in itself, is a confirmation of this medical mandate.

English antecedents

A historical review of childbirth beliefs and practices in western society shows how the development of technology, the professionalisation of medicine and the dominance of male practitioners has led to the changed nature of childbirth.

Before the seventeenth century, female midwives who practised a non-medical lay craft, in the home, assisted in the event of birth. Midwives, who were older women who had had children, were part of the local community; knew the family and lived in before and after the delivery. They used herbs and remedies and practised a non-interventionist form of care. From early in the seventeenth century, however, in the United Kingdom, the term 'man-midwife' appeared, marking the beginning of a struggle between male and female midwives that was to last until the twentieth century.(5)

The modern technology of birth began with the seventeenth- and eighteenth-century French attempts to measure the birth canal in order to measure the female pelvis. Precise methods of measurement were developed that not only enabled doctors to predict the outcome of birth but also contributed significantly to the development of the 'clinical' view of the body as a machine.(6)

The first practical technique that represented a genuine improvement came not from university-educated French physicians but from the trial and error experiments of the English barber-surgeons.(7) In the seventeenth century, a barber-surgeon named Chamberlen found that if two spoons were inserted separately, one on each side of the baby's head, and then locked together, this instrument, called a forceps, could deliver a baby.(8)

By the early eighteenth century, the use of forceps came into regular usage under a male monopoly.(9) In the UK, the female midwives fought against the use of forceps by ill-trained doctors and male midwives. Midwives wrote books in protest:

> lambasting 'man-midwives' for incompetence and licentiousness, for using forceps because they were too 'horse-fisted' to deliver with their hands as midwives did, and for turning 'broken-down pork butchers and sausage stuffers' into 'intrepid man-midwives' after six weeks' training on a wooden mannikin, without ever having seen a birth. Doctors replied by accusing midwives of drunkenness, incompetence and magical practices.(10)

In the UK, most babies continued to be delivered by midwives through the eighteenth and nineteenth centuries, however, but the occupation of midwifery was in decline as the general practitioner gradually emerged.(11)

In the mid-eighteenth century, lying-in hospitals began to be established by male midwives.(12) These hospitals were initially used by working-class women, giving male midwives access to clinical experience and, later on, by paying affluent women who reaped the benefits of earlier experimentation. These lying-in hospitals set a precedent for future institutional confinements and professional medical management.(13) In 1886, medical practitioners in the UK were required to be qualified in midwifery.(14) In the US, however, the medicalisation of birth was more rapid. Obstetrics became the first medical specialty taught in American medical schools in the eighteenth century. Fees for obstetrics were higher than for any other medical procedure, and procedure rather than time spent in attendance determined the fee.(15) With the change to urban industrial life, midwives lost the basis of their practice and the traditional communities were disrupted. Into this gap the male doctors moved though not without protracted opposition.

Australian antecedents

There is very little information on the number of midwives who migrated to Australia. For the early pioneers, there was often no skilled medical or midwifery assistance. There are, however, numerous accounts of Aboriginal women acting as midwives for settler women in childbirth: 'Stories of native women who acted as emergency midwives appear in every district.'(16)

Early Australian developments in the obstetric field were congruent with the English antecedents. In Victoria, for example, a lying-in hospital based upon the English model, including male medical staff and the provision of clinical training for medical students, was opened.(17) In 1862, training for midwives to operate under male medical control was established.(18) Under the Medical Registration Act of 1862, male midwives and not female midwives qualified for

midwifery practice.(19) In 1888, a formal course in midwifery was established but, by 1893, only general nurses could qualify for entry.(20) In this way, midwifery was becoming professionalised by male medical practitioners and subordinated by its incorporation into the occupation of nursing.(21)

Concern about the high maternal and infant mortality in the early twentieth century led to the increasing medicalisation of childbirth. The greatest single cause of maternal death was puerperal fever, an infection caused by the failure of attendants to take the simple precautions of washing hands and changing clothes following each delivery.(22) Midwives, and not doctors, without this knowledge, were primarily blamed for the puerperal fever epidemics. In response, infant and maternal welfare became an official concern. In 1912, a maternity allowance was paid, excluding Aboriginal women, however, so that assistance in childbirth could be afforded by everyone.(23) This allowance removed the financial barrier to medical attendance, and the proportion of births attended by midwives was halved.(24) There was, however, no significant decrease in the infant mortality rate or the maternal death rate.

Nonetheless, the pathology of birth was established, and an exaggerated need for obstetrical care, under medical practitioners, was promoted. As early as 1921, an editorial in the Medical Journal of Australia stated:

> As soon as the wise woman recognises she is pregnant she consults her obstetrician and is prepared to follow his directions throughout the long months of her grossesse... This is the action of the wise woman. The French employ this phrase 'sage femme' for someone quite different. The midwife or 'sage femme' is not competent to guide the pregnant woman at this stage. A thorough knowledge of physiology and pathology is needed and there must be preparedness to apply special measures in the event of a pathological condition being discovered.(25)

At the same time, specialisation within the medical profession in Australia occurred. Obstetrics and gynaecology became separate specialities within the medical profession and received increasing attention in research and curriculum areas. A recurrent theme at this time was the need for a major shift in attitude, for greater attention to asepsis and the provision of a 'surgical environment' for childbirth.

Technical skills relating to intervention during childbirth developed:

> Although the use of anaesthesia, forceps and other obstetrical techniques and, during the 1930s, induction of labour, were the most outstanding issues in the changing management of childbirth, other aspects were also significant. Position of the woman, actual

guidance and assistance during labour, and the amount of bed rest considered necessary after delivery were other practical aspects of the organisation of confinement.(26)

By 1928, the occupation of midwifery was formally incorporated as a specialty within nursing.(27)

Childbirth in the west has become hospital-based, medically managed and male dominated. The natural processes of reproduction and childbirth became the province and specialty of the medical profession and was marked by terms such as 'obstetrics', 'antenatal care' and 'hospital deliveries'. The solutions proposed came increasingly from the realm of science and technology. The demise of midwifery as an ancient female craft had been achieved.

Childbearing the Orthodox Western Way

The western way of childbirth is taught and administered by medical doctors, nurses and hospitals. Intrinsically, it defines childbirth as a medical problem, and once defined as such, it becomes an event controllable by more or less anonymous specialists carrying out standardised techniques on a woman's abdomen and pelvis. Childbirth is an individual matter because the specialists only need to see the pregnant woman: she is the only one considered to have a potential medical problem. And they only need to see certain parts of the body because they are where her medical problem resides. The specialists see the woman in a central place where all people who are thought to have medical problems are expected to appear. This centralisation allows the efficient use of skills and technological equipment.(28)

The specialists and their clients attribute the success of medical intervention to knowledge of gynaecology and obstetrics. In order to use the potential of their knowledge in treating childbirth, the specialists want to see the woman as early in pregnancy as possible. The earlier the specialist has access to the medical problem, the greater the opportunity to control the course and outcome.

For a normal delivery, women deliver in hospital and are confined to bed for much of the labour. By including pregnancy and childbirth in the medical realm, the pregnant woman becomes a 'patient' and is subject to the expectations of the sick. The woman as a patient is relieved of responsibility for her condition, is incompetent to deal with the medical problem she has, and is obliged to seek medical assistance.(29)

Decisions about birth are subject to medical criteria. Medical staff usually decide the timing and type of obstetric intervention, pain relief and sedation. A supine position is usually encouraged, and attendants are gowned and masked. These practices are justified as being the requirements for obstetric safety, arising from the need to control sepsis and the necessity of preparation for an anticipated or unexpected obstetric emergency or pathology.

The western medicalistion of reproduction and childbirth has four major features: the definition of reproduction as a <u>specialist</u> subject in which only doctors are experts in the

entire symptomatology of childbearing; the associated definition of reproduction as a medical subject, as exactly analagous to other pathological processes as topics of medical knowledge and intervention; the selection of limited criteria of reproductive success, that is, perinatal and mortality rates; and the divorce of reproduction from its social context, pregnant patienthood being seen as woman's only relevant status.(20)

Thus, reproduction and childbirth are considered to be the jurisdiction of the medical profession and to be potentially a problematic condition. The development of antenatal care and obstetrics has been seen to make a major impact on the high infant and maternal mortality rates. Reproduction is primarily an individual concern that is divorced from social and cultural contexts. The fundamental basis of childbirth is a scientific and mechanical one where the woman is treated as a complex machine. Natural childbirth has been colonised by medicine.

This orthodox view is conspicuous in its failure to consider that reductions in infant and maternal mortality cannot be directly attributed to obstetric care. It has been shown that the decline in mortality rates during the latter half of the nineteenth century in Britain was brought about by a rising standard of living, and especially by improvements in nutrition, and to the amelioration of national hygiene by way of improved water supplies and the more sanitary methods of sewerage disposal. Mortality began to decline long before the causal organisms of infectious diseases became known and medically treatable; the decline in tuberculosis deaths between 1840 and 1870 is a clear demonstration.(31)

A similar exercise can be carried out in the obstetrics field. The problem with using crude mortality rates to assess the value of obstetric innovation is that these rates conceal secular changes in maternal age, parity and thus obstetric risk. On the whole, the fertility of high-risk mothers has declined most in the last twenty years, so that perinatal and maternal mortality has improved regardless of the consequences of medical innovation. Analysis of the data of hospital confinement rates in relation to perinatal mortality shows that the move towards 100 per cent hospitalisation in Britain has not consistently reduced the mortality of British babies since the 1960s.(32)

These trends show the importance of public health measures and socio-economic determinants in the reduction of mortality. In Britain, women of low socio-economic status are about four times more likely to lose their babies than women at the opposite end of the socio-economic spectrum.(33) The medical profession continues to argue, however, that the responsibility for perinatal mortalities rests with individual mothers who refuse to seek regular antenatal care and who engage in unhealthy activities, such as smoking and overeating.

Home Births and Birthing Centres

Since the 1940s, there has been a developing critique of western obstetrics, including that developed by the medical profession and, more importantly, that developed by lay women. This critique began with Grantly Dick Read in the UK, Lamaze in France, and later Leboyer relaxation techniques were developed. These developments culminated in the 'natural childbirth' movement that has heralded dramatic changes to childbirth practices in major metropolitan hospitals throughout Australia.

The basis of this critique rests with the evaluation of the success of childbirth and reproduction in a more holistic way than the medical frame of reference. The critics claim that some common obstetrical practices have served to 'warp' unnecessarily the experience of childbirth.(34) Research has indicated, for example, that the practice of shaving the perineum and the pubis, a common practice, does not reduce the incidence of infection. Similarly, there is no evidence to indicate that routine episiotomies reduce the incidence of outlet obstruction or neurological impairment in the child.

In recent years, there has been a trend away from hospital deliveries to home births. A growing number of women are now choosing this option, which they consider to be more 'natural' and where they can exert more control and have autonomy. Usually women selecting this option have been screened beforehand and been assured of an uncomplicated delivery. Nonetheless, a small percentage of women are transferred to the hospital following complications in labour. Equally, there is a growing trend within hospitals to afford women greater control over the management of their childbirth. Breastfeeding is encouraged by the almost immediate placement of the baby on the breast and considered fundamental to natural childbirth. Birthing centres have been established on hospital grounds and as independent clinics. Family rooms may be provided, and family members may participate in the childbirth process.

Perhaps the most well-known birthing centre is Pithiviers, which was established by Michel Odent in France. Procedures here may be carefully explained to women, who have complete freedom to elect or reject the practices used. The differences in approach, between the orthodox hospital delivery and the new and renewed alternatives, can be dramatically contrasted. This is an account from a West German hospital:

> They lie like stranded whales, enormous undulations of flesh, immobilised and trapped on narrow tables under glaring lights. From between her legs a wire projects. It is linked to a machine with a rapidly flashing green eye... Another wire, recording uterine pressure, connects with the machine, too, and produces its own eruption of jagged lines. 'Lie still,' the women are told. 'Any movement will interfere with the print-out of the monitor.' But it is not possible for them to move. Each

> has no sensation at all from above her belly down to her feet. Taped to one shoulder is the epidural catheter through which more anesthetic can be injected when feeling returns. A nurse passes quietly between one woman and the next, checking the machines... The nurse frowns critically at something on the print-out, and returns to the next machine.

And this from the Pithiviers Centre in France:

> Another woman is in labor, this time in France. She is in a small room in subdued light, with a midwife and her husband close to and supporting her. She is on a low dais that occupies one corner of the room. It is covered with cushions. But she has chosen to squat, with her man behind and holding her. Everything is very quiet. There are no ticking or bleeping machines, no bells ringing; voices are hushed. The usual bustle or a hospital has been blotted out, phones silenced; there are no hurrying feet.(35)

The development of home births and birthing centres has sparked an enormous controversy among the medical profession and the lay public. The central debate concerns whether or not hospital confinements are safer than domiciliary deliveries, an argument that at its heart undermines the foundation of western obstetrics, but also highlights the emotional and cultural significance of the birth process. Arguments about perinatal mortality dominate the hospital versus home debate.

Perinatal medicine suffers from a dearth of experimental evidence upon which rational practice can be based. Despite this paucity, some of the emerging evidence appears convincing. Perhaps because the medical safety debate is jeopardised, the forthcoming evidence fuels rather than diffuses the debate.

Evidence from international comparisons does not provide conclusive evidence on the importance of hospital deliveries. International figures show that there is quite a variation in the perinatal figures, but the provision of different medical services does not consistently account for these variations. Both Sweden and the US, for example, have virtually 100 per cent hospital confinements. In 1973, Sweden had a low perinatal rate of 13 per 1,000 and the US a very high one of 27 per 1,000.(36) The Netherlands, which had one of the lowest perinatal rates, 16 per 1,000, has approximately 40 per cent home confinements.(37) Italy, which had a higher perinatal rate than the US in 1973, at 32 per 1,000, also has a greater number of doctors per head of population.(38)

The most important factor in determining the perinatal mortality rate is the proportion of low birth-weight deliveries. In 1975, in the UK, 60 per cent of neonatal mortality arose from the 6 per cent of births of infants weighing less than 2.500 kg.(39) A further 20 per cent of all

deaths were related to congenital malformations.(40) Thus, the incidence of the perinatal mortality rate was largely determined by the incidence of low birth-weight and congenital malformations. The place of delivery has no influence on the latter and a marginal impact on the former. Thus, the relationship between the place of confinement and perinatal mortality was indirect. The British births survey of 1970 showed that only 16 per cent of premature babies born at home needed to be admitted to a special unit for care.(41)

A common analysis employed by the defenders of hospital confinement for safety reasons is to compare the perinatal rates with the increasing proportion of hospital deliveries. It is generally held that as hospital deliveries have increased, the perinatal rate has fallen. An English survey in 1970 showed that 70 per cent of deaths in newborns is caused by intrauterine asphyxia, respiratory distress syndrome and malformations.(42) In spite of the fact that high rates of hospital delivery have been justified because they are said to reduce the mortality for the first two causes, the figures remained unchanged between 1958 and 1970, despite a reduction in home confinements from 36 per cent to 12 per cent.(43)

Other studies have shown that this correlation is not significant. In the UK in 1963, in a study over one week, in one particular month, of all deliveries,(44) 41 per cent were booked for delivery in consultant hospitals and 40 per cent for delivery at home though 16 per cent were transferred to the hospital. The mortality ratios were much higher in the hospital, 336, than those at home, 49.(45) The survey quantified many of the risk factors in childbirth and calculated standardised ratios for maternal parity, social class and toxaemia. The risk-standardised ratios demonstrated that only a small part of the hospital and home crude ratios could be explained by the greater proportion of high risk cases attending the hospital.

Similar findings emerge when analyses on maternal deaths and stillbirths are made. A standardised rate analysis was carried out in the UK between 1969 and 1973.(46) In this five-year period, 76 per cent of the births occurred in hospital, including a slightly greater proportion of mothers of high-risk age and a much greater proportion to mothers of high-risk parity. Nevertheless, standardised rates showed that there was a higher proportion of maternal deaths, 21 per 100,000 in the hospital than in the home, 15 per 100,000.(47) similarly there was a higher proportion of stillbirths in the hospital, 19 per 1,000, for the high-risk group than for home deliveries, 7 per 1,000.(48)

The second line of defence of the hospital advocates is that hospital rates are higher because a relatively greater proportion of births have more than one high-risk characteristic. A cross-classification of age and parity again confirmed that the proportion of stillbirths that fell into the high-risk group for both characteristics was greater in the hospital, 22 per 1,000, compared to 10 per 1,000 in domiciliary confinements.(49)

Further evidence about safety has been derived from figures gained from birthing centres. The findings are comparable to those described above for home births. In the

US, in 1980, a collaborative study was initiated in eleven birthing centres.(50) The mean age of the 1,938 women attending these birth centres was twenty-five. Half of the women had living children and for one-third of these women, it was their first pregnancy.(51) Of these, 99 per cent began labour spontaneously, 60 per cent were conducted without analgesia or anaesthesia, and 15 per cent were transferred to a hospital.(52) The neonatal death rate for the centre, excluding transfers, was 3 per 1,000 live births.(53) Similarly at the Pithiviers Centre in France, where there is no screening, the perinatal mortality rate is 10 per 1,000 with a caesarian rate of only 7 per cent.(54)

Equally and related, controversy exists about the value of intervention in labour and its possible abuse. A common case cited is the overuse of induction and the acceleration of labour. Induction can be life-saving in a few specific situations when, for example, a mother has toxaemia or the baby is considerably overdue. In the UK, the induction rate in 1963 was 37 per cent, which rose to 41 per cent in 1973.(55) It has been said that induction has been used in order not to inconvenience medical practitioners.(56)

In recent years there has been speculation that women tear because they are encouraged to use the dorsal position, rather than the vertical one, in which they may also be more comfortable.

Four random, controlled clinical trials, two in Denver, one in Melbourne and one in Sheffield, showed no difference in neonatal mortality rates with the use of electronic foetal monitors.(57) In all four studies, the caesarian section rate was considerably increased with the use of the electronic monitor. It was more than double in all trials except in Melbourne.(58) The only suggested benefit of electronic monitoring was for low birth-weight babies.(59)

Conclusion

The critics of the advocates for hospital confinement state categorically that no one would deny that each infant and maternal death is a tragedy to be prevented at all costs; or that modern obstetric care, which was developed in a hospital setting, has been at least partly responsible for the dramatic decrease in both perinatal and maternal mortality over the past century; or that obstetrics is not indispensable for 'high-risk' deliveries.(60)

Rather, in reviewing the history of obstetric care, critics wish to highlight that the medical takeover was a gender, professional and class one and not one based on medical and technological successes. The critics claim that the decreases in mortality rates were caused primarily by improved hygiene and sanitation and not by the introduction of hospital deliveries, antenatal care programmes and the technological innovations used in birth. The truth of this continuing cycle, the critics argue, can be seen today in the lack of any significant correlation between hospital confinements and safety for the mother and infant. And, in this takeover, female autonomy has been lost.

Women are socialised to view birth as a medical event 'where things can go wrong' and so the hospital is selected 'especially for the first and where we can be near emergency equipment in case a life-saving situation arises or in case I can't cope with the pain'. Hospitals, we learn, are for sick people with pathological conditions.

> A society's way of defining birth powerfully shapes and is shaped by other locally invariable features of birth in that society. Thus, the local conceptualisation of birth determines and serves as a justification for that system's particular birthing practices. At the same time, this conceptualisation is determined by those very practices.(61)

And the critics raise the following questions. Why are research funds allocated for developing high-technology interventions such as electronic foetal heart monitors rather than low technology appropriate to most childbirths?(62) Why is it that the use of high technology on pregnant women has become the norm rather than the exception? Why are nutrition and living conditions not researched more seriously?

Despite the growth in the return to home births and thus the use made of the new birthing centres, women who engage in traditional birthing practices are under great pressure to change to western obstetric care:

> Some of the very obstetric practices that are currently exported to developing countries by the medically oriented, technologically sophisticated nations have ironically taken on a controversial status at home... The high-prestige, western medicalised model of birth has recently been overwhelmingly, and usually uncritically, adopted as the standard to which to aspire, usually leading to a devaluation of traditional ways of doing birth. As a result, the possible contributions of traditional birthing practices in both modernising and modernised societies are ignored.(63)

This simple review of western and indigenous medicine shows a diametric opposition between the two in beliefs and practice. The gulf between them is culturally wide and historically deep. The approach of one is mainly specialist, gender specific, mechanistic and scientific, and in it the emphasis on pathology is paramount. The other is holistic and embedded in the cultural traditions of the Law and Dreaming. The practice of western obstetrics is specialised, involving the presence of an educated elite and its individual clients, and childbirth is technologically managed in hospitals. The practice of borning is generalised, collective and comprehensible in the domain of women's business and the Law. It is non-interventionist (Aboriginal women literally 'catch the baby') and grants women control and autonomy. Borning is a progressive cultural process that goes far beyond the event of childbirth.

There appear to be some points of similarity between the borning process and western obstetrics when things compared are dislocated from their original contexts. Both are marked by forms of 'antenatal care' and birth attendants and particular procedures, techniques and medicinal care are used during childbirth. Despite these similarities, there are far-reaching differences.

It should now be clear that official caretakers in the Northern Territory Department of Health have uncritically advocated the practice of western obstetrics as the safest for Aboriginal women, without heeding the critiques that led to the 'natural childbirth' movement. The failure of these official caretakers to recognise the traditional borning beliefs and practices of Aboriginal women in the Centre and instead to impose western obstetrics on them must make childbirth for these women delivering in the Alice Springs Hospital highly traumatic. If Aboriginal people were given the control, resources and knowledge to develop appropriate borning services on the basis of traditional practices and the opportunity to use the best western obstetrics these services would differ markedly from those mainstream services offered to Aboriginal women today.

It appears that the high infant mortality and morbidity rates among the Aboriginal population occur in a context of general ill health, which does not provide a justification for the unqualified use of western obstetrics.

3 PASSIVE RESISTANCE: 'THE WHITEFELLAH WAY IS SHAME, PROPER SHAME'

> I had my grandmother and aunties with me the first two times. That felt very good. In hospital I was too shy. I was too shamed. They left me by myself. No one was with me. They just let me sleep by myself.

This tribal woman echoes the voices of many other Aboriginal women in Central Australia whose voices differ only in detail and emotion.

Is it any wonder that this Aboriginal woman says that borning the Aboriginal way according to the Grandmother's Law feels 'very good' and that the whitefellah way is a 'shame'? Aboriginal women had and still retain control over indigenous borning processes that are grounded in the Law and Dreamtime. They have little knowledge and no control over western delivery practices, for childbirth in the Alice Springs Hospital is a whitefellah affair. This way is 'a shame, a proper shame', because women are 'frightened', unknowing, physically shamed, silent and alone in an alien place. What for many white women is a joyous, sharing and close experience is for most Aboriginal women an experience of pain, fear and 'shame' from which they flee as soon as possible.

Faced with changed spiritual and material conditions of life and new diseases and with a variety of medical staff and institutions, Aboriginal women have been forced to consider the new circumstances. In part, there has been a resistance, a maintenance of their traditional borning practices and in part, there has been an acceptance of the new, finding a place for the whitefellah way alongside the traditional ways. In part, this acceptance has been compulsory.

In this section, stories of how people see the new in relation to the old are told. The attempt to come to grips with the new is a difficult and anguishing process and one that occurs in a context of shame and ignorance. The accounts outline many of the difficulties of managing childbirth according to western criteria in a situation where western obstetrics has been imposed on indigenous practice. Although Aboriginal women have managed, through acts of passive resistance, to retain their borning ways intact, with some circumscribed changes, the accounts also reflect the erosion of knowledge and control over borning matters. Women have gained a very limited understanding of western obstetrics.

No woman should have to suffer the traumas and gross indignities that the Aboriginal women painfully and hesitatingly express in their accounts of their birthing experiences. It will become clear that Aboriginal women do not have a choice over the how and where of borning and no rights over one of the most sacred and symbolic of life's processes. The women were almost 'too shamed' to talk about their 'shame'.

Why the Whitefellah Way?

Women attribute the need to use and incorporate the whitefellah way to changes in the old time way of life, the introduction of new diseases and the subsequent undermining of the Law. Hospital deliveries are partly accepted in preference to bush births for these reasons. These factors, which underlie transition and high mortality rates, are rarely acknowledged by the official caretakers. The merits of obstetric care, hygiene and education are advanced in a vacuum, independent of the impact of white colonisation. Aboriginal women have a sophisticated understanding of the causes of high mortality rates and the need for additional obstetric care alongside borning practices taught by Grandmother's Law.

The Old Time

Many women when talking about borning problems today referred to the old time, when there was plenty of 'bush tucker', babies were 'fat', women were older, 'big and strong', there were 'proper marriages' and the Law was 'strong'. In the old time, seasonal movement around the country and a plentiful supply of bush tucker provided a healthy environment, exercise and nutrition in which to nurture the spirit child:

> Long time, old people used to look after the mother and baby with bush foods like goanna, kangaroo and wild berries.
>
> Before when she was pregnant for her kids, she ate a lot of bush tucker, like sugarbag, wild potatoes, witchetties and yam. That's why she had healthy children.

> Long ago, my mother, my family lived in the bush, no flour, sugar or tea. Our family grew us up on traditional food (emu, kangaroo, berries, etc.). Us kids just grew up on bush food. We didn't know white man's food. We were taught what bush food to eat, and that's all we lived on. We never got sick. Not one kid. That's the way we lived.

> Long time ago, our grandmothers used to go out bush hunting for bush tucker to give the young mother who had just had a baby. Some of them go hunting for kangaroos and bush tucker and wild honey. They didn't have any sugar at that time. They didn't know any sugar. All of them used to gather seeds and grind them on a flat stone to make damper for the families. They used to drink only water all the time.

Moreover, tribal marriages according to the Law assured health and older, childbearing women who were big and strong:

Long time ago all the woman used to eat good food, bush tucker and bush mets. They used to look real well when they eat our bush foods. They grow up into big young woman. That's when young mens asked them get married. That's the time when they have their first babies. But nowadays the young woman or girls have their babies.

In the old days our grandmothers had babies. Our grandfathers married our grandmothers. They had a lot of good food. They were big women when they were ready to have their babies. The husband used to chase his wife for months and months, when the woman used to go with her family. Her husband chased her until they were married. After one year the mother had a baby. Husband and wife used to look after their child properly, they had plenty of bush food. What about today? What about the new Law? The really young girls are getting pregnant now. We are sorry for these young girls.

In the olden days before we were big women and older, we had our babies in the bush with our mothers around. Mothers and babies didn't die then. Only young girls nowadays are having their babies in hospital. We were strong then and had babies and stayed out bush.

I am talking about the olden time, how it was then. There were a lot of pregnant women then. They were all fat and strong.

I was a big woman with big stomach and big breasts. That's why I had my children fat. Some of these mothers today are too young. Our daughters are real skinny with narrow hips.

Long time ago and people used to get pregnant only when they were grown up women. We must keep this Law strong.

'The Coming of the Whiteman'

Many women referred to the problems caused by the coming of the white man. The Aboriginal women specifically referred to the introduction of large amounts of carbohydrate, sugar, cool drinks and 'rubbish food', which has partially replaced the high-protein bush tucker:

> In the olden days, older women before were healthy and happy to have their baby out bush, and they had better foods to eat those days. Now pregnant mothers eat white man's food, and it's not good for them. They eat a lot of sweets and lots of rubbish food, and don't eat the right food.

> We had that Law before but now we drink cool drinks and everything.

Aboriginal women recognise that a dire consequence of the coming of the white man, bringing dispossession and disruption, has led to the introduction of such diseases as diabetes mellitus, hypertension, anaemia and obesity. With these new diseases, Aboriginals now require, among other things, whitefellah treatment; they cannot be fixed the Aboriginal way. Thus, Aboriginal women accept that western medicine and western obstetrics has a place alongside their traditional Law:

> Old generation, long time ago, when people had no doctor, they had babies with no trouble. In the new generation, young mothers have problems like kidney trouble, some have diabetes, some have high blood pressure and other diseases when they are pregnant without even knowing.
>
> Now I see very young girls getting pregnant and they have lots of sickness, miscarriage.
>
> How can we go back our own way, the old way? Nearly all of us, we've got diabetes, we've got lung troubles, blood diseases, and now we've got a new generation of young people, and we're trying hard to make a way.

At one meeting, the Aboriginal women referred to the secondary consequences of the Emu Junction and Maralinga bomb tests, a recent legacy left by the whitefellah:

> Some of them might be weak because of being close to Emu Junction and Maralinga. Because of all these people they live close to where Maralinga was, and some of the kids of the younger generation are growing up. Some of them have got a weak heart, and some are real delicate. Some of them are not well. Some have weak hearts or blood pressure or anaemia so they say they shouldn't try the old way.

Alcohol was identified as a problem caused by the coming of the white man, causing illness and affecting maternal care:

> Women drink grog and the baby is born skinny and tiny one, that's right, and nobody looks after him. Not looking after kids while she's mad for drink.

Borning Practice Today: Aboriginal Resistance

The Aboriginal women recognise that these changes have led to the need for new childbirth practices. Having accommodated two notions of illness, Aborigines have accepted two forms of treatment: indigenous and western. The borning practice of

Aboriginal women today in the Centre is largely to have hospital deliveries. The official policy of the Northern Territory Department of Health is to encourage Aboriginal women to have antenatal check-ups and hospital deliveries, the whitefellah way. Given that the department has white and Aboriginal medical workers stationed on remote communities monitoring the progress of pregnant women and that it controls all the resources, for example, the Royal Flying Doctor Service, ambulance and clinics, there is no official alternative for Aboriginal women. An Aboriginal health worker on a remote country camp typically describes her role and the sisters in relation to pregnant women:

> I'm the health worker here at Nyrripi. Two of the sisters from Yuendumu comes out every fortnight. We then see and check the pregnant womens. They don't come and see me. They feel shy. Only the sister check up on them, and they usually take medicines out here for the womens. Then I give the womens their tablets. Later, maybe when they start getting pains, I usually take them into Yuendumu and then to Alice Springs Hospital or I radio for help. Someone comes out to get the patient, take them back to Yuendumu and get them on the plane to Alice Springs. I give the medicine. They don't usually tell me if they're pregnant. I see them if they are fat. I tell them to tell sister so that they can have check-up and tablets, 'the sister and I know you and look after you', because she might have early baby like X. She only told her mother at Emu Bore. I didn't know that she was pregnant. I thought she was sick. Then I heard other radio that she had baby. They get shame, and they don't tell us. Others tell their mothers. That's all. They don't tell me.

Another Aboriginal health worker described the role of the sister employed with the Northern Territory Department of Health on a remote community: 'Sister comes here and tell them you have to go to big hospital. The sister tells them what month the pregnant woman is going into Alice Springs.'

The whitefellah way is primarily accepted by Aboriginal women on the basis of safety, emergency and symptomatic relief, albeit with great confusion and widespread misunderstanding. Sometimes, however, the baby comes 'too quick' for those women who intended to use western obstetric care:

> But if it happens real quickly, will have the baby in the older way they used to do it. Like it happened here one day, we still had the hospital here, but it was too late. Her baby was born on the ground.

Women distinguished between 'young' women, with 'first baby' or 'sick' women who need whitefellah care as opposed to the 'older' women or 'healthy' women.

> I have two older sons and one younger son born at Yuendumu. We didn't have any problems. When they have problems maybe fifteen to sixteen maybe they should have it the whitefellah way.
>
> If the woman is sick she might have to spend time in hospital or if the baby is sick.
>
> Nowadays these young ones with skinny hips have babies in the Alice Springs Hospital.

Aboriginal women, however, have fundamentally resisted the whitefellah way, primarily trusting the time-honoured and ancient borning practices of their Grandmother's Law. In many cases, the rites and rituals, for example, smoking ceremonies, are continued following the interruption of the hospital:

> Even after they come back from hospital we do the same thing to all babies. We smoke our babies so they will grow strong and not get any sickness.
>
> When the woman have a baby in the hospital we tell sister not to worry about her because we will look after her. When the baby and woman out bush to put through warm ashes and smoke. When baby and mother come back from Alice Springs Hospital they come back weak.
>
> I am saying that I am from Papunya and my name is Gladys. The children from there. The young girls they came here to this hospital to have their babies. When they have their baby, they wait until the baby is a bit big, and then they take the baby back home where we wait and put the baby in the smoke. I put my daughter in the smoke too. I am a mother, and I wait and put the baby in the smoke. That's what I do. I don't leave it for later. When she lands from the plane, I take her straight away to the smoke, and I do not take them straight away to show the father. Only at night they get together to sleep. That's the way it is. That all I can say.

The lack of trust in and acceptance of western obstetrics is manifest in the women's belief that the baby may be left 'mad' or 'sick' following the practice of a hospital delivery. The women, in these instances, will always practice traditional borning rites on their return to their communities:

> The sister told me to go home. I got home. My baby started crying a lot. Then, I thought the baby was mad. Straight away I was told to take my baby out bush to put baby in smoke.

The number of bush babies born on the ground varies from place to place, and greater numbers are found where sisters are absent and in places where the traditional Law is strong, namely on country camps or Aboriginal-owned cattle stations. In every meeting, women pointed to and named with great pride the number of fat and healthy babies born on the ground with their help.

Thus, the white official caretakers have trampled on traditional Aboriginal borning practices by a one-way service delivery, and Aborigines have resisted by accommodating the whitefellah way alongside the Aboriginal way. In detailing their preferred practices, the women give a more comprehensive account of their actual practices. It will become clear that the hospital experience is considered most undesirable and inappropriate.

Hospital Birth - 'A Proper Shame'

Hospital birth, for a number of cultural reasons, is often regarded with great trepidation. The hospital experience is usually a highly traumatic one. Hospital deliveries are so alien to Aboriginal women that they constitute a gross injustice. Not only do Aboriginal women hold radically different beliefs and practices from whitefellahs but they are condemned to have a child in a silent, fearful and unknown world. The 'loneliness' of Aboriginal women is exacerbated by the absence of warm, supportive women and confirmed by the use of English as the main language, with no assistance from interpreters, and by the essentially unknown and terrifying paraphernalia of technology and gadgets. But worse than this are the assaults made on traditional autonomy, the Law, the Dreamtime and the country. Women are 'shamed by man-doctors', and they lose 'their baby's place', forsaking their Law and suffering great indignities because the whitefellah doctors give them no choice if they want to have 'healthy babies'. The flowers and smiles that brighten the hospital rooms of European women are not found in the rooms of Aboriginal women. Most of the Aboriginal women 'run away' the next day back to their own country.

The stories of the women have been recorded at some length. In their recall of the hospital experiences, the Aboriginal women have redefined the crux of the borning problem. Their fear and bewilderment shapes their non-compliant behaviour and high absconsion rates. Each violation is a form of malpractice against their traditional Law. The Grandmother's Law underlies each practice, uniting them into a cultural whole. They have been distinguished in the following pages, in fear of violation, for the sake of clarity and emphasis. Ultimately, what the Aboriginal women are saying is that there is no traditional Law in the Alice Springs Hospital; barbarism prevails.

I am talking about this morning and yesterday and about long time ago and not too long ago. Long time ago the Law has disappeared for all the people of the east, west, south, north. Our Law just finished long ago. Long time ago our Law was lost. The year the white people took all the half-caste children away to Adelaide and other places that's the time our Law finished and whitefellahs broke the Law of the Aboriginal people. Then the Aboriginal people forgot their Law. Whitefellahs built houses, hospitals. The Alice Springs Hospital was the main one. Doctors and sisters use to go to lots of places and used to send the pregnant women to the hospital. The women were frightened, lonely, homesick and shamed when they had to go the hospital. That's the time when our Law finished.

Other women get frightened at the Alice Springs Hospital. That is not good. Our Law has vanished. The white men have spoiled our Law. Because long time ago, they have taken our Law away.

Man Doctors

The old-time borning way, by the Grandmother's Law, is directed and carried by Aboriginal women, in the security of ancestral tradition and the warmth of the Alukura. Only the women participate and assist in childbirth, which they do in a non-invasive, supportive, dignified and knowing way. Thus, for Aboriginal women to be attended by white male doctors, in compromising positions, is a gross cultural shame:

> It's embarrassing when they put your legs apart when it's time to have your baby when man doctor's there.
>
> It's now allowed the old way, for man doctors to see another man's wife having baby.
>
> Man doctors shame. Aboriginal women never had men anywhere near while they gave birth because it was women's business. So men kept away from the birth place. Only women allowed there. Now the white man doctors make a woman shy when they deliver their babies.
>
> Sometimes the male doctor helps them to get baby out. But it's not a good idea. It's shame job that male coming in when having that baby. We know that he's a male doctor and a white doctor.
>
> Like in Alice Springs Hospital, her husband might come in to see a male doctor standing

next to the bed. He might start to get angry with her, and she'll run away from the hospital.

At the big hospital they get shamed of doctors and sisters when they try to force open the legs of pregnant girls.

We don't like man doctor, we like woman doctor. We get shamed.

It's really embarrassing for a man doctor to see old middle-aged private part when she is having a baby. Before they didn't do that sort of thing. Like in the old days. Some women used to sit behind her and rub her back while she is having her baby. We never used to look at her private parts suspiciously.

Because of them male doctors. They sort of frighten women. Only woman doctors should see her that way.

They don't like to see the man doctor. They like only the woman doctor - they get shame. Olden times, man never come close up to see woman. The man gets shame. Man doctor this time, he is looking after woman. They get shame.

Doctors real rough ones and sisters get rough. Man doctor big shame for us. I used to speak up and tell the sisters off when the man doctors weren't there.

We get shame when male doctor see us when we having baby. Makes us feel no good.

'Lonely and Homesick'

Many Aboriginal women who deliver in the Alice Springs Hospital are a long way from their country, husband and children. They are not comforted by the familiar and knowing faces of their grandmothers and aunties, who are present in the Alukura borning business. The women 'feel lonely and homesick' and they are left alone to cry. Their loneliness is compounded by having to deliver in a culturally estranged place:

I was too shy. I was too shamed. They left me by myself and no one was with me and they just let me sleep by myself.

I used to get homesick. Sisters used to tell me not to get homesick.

> When they go to hospital, they get lonely. No mother, sister or relations. In hospital thinking for grandmother and mother. Thinking they might die.
>
> When she was young she was pregnant. She was told to go to Yuendumu to have her baby. She said, 'No.' She was lonely to leave her country. I wanted to stay. I was forced to go to Alice Springs. I cried.
>
> No one helps her, not even the nurse. And there she's having all this pain, and sometimes get very lonely. Like, there's one woman who I maybe rub, and she'll better then. Grandmother or sister should be there, old way They should take her there.
>
> I didn't want to leave my other children behind. I was still forced on the plane. When I go there, I had my baby after a week. I was getting lonely in hospital. Then some of the ladies in hospital I knew spoke Warlpiri. That made me feel better. Then one of the ladies told me not to run away. That I'd get very sick. I told them I would run away 'cause I really wanted to go home. Then my husband came and saw me in hospital. I was lonely to see him go. I was very lonely, homesick and cried to go home.
>
> When the doctor used to say to me, 'Oh, you can't go home', I'd feel like crying. Because I feel like going home, because I lonely in there.
>
> The young ones go to hospital and when they go in there they get real lonely because they got no company. That's why they get frightened.
>
> At the hospital they put you in a room by yourself in pain, screaming and crying, while the sisters are talking and there is no one there to help them.
>
> In hospital, when they put 'em in labour room they get lonely and cry for mother.

The social and cultural isolation experienced by the Aboriginal women in Alice Springs Hospital is intensified by the absence of medical staff who can communicate in language and by the absence of interpreters:

> There's no interpreter in the hospital. There's only white people.

> Mothers from the outstations, they don't speak English. It's lonely for them.

Not surprisingly, the fear generated by aloneness and exacerbated by cultural alienation frequently compels the Aboriginal women to abscond from the Alice Springs Hospital:

> Some bring the baby without asking sometimes, when the baby is in the glass, they still get it out and run away with the newborn baby.
>
> They take off at night with the baby. And doctor looks around and says 'That bloke took his wife and newborn baby from here.'
>
> When they come into big hospital, the husband always take them away when they get lonely and no relatives and no one to talk to, and they run away.
>
> Why all the blacks leave the big hospital? Because some are frightened. She is frightened because she is by herself there, and she don't know what to do.
>
> Then when they go to the big hospital sometimes, they get lonely and homesick. They run away. Like from Ernabella or from Amata. They run away with baby and they can find them there. Because they get real lonely there. That's why.

Operations/Medicines: 'We Don't Know'

Hospitals are usually associated with surgery and operations. Many Aborigines fear or oppose surgery, for there is no corresponding treatment in the traditional health system. Furthermore, Aboriginal women are condemned to a powerless idiocy in the absence of knowledge and understanding of the various procedures, operations and medications used in western obstetrics. Many women do not understand the necessity for caesarian operations or drips which make people 'weak'. Women don't know what is going on and despite their 'compulsory' acquiescence in medical procedures, a fundamental distrust of whitefellah ways is apparent:

> And there was this woman from Utopia. She didn't know what was going on, and the doctor and nurse took her to theatre, and she fainted. And she cried a lot. All night, 'Help me, help me, don't let me be cut open.' Lucky I knew her, so I could talk to her. Next day, after the operation, she ran away from the hospital with her stitches and left her baby there. Why they cut her? She had her first baby all right.

When I just went in to the Alice Springs Hospital I a bit scared and shamed, and doctors didn't tell me anything. I asked the sisters. She didn't say anything, and there were too many doctors around and no one to help you.

I got real skinny in that hospital. I got this awful infection in the back. It was horrible there. Another woman got crippled by that injection for good.

When I was in big hospital, I was scared and worried. The older ladies from Utopia and Pitjantjatjara side, they were scared, and the doctors say it's all right to have operation, and they didn't like it. They want Aboriginal ways instead of white people's. They really want their culture back. They keep asking man doctors if they can go back and they say, 'No, you have to be cut open.' The woman are scared. They don't want to spoil their bodies. They don't know what's going on in hospital. It's a big shame.

I was really scared if they do operation on me. I will die. That why. When they took me to operation I was scared. But they put me to sleep.

Like today they're going to the big hospital. Then over there they have operations, then they get the baby out. That's real sad thing. Poor thing, poor thing.

If the woman has her baby in Alice Springs and she has trouble, the doctors watch, and then they decide to have operation on the woman. Maybe the baby dies or gets very sick. Some woman don't want to stay at that place if she lose her baby.

At big hospital they don't do the things we used to. They just waste a lot of blood. They are still sick there. Next time they'll check you they'll say, 'You got no blood.' That way it's better to do our way. And then they send her back to put drip-in medicine.

Yes, I was crying in the labour ward, and my blood pressure went up. I thought I was going to pass away. I didn't know what was going on. Doctor comes in and says, 'Hey, what are you crying for?' 'I don't know what's going on.'

'Doctors Don't Bury that Baby Bag'

According to the Grandmother's Law, the baby bag (placenta) is buried where the baby was born on the ground, linking spirit child, woman and country. The medical staff in the Alice Springs Hospital put the baby bags in rubbish bins for incineration. To the Aboriginal woman, this practice represents a great sacrilege to their Law:

> They say that when they have babies born in Alice Springs Hospital they have operations and then they throw the baby's things [placenta] into the rubbish. Even when some people go to the rubbish dump, sometimes find them things there. That's no good. Make us feel sad and upset.
>
> Today, in the big hospital, the man see that; before only woman see that thing [placenta].
>
> When they have this operation done, the doctors throw that baby's thing [placenta] into the rubbish. Sometimes they burn them or sometimes they just throw it into the rubbish bin. We call that baby's thing [placenta], that baby's home or place.
>
> In hospital they burn it [placenta] in the rubbish bin. That's why some get sick.
>
> Before we buried them [placenta]. When they burn them at the hospital, they get sick.
>
> We are thinking about this. In Alice Springs Hospital they treat the womb like a bit of rubbish. They throw it in the rubbish dump. Or maybe they throw it away in the drain. They burn it too. We've heard that story down at Kalka.

'They Shouldn't Cut Them That Way'

Another practice that violates the traditional borning Law of Aboriginal women is the way in which the umbilical cord is cut by the medical practitioners in the Alice Springs Hospital. Aboriginal women prepare and cut the cord in a particular way and at a certain length:

> Sisters shouldn't cut them that way. They get sick. But when cord itself breaks, that's real good for baby.
>
> The baby gets sick if the cord is cut too short. They put on those great big plastic clamps and pull it off before the cord is ready to come off. The cord should be there longer.

Waiting

A number of women referred to the waiting delays in the hospital which can cause shame: 'Sometimes they get shame in the big hospital when they are waiting for their appointments. And some of them go into the hospital and wait and wait.'

Women, however, appear to be more concerned at the lengthy time spent in Alice Springs while awaiting delivery. Transport on a weekly mail plane can increase delays for women travelling to and fro from remote communities. These delays unnecessarily increase loneliness and homesickness.

'Too Soon'

Some Aboriginal women expressed the concern that hospital deliveries have led to new practices that violate traditional Law. Here, the women specifically refer to the practices of well-intentioned husbands coming to visit or to pick them up, leading them to see the wife and baby earlier than they do when the women deliver in the _Alukara_:

> But today the father go into the hospital and old the baby. That it is not good. And they go straight to the husband.
>
> Not like big hospital. Father can go straight away and look at the baby.

Drinking

A number of the bush women referred to the problems that drink in the town area can cause for themselves and their husbands. This concern stems from being away from their country in a strange land:

> Some women from other area, while in hospital waiting for the birth of the baby, often have run away to go drinking.
>
> The young women, when their husbands arrive in town and drink and then turn up at the hospital drunk. All the woman wants to do is run away and go home.
>
> Sometimes some of the husbands go to visit them there and also ask for money when they're drunk. Sometimes this makes them frightened, and they feel upset. Sometimes, some women when they have been sent to hospital to have baby, drink wine and get drunk. Some of them go and get drunk before the baby is born. That's no good.

It is clear that Aboriginal women do not object to the practice of western obstetrics _per se_, but to particular manifestations of this practice, for example, 'man doctors'. It is clear that the way of having babies in the Alice

Springs Hospital is culturally inappropriate and shameful. Equally, it is clear that changes could be made to ameliorate the shame and the practice of cultural genocide. Many of the practices of western obstetrics are dispensable. The cultural barbarism displayed in the Alice Springs Hospital in relation to pregnant Aboriginal women has very little to do with 'healthy babies' and arguments about medical safety.

It is now opportune to review the beliefs expressed by the Northern Territory Department of Health medical caretakers in relation to the borning problem. The importance of these beliefs cannot be underestimated, for they shape the policies, structures and practices of western obstetrics at the point where they interact with borning practices.

Medical Dominance

The following accounts from the Northern Territory Department of Health employees reflect an overwhelming faithfulness and unquestioned adherence to the delivery of western obstetrics. The outcome of obstetrics in the Centre is based on the abnormal and negative aspects of birth. The virtues of medical dominance and crisis intervention are particularly legitimated in the Centre because Aboriginal women are at 'high risk', evidenced by the comparatively high infant mortality and morbidity rates. The certitude in the appropriateness of western obstetrics had led to a devaluation of traditional borning practices. Thus, cultural power is exercised by the non-Aboriginal medical agents, as it always has been, but it takes a different form today. The one-way delivery of western obstetrics, unmediated by a consideration of traditional borning practices, is justified by the arguments of medical safety and maternal and infant health. The contradictory statements made in some of the accounts, however, demonstrate some uncertainty and some awareness about the problematic nature of delivering western obstetrics in a cross-cultural situation.

Western Obstetrics

The official policy of the Northern Territory Department of Health is to encourage Aboriginal women in the Centre to use the Alice Springs Hospital for antenatal care and hospital deliveries. This policy rests on the acceptance that hospital deliveries have had a major impact on the infant mortality rates:

> Hospital delivery is obviously an important step to avoid problems, and naturally the impact is considerable. Compliance is coming more and more, and the perinatal mortality of patients is declining.
>
> Antenatal care encourages women to go to hospital for delivery. A hangover from the days of infant mortality, and it's safer from a technological sense.

> Encouragement is a better option. No one must be forced. In the bush, there is much more chance for disaster.
>
> We have an excellent obstetric unit. A specialised unit. Sheer madness not to accept it.
>
> Despite the cultural points of view, one gets the best clinical results in the hospital. In the early days, hospitals meant death for Aboriginal people, but today they are happy.
>
> In my time there has only been one bush birth, which should have been in hospital.
> 'Why?'
> 'Well, it's the policy.'
>
> Early assessment, early diagnosis and early attendance will improve the mortality rates. Very conventional western obstetric care is needed. Not anthropology or anything else. It's about new gadgets, new techniques, monitoring of foetal distress, and so on. It's worked and it's working. Anything else is turning the clock back. The first fifteen minutes of delivery is crucial, and so are the next few days. If you want a healthy baby you come in here and, for the best part, Aboriginal women have responded to this. I'm just talking as a working obstetrician.
>
> Yes, of course antenatal and hospital delivery has had an impact. The hospital deliveries go up and the mortality decreases.

Thus, the supremacy of western obstetrics in the Centre is sustained by the virtues of expertise, technology and success. That is, it's superiority is expressed in terms of its own assumptions, a symbolic universe that allows no place for other thoughts and practices.

In advocating the model of western obstetrics, the medical caretakers have defined the problems and prescribed solutions with self-assurance. Non-Aboriginal medical caretakers believe they know what is best for Aboriginal people, and they are reinforced in implementing services of a white manufacture and design, by their 'religious' belief in medical science. Thus, Aboriginal women have been portrayed as people with problems whose habits promote unhealthy lives. Individual culpability is seen as the problem, for 'they couldn't care less'. In a more acceptable version, it is said that the cultural differences of Aboriginal people, their Aboriginality, is the problem.

> If Aboriginal people want the same mortality as white people then they have to change their lifestyle like whitefellahs.

> Antenatal care. The problem starts with women not recording their menstrual period and so right from the start we do't know how pregnant they are. Health is no publicised amongst these people. Although the Northern Territory Department Health tries, in general they could not care less. Because, there is less understanding of the consequences. If there is any problem, it is in the budding stage because they won't come, they won't accept. They wait. This is a cultural problem because it is not normal for them to see people. Pregnancy is not normally expressed and so we have to pick up someone who looks big. There are naturally problems. I've been told that in more tribal groups, the baby is not accepted as a live object until he is born. Gradually people are getting to know about care.
>
> I wish for an easier way around the problem. But I have no idea. Having a baby for an Aborigine doesn't mean the same to you and me, as their babies are not accepted until born. They are so used to losing their babies.
>
> Before, there were disasters occurring without antenatal care and it was impossible to talk to women about antenatal care because they wouldn't talk about the dead and unborn and the cultural stuff was poorly understood and because no names were given for two years. This was a big barrier to improving mortality.
>
> The problems include: venereal disease posing a threat to the baby; bigger babies now due to adolescent pregnancies; prematurity; tendency to pre-diabetes; alcohol; low socio-economics; poor nutrition. These are white-orientated problems with many being able to be treated antenatally.
>
> I am concerned about the terror of experienced young prima gravidas who have no knowledge or education. Formal classes are not going to work.

The over-riding acceptance of western obstetrics has led the medical caretakers to stereotype the cultural characteristics of traditional borning practices, which are mistakenly seen to inhibit presentation. The focus on the individual determinants of morbidity and mortality or on the deficiency of the culture has blurred and obscured the underlying socio-economic and political causes of ill health. Moreover, it allows the medical caretakers to export a foreign and alien obstetric practice in a manner that is all-powerful and free from scrutiny. The lack of understanding on the part of Aboriginal women, according to this way of thinking, is produced by the limitations of traditional practices and not by the lack of cultural appropriateness and accessibility of western obstetric services.

Traditional Borning Practices

None of the Northern Territory Department of Health medical caretakers who were interviewed had a comprehensive knowledge of traditional borning practices. In keeping with the assimilationist way of thinking, it was said that traditional borning practices were no longer relevant:

> Only a trickle of women deliver in the camps and therefore only a few traditional practices are continuing.
>
> Aborigines are not tribal any more. They're just about more Europeanised than we are.
>
> X community is one of the most westernised communities, and the community likes the medical care, and they accept our policy out there. Apart from that, I don't know anything about traditional practices.

These comments reflect considerable cultural estrangement between the medical caretakers and the clients. The majority of Aboriginal people living in Central Australia live in a manner consistent with their traditions. The community referred to above, an Aboriginal-owned cattle station, is one of the most traditional communities in Central Australia.

Another medical practitioner justified his lack of knowledge on the grounds that traditional borning practices are gender-based. This was a surprising rationale, for this medical practitioner is an advocate of employing medical obstetric staff for Aboriginal women, regardless of gender:

> I know nothing about the traditional Aboriginal way. Dr X knows about the men in traditional obstetrics. Man and relatives are active spiritually, earlier on with singing, but I don't know about obstetrics in a traditional setting in a hospital. I haven't asked the women if there are any cultural traditions because of myself being a man.

Most Northern Territory Department of Health medical staff were unabashed about their ignorance of traditional borning practices:

> Traditionally, I know very little. Cultural aspects are taught within the midwifery training. I get the information from books and the people I have nursed.
>
> I'd just like to reiterate that the Alice Springs Hospital is a good place. I'm unsure if the nurses know the traditional ways. There is no in-service training.

> I haven't found out yet about tribal practices re birthing. Do you know? The grandmother or mother, as Dr X will tell you, are busy looking after their children. They are welcome, most welcome here, but they have a tremendous priority for their children.

Because of the absence of knowledge about traditional borning beliefs and practices held by medical caretakers, the interaction between western and indigenous medicine is barely considered. The absence of a two-way process is justified by the supposed heterogeneity of cultural practices among Aboriginal people or, alternatively, by the supposed individuality of cultural action:

> Culturally, I'm not sure what's important. There are conflicting stories among the Aboriginal women. Cultural practices vary from one place to another. It is difficult to find a blue-print for everyone.
>
> I believe they should be able to deliver the way they want to, but like with any culture, it is an individual action and one cannot talk specifically.

One senior doctor categorically claimed that a two-way process of obstetric delivery was inconceivable: 'I haven't a clue what an Aboriginal hospital designed for/by Aboriginal women would look like because a hospital is a whitefellah place.'

The compromises between western and indigenous borning practices, which have been said to have been implemented, are either inadequate, inadequately understood, or have not been encouraged.

> We try and give them dignity. We have a compromise position during labour. The women rest with two pillows which is not the classic position. Squatting is quicker, but all the theory books tell you there are many more complication.
>
> One of the sisters was interested in the request of the women concerning the placenta as no similar request had ever been made by the women delivering in the Clinic Hospital. We could sometimes wait till the cord stopped pulsating, but till the placenta is delivered it is not very practicable.
>
> Relatives are a good thing and the ward staff are open to them.

In keeping with the absence of a two-way process, knowledge about traditional practices are left to the 'exceptional individual' to acquire in private time:

> Staff are given credit for the amount of concern for Aboriginal people. Staff lack knowledge of geography, customs and culture, and there is no continuing education in Aboriginal matters within the hospital. It's up to the exceptional individual to follow up, for example, Institute of Aboriginal Development Courses, in their own time.

Man Doctors - Gender is not Important

The dominance of western obstetrics and the ignorance of traditional borning practices has led to a great cultural chasm between the Norther Territory Department of Health medical employees and their Aboriginal clients. It is difficult to reconcile the dismissal of the importance of female doctors made in the following accounts with the statements of profound personal and cultural shame made by the Aboriginal women. Only three departmental interviewees recognised that the attendance by male doctors may be feared by Aboriginal women. This recognition was qualified by the fact that the hospital is an alien place anyway, that Aboriginal women are gradually accepting it, the majority of staff are female and that it is difficult to generalise for all Aboriginal women:

> Women do get worried and frightened. Male doctors are a worry for them, especially vaginal examinations. They do cope better with white woman than white man. They are, however, accepting male doctors more.

> The male doctors are a worry... Females are more effective due to the rapport, but Dr X [female] is widely accepted in the hospital and two-thirds of the staff are female. One can't generalise about how the women feel. Some feel embarrassed.

The majority of the departmental staff interviewed, however, claimed that gender was not important. The prime considerations for Aboriginal women in relation to the doctor-patient relationship were said to be 'confidence, reliability and dependability':

> It is not a question of whether you are male or female. Well, acceptance is a matter of confidence, isn't it? The people don't know me [male doctor] yet.

> In general, the people are shy and like to talk among themselves, and if they're sympathetic and understanding then it's okay. I've seen male doctors who are sympathetic enough, gain the women's confidence. One has to accept the fact that a woman doctor would be their first choice because there is more

> understanding, but sympathetic males are acceptable. Reliance and understanding takes time, but once one gets to know someone we take it from there. Dr X [female] has enormous understanding and has really tempered her training for Aboriginal women. Women think she's great and really relax with her.

> No problem about him being a man. Dr X [female] has been a great success. The individual is more important than the gender.

Although most Northern Territory Department of Health staff claim that gender is not important in the interactions with a female Aboriginal patient, most referred to the advantages of having a female obstetrician employed at the Alice Springs Hospital. That is, the 'good rapport' supposedly established between these two parties depends precisely on the gender of the doctor! Most departmental employees, faithful to the model of medical dominance, have completely ignored cross-cultural context of their occupations and upheld the 'ideal' relations between doctors and patients. The basis of trust and confidence surely rests on knowledge and understanding. It appears, however, that Aboriginal women do not understand the beliefs and practices of western obstetrics and, moreover, because of the dominance of the English language, are limited in their communication with the medical staff.

Language and Communication

The following accounts were somewhat contradictory in relation to whether or not the Northern Territory Department of Health employees consider that there may be some language problems. Despite this confusion, most concluded that Aboriginal women can speak English and, in the event of problems, an interpreter service is available:

> Aborigines are not a voluble race, but things would improve with knowledge of what might happen during birth. They now have a good command of the English language, so interpreters would not necessarily help the problem... They don't tell us what they want and how can you find out when there are so many different languages? No one knows what an Aborigine wants to do in labour. But does she know? There needs to be more two-way communication and understanding.
>
> 'Is there a problem gaining the confidence of more tribal people due to language differences?'
>
> 'Oh, there is an interpreter service which can be used at any time. We have free access and we can ask for help whenever, if necessary.'
>
> 'Do you use it then?'
>
> 'No, we don't need to use it.'

> I'm sure women understand what's going on. Yes, I'm sure there is a big problem with language. Yes, language is a problem.
>
> All the women of the reproductive age can speak English. English has become the language which many people use. They know how to scream in labour, how to tell you to get out and that they're paining and ask you to pull that baby out quick. Language is not a big problem. I don't feel I'm up against a barrier with English. I can usually get through to people. I haven't got time to learn a language and, if I did, I'd have to learn Greek, Italian, and so on. I'd be a multilinguist with all the different languages the patients speak that I see. Aboriginals have more English than the new arrivals like the Vietnamese. I don't recognise that there is a language problem.

These accounts reflect an extraordinary state of affairs. It appears that highly educated medical practitioners are not able to ascertain whether or not there is a language problem. Some explain away the silence of Aboriginal women by the absurd generalisation that 'Aborigines are not a voluble race', exemplifying the ethnocentrism and social distance of the medical caretakers. Despite this shyness, it is said, Aborigines 'will make deputations if they are unhappy'. Other Northern Territory Department of Health workers say that most Aborigines speak English or enough 'to scream out and say get out of the labour ward'. Others make reference to the interpreter service in case of need.

A few reminders are salutary. At least 50 per cent of the Aboriginal women who deliver in the Alice Springs Hospital are tribal women who live in remote communities. Those who are not, may have a good command of English and the majority of rudimentary understanding of English. Many do not speak English at all. The interpreter service is available through the Aboriginal-controlled organisation, the Institute of Aboriginal Development. By all reports, this service is rarely, if ever, used by the Alice Springs Hospital. Moreover, there are few Aboriginal workers employed by the Northern Territory Department of Health in the hospital who can act informally as interpreters. Similarly, few relatives attend a delivery and so there are few other informal interpreting channels available.

The confused nature of these accounts suggests that language and communication is a very real problem in the Alice springs Hospital. Surely a cardinal ethic in the doctor-patient interaction is the ability to communicate effectively? It is no wonder that one medical caretaker said, 'No one knows what an Aboriginal woman wants to do in labour.' It appears that many Aboriginal women are condemned to deliver their babies in solitary confinement.

People who have been ill in foreign countries may begin to understand the 'terror' of not being able to communicate in English and understand the diagnosis and the treatment.

Interpreting services in most Australian states are recognised today as an essential service, particularly in health care. The absence of an interpreter service, let alone any Aboriginal health workers, in the face of language difficulties, provides on tangible indicator of the cultural chasm that exists between the non-Aboriginal, medical, agents of western obstetrics and their 'shy' Aboriginal clients. This ethnocentrism is again symptomatic of medical dominance.

Hospitalisation

The full implications of the cultural differences between western obstetrics and traditional borning practices which lead Aboriginal women to 'feel shame, proper shame' delivering in the Alice Springs Hospital were not acknowledged by the Northern Territory Department of Health staff. The responses generally fell into two camps. In the first, the accounts tended to be ethnocentric, for it was assumed that Aboriginal women hold the non-Aboriginal values of hygiene and comfort, for example, in high esteem. The discomfort caused by cultural differences was likened to the discomfort experienced at a dentist or using a lift for the first time:

> In the hospital, it's much more comfortable where they're fed and washed. Some young women really want to have babies the white way, being in the hospital and with the help of sisters. It's less hassle, just less hassle... Aboriginal people are very easy with white medicine... Also, they love their little babies and want to see them healthy and so they see the Alice Springs Hospital as doing a pretty good job.
>
> The hospital was designed in Melbourne, and it has its constraints, but it is technically appropriate. It's all part of the changes that Aboriginal people are going through like getting used to the lifts in the hospital.
>
> The women felt that going to the hospital is like going to the dentist. It is not particularly pleasant, but it is necessary for most women.
>
> The question is about acceptance, and they're learning to accept the hospital. They might possibly want to be more spread out and be more outdoors, but they are accepting that care in an institutional situation must have certain things like buildings, and so on. Take the lift, for example. I have seen people terrified of it and looking for the stairs, and one week later they are using the lift.

> It's obvious that Aboriginal women have had to make adjustments coming to the hospital, which is very different. But they like the hospital. They come here because they are safe. They feel safe. They say they're 'paining' or make excuses just so they can come here.
>
> It is a good hospital, but it is geared toward western society. The old hospital was more geared for Aboriginal people, so it's a shame. The positive aspects of the hospital are not accentuated while the negative aspects are. Health care has improved 100 per cent for everybody.

The two accounts that referred to the 'terror' that lifts in hospitals can cause Aboriginal people are illuminating. First of all, the equation of making an acquaintance with a life and giving birth in a culturally appropriate place is extraordinary in its failure to acknowledge the significance of the birth process. The fear of lifts for Aboriginal women must pale in comparison to the fear felt by the jungle of technology, gadgets, beeps, drips, white coats and foreign dialects that surrounds them during delivery. There appears to be a major discrepancy between these accounts and those that refer to Aboriginal women being 'easy with white medicine' and 'feeling safe in the hospital'.

In the second place, special problems for Aboriginal women delivering in the Alice Springs Hospital were not recognised. These views are based on an appeal to the commonality of human nature, found in the remark, 'No one likes going to hospitals', which is equivalent to saying, 'There is no difference between black and white clients:

> No doubt the less-pleasant aspects of hospital delivery would apply to non-Aboriginal people.
>
> I can't say how an Aboriginal woman feels. They have individual opinions just like anyone else. The hospital is a good idea due to the problems, and the hospital gives the care they need.
>
> Do you like being in hospital? (No.) Exactly... Don't assume that Aboriginal women hate the Alice Springs Hospital any more than white people do.
>
> Tribal areas are surely a problem we are concerned about, but people come from Ballarat and Tasmania, and so it's the same for them, white or black. Just a strange feeling being in a new place.

Apparently, Aboriginal women in Alice Springs are 'learning to accept and are learning 'to make some adjustments'. How is it then that fears can inhibit presentation and lead to death?

> There were two maternal deaths at the hospital last year. Both the women refused our help and refused to come in. They stayed out by the bushes. They died and their babies lived.

This medical caretaker was at pains to stress that 'it's their choice':

> If they don't want to come here, it's their choice. They don't have to and no one forces them... When Aboriginal women decide to leave the hospital, it's because they're ready to. They're busy... They can have their babies out bush if they want to. But if they want a healthy baby, they choose to come into hospital. It's their choice. They can choose.

Few people willingly choose 'fear' or 'death'. The choice is presented as 'fear' or 'death', which is hardly a choice. The truth is that the choices are constructed by these medical authorities who cannot work with or 'imagine' other approaches.

> Women you should think about other young women, I tell you about my young daughters. When a young woman have a baby, even if a baby dies, they don't even go and visit the doctor or go back to see the doctor any more. If the young woman had lost her baby, the baby dies, the woman don't want to go back to the hospital, not even for a check-up, after birth.
>
> I think the doctors don't explain what might have happened, why the baby might have died.
>
> Some time the young woman don't want to stay at the hospital.

These words are a strong indictment against the delivery of western obstetrics, a one-way process, in a radically different cultural context. 'Fear' and 'death' and a lack of knowing makes the Aboriginal women 'run away' or 'stay away', sometimes leading to further death. These are the harsh consequences for the powerless Aboriginal woman, upon whom alien beliefs and practices have been forcibly imposed. And then, these Aboriginal women must live in silence in their shame. Culturally inappropriate western obstetric practices, in generating this fear, are contributing to and reinforcing the high infant mortality and morbidity rates. Under these circumstances, how can 'hospital deliveries' be equated with 'safety' and 'healthy babies'? It is a form of cultural genocide that has severe consequences for the ill health of Aboriginal people.

> In olden times we had Alukura and Congress Alukura the same.
> They like to have this baby on their grandfather's and grandmother's place because that's their own place as well.

Aboriginal women have engaged in passive forms of resistance in borning practices and have maintained their traditional Grandmother's Law, which is practiced when babies are 'born on the ground' or following delivery at the Alice Springs Hospital. Mostly, however, by virtue of an official policy of encouragement, Aboriginal women have been restricted to the services of western obstetrics. Their indigenous beliefs and practices have a de facto and illicit status and are not recognised in the available health care services. Thus, Aboriginal women have been coerced to use culturally inappropriate services that are intimidating and alien.

Western obstetrics have not alleviated infant mortality and morbidity or guaranteed safety for complications that are a consequence of people living in Third World conditions. Thus, the rationalisations that have been employed to defend the delivery of western obstetrics in a one-way process have been shown to lack conviction. The unswerving belief in the superiority of medical dominance has been largely responsible for the health infrastructure in the Centre and the outcome of ill health.

The World Health Organisation

The World Health Organisation has been promoting the use of trained traditional practitioners, as one among several approaches, to meeting the basic health needs of people:

> The health needs of women and children, particularly of those living in the rural areas of developing countries, are not being adequately met. Infections, malnutrition and the complications of pregnancy and childbirth continue to take a heavy toll of life for many reasons, among them inadequate health care coverage, poverty, ignorance and changes in the social environment.(1)

Fully-fledged recognition of traditional borning practices has been granted because of the 'deficiencies' of the mainstream health services, which include:

> lack of or weak health infrastructure, as a result of which the majority of mothers and children in any developing countries either lack health care or receive a type of care that is not proportional to their essential health needs...

> distant location of village communities from health facilities...
>
> lack of effectiveness of the system of education of health personnel to suit the health needs and available resources of the country and provide preparation for facing health problems...
>
> reluctance of health personnel to accept elements of local culture - traditional healers, birth attendants - as participants in programmes aimed at the promotion of health, and to regulate their training and practice...
>
> lack of effective community participation in health programs.(2)

These 'deficiencies' are congruent with the outmoded childbirth practices of the Northern Territory Department of Health in a cross-cultural context.

These 'deficiencies' have contributed to the World Health Organisation re-examining the role and practices of traditional birth attendants (TBAs) and how their services can work with those of the formal health services. The World Health Organisation has not implemented the integration of traditional practices with mainstream services:

> Allusion has been made at times to the notion of 'integrating' the TBA into the organised health system... If by integration is meant that TBAs should be so intimately connected to the organised health system that they finally lose their identity as perceived in the traditional sense, this might well lead to conflict between the TBAs and other categories of health personnel in the organised services, as well as between TBAs and the communities they would be expected to continue to serve. Integration in this, the true sense of the term, should be avoided at all cost, since it would defeat the purpose of programmes to extend health services to underserved populations...
> Thus, the question should not be one of defining the role of the TBA in the modern system of health-care delivery but on of defining the role that the modern system can play in helping TBAs to perform more safely those tasks they generally perform on the basis of mutual help and humanitarianism.(3)

Thus, the strategy adopted by the World Health Organisation, calls for trained birth assistants to work with the health-care system and progressively to assume the task of promoting and improving health care, particularly during pre- and

postnatal care, delivery, and care of the newborn and of children. The general objective is 'to reduce maternal and child morbidity and mortality'.(4) Most trained birth assistants are middle-aged women or grandmothers who have earned the confidence and respect of their communities. There are training programmes, they are paid and co-ordination mechanisms have been implemented between the trained birth assistants and the mainstream services. Recognition of indigenous borning practices alongside western obstetrics in the past decade has proved successful in many developing countries, including Ecuador, the Philippines, Sierra Leone, Sri Lanka, Sudan, Honduras and Thailand.(5)

According to international health standards, there is no apparent reason why Aboriginal women must resort to actions of passive resistance. Passive resistance has occurred because Aboriginal women have not, if ever, been systematically consulted about their preferences and because obstetric services have been delivered to them on a one-way basis. Aboriginal women do have preferences, some of which are congruent with official policies; even when this is the case, however, funding priorities often do not permit Aboriginal preferences to be taken into account. It will become clear that Aboriginal women do have very comprehensive ideas on how the borning problem can be partially resolved and how an incorporation of western obstetrics need not constitute shame. Their preferences, despite some differences, are congruent with those granted by the World Health Organisation to indigenous women in Third World countries.

What is striking about the following accounts was the extent to which Aboriginal women elaborated on their preferences. The simple question asked was, 'How and where would women like to have their babies?' This subject, more than any other matter raised in the research meetings, received the most spontaneous, voluble and earnest attention. This was surprising given the reticence usually attached to women's business and the fact that women are not used to participating, whitefellah way, in discussing problems and solutions. The following accounts serve to illuminate the borning problem, the limits and merits of current practices and prescriptions for future initiatives. The repetition of the accounts is a testimony to the continuity of the Law and the shared nature of common problems.

Congress Alukura

All the women in all the communities visited and during the conference, vigorously discussed and strongly endorsed the option of a Congress Alukura where women can deliver babies the Aboriginal way and with the advantages offered by western obstetrics. What the Aborigines mean by a Congress Alukura is a women's place, controlled by the Central Australian Aboriginal Congress, where normal deliveries can take place, without disrupting their traditional practices.

Reassertion of the Grandmother's Law

The underlying motivation and basis for the planning of future childbirth services is the reassertion of the Grandmother's Law and a return to it in service delivery:

> We are black women. Our Laws have been taken away from us, but now we will take our Law back and make sure we keep it. We all want this. Black women can take care of our ways at the Congress Alukura.
>
> We want to make Congress real strong for us and for our children's children.
>
> We are going back to that same Law before.
>
> I think today there's a new generation, for the old way. It's a bit hard for you and me today, but we can try. Let's try... We're looking for our way, anangu way.
>
> We're just talking to Mimili and Indulkana about how we want to try back the old ways.
>
> And we going back to our Grandmother's Law. If we think really hard, we may be able to go back to that grandmother's Law. We might leave that big hospital and follow our Grandmother's Law.
>
> I don't know whitefellah way now, we all go along doctor. But we got to go back like that early days, we got to start off now. We got to finish long hospital. We got to have our Law and finish up whitefellah way.
>
> These people were talking and want us not to forget our grandmother's Law, but to keep the old Law.
>
> Women from all over the country, we all have one Law. Today we all would like to have our Law here in Alice Springs, so that it will be her for us. So that women from all places can come to the Alukura to have their babies.
>
> We all women. We got one land here and one Law.
>
> We should keep our women's way, should have been in the olden days. That's the proper way to do it, here at Congress. Some of our kids are from bush, and we want to keep on doing our olden ways from long time ago.
>
> These young women should take note of how it was done years ago. We would like our young

> women to learn how to deliver babies so they can carry on teaching one another; their younger generations like our elders taught us.
>
> They like to go back to the old Law. They don't like it now.

<u>The Role of the Grandmothers and Aunties</u>

Aboriginal women want this traditional Law maintained by the grandmothers and the aunties who can pass on their knowledge and provide communicable support to the younger generation during delivery:

> They can have Aboriginal way at Congress <u>Alukura</u> because in the old days they used to have babies in the <u>Alukura</u>. They can teach them the Aboriginal way while they are at the Congress <u>Alukura</u>.
>
> We want to know from the older women who had delivered babies before us. We want to learn more about it.
>
> They can build a place where the grandmothers can help deliver the babies. They can have our grandchildren there. This is really good because they are trying to work the safe way for the future.
>
> So they need this birthing centre so their aunties and sisters and grandmother can follow them and stay with them. Because they need help. They need people to talk with them, to make them happy and healthy when they're having their babies.
>
> Well, she tells herself to her sister, 'I am ready now', and sister takes her to Congress. A lot of women there, they will help her to have baby. Like she might know that person well. She might ask her to go with her. 'Oh, I got person I know well. She will help me to have baby come out. She helped me before.' That's way now... Cousins and grandmothers can go with her to Congress. They can pay them.
>
> Congress <u>Alukura</u>, we strongly want it. Grandmother, mother and sister-in-law to look after the mother at Congress before and after birth and also during birth. Congress hospital have to be like old way, bush way. This idea is good idea, this <u>Alukura</u>. We want it real strong so that our young woman can learn old way if they want.

> Congress Alukura that makes me think very good. When talking about Congress maternity ward, that important for Aboriginal people 'cos people from outstations not understand English very much, and they don't see Europeans very much, and grandmothers and aunties can go and make the woman happy, see a lot of Aboriginal people and talk with one another and more Aboriginal way then.

> We were thinking about having a hospital in the Congress yard, a maternity ward there for womens from the bush come in have their babies, instead of going to the big hospital. We'll be happy to have our own Aboriginal hospital. Only the native women who is employed at the Congress can assist the women in pain and deliver the baby, clean the women and baby afterwards; she has to stay there all the time. That's how it was in our time. Now this time it's different. The young ones go into big hospital to have their babies, but we want an Aboriginal person to be there when the baby is born, and they can do it their way not the white people's way; that's what we had in mind all the time. I had all my children here at Amata clinic. I didn't go into Alice Springs.

> Maybe, too, Congress can help us to go out bush and get more Aboriginal things or collect Aboriginal ladies to help us and for the younger ones who don't know.

> In old times the women make a windbreak at a single woman's camp, and at Congress they should make a big single women's camp, and when ladies are ready to have that baby they should go to that place.

> That's right. We would like to see a place where women can feel happy to stay at while she have her baby. They want white women doctor and sisters and also Aboriginal women.

Female Staff Only

The Aboriginal women want to be attended only be female staff, including medical practitioners:

> We don't want man doctors to be there when they are having baby. It's embarrassing thing to do. We don't want to go to the big hospital. We want to go to Congress because it is an Aboriginal hospital. Because at the big hospital they get man doctors, but here, at Congress, they can take our own relations to help us to know what to do our own land way.

> We don't want man doctors to patch things up when they had a baby. They should go under smoke to make them tough inside. Our way... man used to see women all the time, and that's why Congress people feel sorry, because man doctors used to see women's private parts. They used to play around tummies of pregnant women. That's why we don't want man doctor to see us pregnant women. Only women doctors and our own witchdoctors to come and see us when we are pregnant and also when we are have our babies. Women doctor and sister will be there just in case we need help. We keep women's way like in the early days.
>
> When they go to big hospital where they have operation and there also stand male doctor and kids get frightened. We would like Congress to do something about this. Only the female is allowed to see her, and that means woman to woman. That's good. Only woman can see her there. They would like to take their mother or grandmother there They would like that. And she can be there with other child, so when baby is born, the other child will see she had a baby sister or brother.
>
> The young mothers, their mother or grandmother can look after her, and they can come back together with baby. Don't like man doctor or nurses; they can smoke them born, and mother can have lots of breast milk for that baby.
>
> We don't want men doctors to come in when we are about to give birth. We want the sister to be there with us, not men doctors, only sister or a lady doctor to be there, but the men doctor go and see the woman and then go straight out of the room, and come back later to see the mother and baby. We want Congress to make a hospital for us bush womens; some can go to the big hospital if they want to. We want to make Congress real strong for us and our children's childrens.

The Rites and Rituals of the Grandmother's Law

The Aboriginal women wish to be able to carry out the particular rites and rituals of their Grandmother's Law, including smoking, burying the placenta and cutting the cord correctly at the Congress _Alukura_:

> They would like a mattress on the floor to have their babies on unless the person rather have her baby on the bed. We want older women to do the delivery of baby. We want smoking, too, so our babies not get any sickness. All women must

know not to cut the babies' cord too short. A bit longer the better because you might cut it too short and maybe kill the baby. The rightful ones to deliver babies are the woman who's giving birth's sister or her grandmothers. It was done like that as long as we remember the elders say. They can stay for one or two week at the Congress birth centre. So that woman feels at home with her grandmother. We bury then the afterbirth.

Before the mother goes have with her new baby she has to do this. The other women dig a hole, put two sticks across it, then the mother sits in it with her baby so the child won't keep crying. That's what we want to help other women learn the old way at Congress Alukura.

At Congress Alukura they can bury them [placenta] there. At Congress Alukura they can smoke her and baby before she goes home. We really happy for this Alukura.

The mother and baby can go under smoke and ashes; from that they will grow strong and fat. Before witchdoctor used to straighten baby inside the belly. And their other women who's helper they get both naked and she starts singing song. If it's boy she'll sing boys' song. Same goes for the girls' one. That's why at Congress we want all the women to go there.

At Alukura we got to bury the baby pouch like the old ways.

At Congress Alukura they can have their family staying with them there till after baby is born. In big hospital mother always worry for her other children, but at Congress they can always be with the mother. The baby bag gotta be buried. Everything has to be done Aboriginal was at Congress.

She would be happy if her mother went in with her, and she also took her other kid from there with her. The grandmother should go and see her. And then they can put on the smoke after the grandmother's footsteps. And then put some warm ashes on baby's cord. That help baby a lot, and it won't hurt as much. Like this we would like to do it at Congress. No men go and visit.

Future Borning Practice: The Old and the New

The first preference of Aboriginal women is the desire to deliver normal babies 'on the ground' in their own country, in the old way:

> Long time ago women knew all this. Not so long ago the older women didn't show us anything; only the white sisters taught us and told us things in the little clinic at Ernabella. Well, a lot of women think we should not go to Alice Springs to have our babies, we should have our babies here, in our own country, on the land where we were born and got pregnant. That's what they think. They think why should we go to the white man's hospital? When they have their babies there, they lose everything, culture, Law, everything Aboriginal way. Then they know nothing. We think all women in their own country should do these things so that they all know women's law delivering babies.
>
> All the Yankunytjatjara women in Indulkana, they said that the young girls might be frightened to have them in the Aboriginal way, our way, and some of them might be weak because of being close to Emu Junction and Maralinga. But if there're not frightened, and doctor examines them and says they're strong, then they'll have them our way, in the bush. Because I was born in the bush, no doctors, right in the bush. No medicine in those days, and I'm still living and healthy. My mother had me in the bush. But I went away, sent to school, past Adelaide, and I lived in a place called the River Murray, and I had all my children there - and I finished up with one - in the whitefellah way. And I think now that our way was best - Aboriginal way, from long time ago, our grandmother's way. They had them in the bush, and they were all healthy... and I lost three, and finished up with only one son. So I think to myself, I was an unlucky one, I shouldn't have gone away and lived whitefellah way and lost my children. I think now our ways are best.

Aboriginal women believe that 'borning on the ground' is most appropriate for women delivering their second 'normal' baby or for older women who have not experienced previous complications:

> But those who have had their first baby all right, and are having their second baby, they can all have them in the bush.

> And when they have their second one, maybe they can have that one at home on their country.
>
> All those who had babies before should stay at their communities and have their babies there.
>
> So now the middle-aged women can have their babies in their communities. Grandmother, big sister and aunt can look after her and baby, and they can be smoked. But if she is all right and baby is in the right position to be born, she can have it on the ground.
>
> Bigger women, who have already had a child, maybe they can have their babies on their own communities with the older women who know how to look after them.
>
> But those who have had their first baby all right, and are having their second baby, they can all have them in the bush, because last month, one girl, she had her second baby in the bush, in creek, and that baby's really healthy. We do it our own way - smoke, warm sand and everything in old people's way. The midwives, the women who know, they helped that girl, and the baby had nothing wrong. Doctor examined that girl and said nothing's wrong with that girl and baby's healthy...
>
> Older women, twenty-two or twenty-three, or more, they should stay at home and have their babies on the community. The old ones should teach the young ones.
>
> The ones who is not sick, they can have their babies out here at the community.
>
> Only those women who had babies in the bush will stay in the bush.

It appears that Aboriginal women are increasingly having babies on the ground in their own country. This appears to be occurring particularly where Aboriginal people are on their own land and in control of their own lives. In the past twelve months at Kintore, for example, there were thirty-one births and eleven of these took place at Kintore.

Borning 'on the ground', according to Aboriginal women, can take place in a distant _Alukura_ camp, or nearby a community clinic, or at the Congress _Alukura_ or nearby a 'mobile' Congress team. The Aboriginal women recognise that their bush deliveries may require some medical assistance.

Most Aboriginal women said they would prefer all the 'young' women, having their 'first babies' to deliver at the Congress _Alukura_ and also women who may have minor complications:

> We are frightened for the young girls who is going to have her first baby out here, something might happen out here, so we want Congress to have their own hospital, so we can send some our women in there to have their babies and stay there until they're ready to go home country. After the young women who just had the baby, she can stay with her grandmother there for two weeks.
>
> And our daughters, the young girls with their first baby, maybe they could go to the Congress hospital, and they could stay there and wait for their baby. They could wait there and then have their baby there, and after that they could take them out to be smoked, the mother and the baby, and then they could go back to the Congress hospital so that the doctor could keep an eye on them and make sure that everything is all right. The baby should stay for quite a while, until it was strong and putting on weight; and the doctor, the woman doctor working there, could check them and say they are all right to go home.
>
> Now talking about young girls like fourteen or fifteen years old, we've got a lot of pregnancy out there at Ammaroo, in the younger ones, and they're frightened to go to big hospital. And they need help too. I always call doctor for younger ones for check-up. They've got to check up all their tummy, listen to the baby, and check up for blood pressure. That's why we need Congress doctors. We need help. The olden time way they can't do anything for things like high blood pressure. That's why we need help from Congress Alukura too.
>
> Some of these mothers are too young. Maybe baby's wrong way and grandmother can't straighten baby before it is born. Only those having their first babies should go to the Congress Alukura.
>
> First one in Congress Alukura because there might be some worry.

Antenatal care

The Aboriginal women also recognise that the Congress Alukura can play an important role in providing culturally appropriate antenatal care:

> This time we have clinic and own doctor. Everybody should help Congress mob and health workers. We never had health workers like that before, only health workers at home on the settlements. But now we got some in Alice

> Springs. We should help them and tell them, not only women with young babies, pregnant ones, too, young woman and talk to the young woman and tell the health workers you know. Like this - one lost her first baby and we gotta help her now to have another baby this time. You gotta talk to the doctor together at the Congress Alukura and tell her to talk to you about the baby. That is all.
>
> The ones who want do have their babies at the Congress birth place should have check-ups always. You can't just come in and have your baby at the Congress birth place. You have to have check-ups always before you have your baby. So that you and your baby are well when you give birth to your baby. Make sure that your baby is strong and well.

The Alice Springs Hospital

The Aboriginal women understand, in a general sense, that if there are serious complications, they will be encouraged by the Congress Alukura to deliver in the Alice Springs Hospital:

> If the woman is sick she may as well be sent to the big hospital. She may as well have her baby at the big hospital with the help of someone that knows better just in case of losing baby or mother might be fairly sick.
>
> Some of the women who has delivered a baby before so they know what to do after the baby is delivered. They can send some women into Congress who is going to have their first baby, the ones who are sick; the doctors at Congress sees them there and give them tablets for them to take or send them in straight into the hospital if they are real sick to take medicines.
>
> If the women ashamed or afraid, she might not go and see sister because she frightened to go see the sister at the clinic or hospital. The sister and the doctor help us. We don't get frightened from them. We know they want to help us. All the little children who was born out here they were all right. Some of the young womens have trouble with themselves; they are sent into Congress or the main hospital for treatment.
>
> If pregnant woman is sick, she can go to hospital, and doctor can help her. If young girls are playing up, they can get disease and the baby gets infected. Maybe that baby might die inside, and that's why they have to go hospital.

Those girls who are not well, some have weak hearts, or blood pressure or anaemia - so they shouldn't try the old way.

Women from everywhere don't like the Alice Springs Hospital. But if you are sick or has high blood pressure then we must go to the Alice Springs Hospital.

The Aboriginal women, at the final conference, however, made some strong recommendations for change in the Alice Springs Hospital. They want their Grandmother's Law recognised and respected in the Alice Springs Hospital.

The Congress Alukura Model

Comprehensive details of the proposed Congress Alukura were prepared by Dr Mary Wighton and Sister Pip Duncan and the Aboriginal women living in Central Australia. The model of the Congress Alukura was ratified at the final conference of Aboriginal women in August 1984 - July 1985.

Underlying philosophy

There are some fundamental principles underlying the Congress Alukura that should be stated at the outset:

Aboriginal people are a distinct and viable cultural group with their own cultural beliefs and practices, Law and social needs.

Every woman has the right to participate fully in her pregnancy and childbirth care, and determine the environment and nature of such care unless medical complications indicate otherwise.

Every Aboriginal woman has the right in pregnancy and childbirth to maintain and use her own heritage, customs, language and institutions, or to chose other options as she wishes.

Provisional aims and objectives

The aims and objectives of the Congress Alukura, which were ratified at the women's conference in August 1985, are:

Aims

To preserve and recognise Aboriginal identity, culture, Law and languages in general.

To preserve and encourage Aboriginal women's culture, Law and practices in relation to borning matters or pregnancy, childbirth and the aftercare of mother and baby.

To support each Aboriginal woman in her informed choice of where and how she has her pregnancy care and gives birth to her baby.

To increase awareness and understanding among non-Aboriginal health-care providers of the social and cultural needs of Aboriginal women in pregnancy and childbirth.

To encourage mutual respect and understanding between all providers of obstetric care and borning care.

Objectives

To provide a place in Alice Springs, where Aboriginal women, with their chosen relatives, can have pregnancy care and normal deliveries, in a way consistent with their personal, cultural and social needs.

To support any Aboriginal woman who chooses to give birth in her own country, 'on the ground'.

To develop through mutual consultation between Aboriginal women, health workers, traditional 'midwives', ngangkaris, and non-Aboriginal Alukura health staff, a series of health educational programmes and materials in Aboriginal languages, relating to health problems and care in pregnancy and childbirth.

To develop through similar mutual consultation a training programme for Aboriginal health workers in their own languages, incorporating those traditional Aboriginal 'borning' and western obstetric practices that are most appropriate to their role and circumstances.

To visit each Central Australian Aboriginal community at least once a year for health educational activities and for women's meetings to elicit continuing feedback about their borning needs and preferences.

To visit and hold women's clinics at least twice a year in those Central Australian Aboriginal communities not regularly serviced by female health staff.

To advise and support any Aboriginal communities that want to establish their own equivalent of the Congress Alukura.

To reduce the infant and maternal mortality and morbidity rates in a culturally appropriate way.

Site

Aboriginal women want the Congress Alukura to be a quiet, totally secure place for women only where family groups can stay together and where Aboriginal Women's Law can be

practiced. The Aboriginal women want the Congress Alukura to be situated in Alice Springs in close proximity to the Alice Springs Hospital.

Aboriginal women want space for the cross-cultural functions of the Congress Alukura in an Aboriginal setting.

To satisfy these criteria, the Congress Alukura site will have to be a minimum of five acres of clean bushland on the perimeter of Alice Springs. All such potential sites are in fact less than ten minutes drive from Alice Springs Hospital.

A search is underway for such a site, which will have to be approved by the Traditional Owners of the land and be acceptable to the Northern Territory Lands Department.

Functional design and facilities

Aboriginal women's design of the Congress Alukura is based on a self-help concept. Figure 4.1 on page , discussed and approved at the final conference, shows the approximate functional layout. It is not to scale.

A high fence and locked gates completely enclose the Congress Alukura. A single main entrance is open to women only, and a service and an ambulance entrance are locked unless required.

The Congress Alukura contains a living area and a birth area. In the living area, health-related activities will be interdependent with daily activities.

The clinic is situated at the front of the Alukura, ensuring accessibility. It will contain a reception/medical records area, a radio for bush communications, an activities area, two private examination rooms and a procedures room. It will be closely linked with the health education and craft centre.

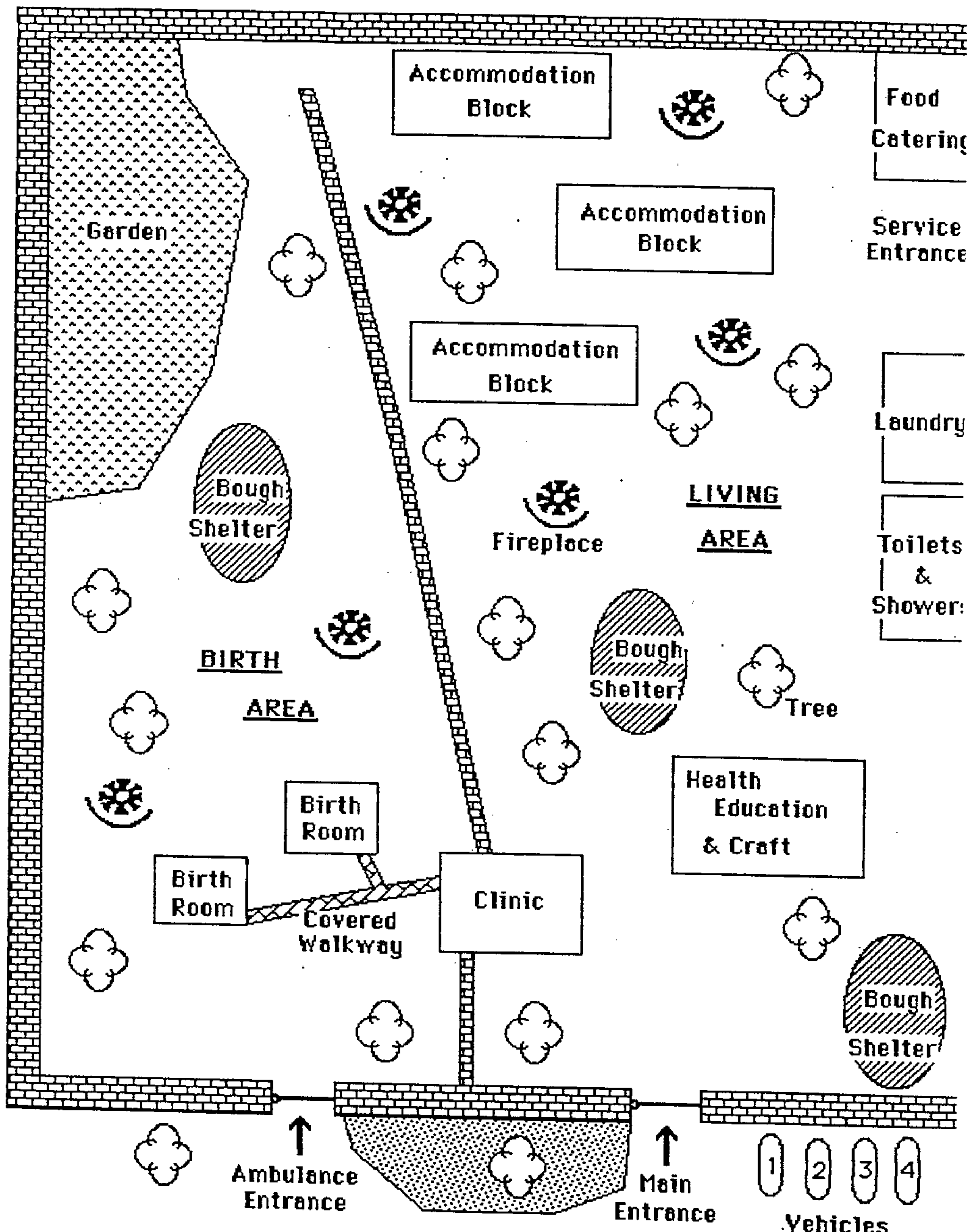
The health education and craft centre, with its large meeting room and facilities and resources, will provide a focus for the many cross-cultural functions of the Congress Alukura.

In the accommodation area, family groups can camp in rooms or in the surrounding area of shade trees, windbreaks and open fires.

There are simple kitchen facilities in each accommodation block and a food catering area. Nearby are communal showers, toilets and laundry.

The birth area will contain two birth rooms. They will be simply furnished, each with a large double mattress on a slightly raised platform, some comfortable chairs, a table and background lighting. They will be connected by covered walkways to the back of the clinic where portable resuscitation equipment will be kept. They will be connected freely with the outside area, which is needed for traditional ceremonial activities including correct placenta disposal. The birth area will be accessible by a locked ambulance gate.

The parking area will be outside the Congress Alukura.



SCHEME OF CONGRESS ALUKARA

(not to scale)

Car Par

Congress Alukura Functions

1 Self-help family accommodation

The Congress Alukura will rely on and reinforce traditional Aboriginal systems of care within the extended family. It will provide a safe, women-only environment where family groups can stay together.

Each family group will consist of the pregnant woman and those immediately involved in or affected by her pregnancy: her two traditional birth attendants* (grandmothers, aunts, sisters-in-law or elder sisters) and her youngest child.

Family groups will travel together and be accommodated at the Congress Alukura in the following circumstances: during antenatal visits (for Congress Alukura and hospital visits or both; while awaiting delivery, whether expected to be complicated or uncomplicated; for normal childbirth and the postnatal period (women expecting complicated deliveries would transfer to the Alice Springs Hospital at the appropriate time); for postnatal review.

Family groups will camp together in the living area, cooking and cleaning for themselves, supported by the Congress Alukura. The family group will actively participate in the many cross-cultural functions of the Congress Alukura.

We estimate that thirteen family groups will stay at the Congress Alukura at any one time, but the flexible nature of the Congress Alukura's self-help family accommodation will cater for widely varying numbers.

2 Bush communication network

Aboriginal women have asked for a women-only radio channel so they can communicate directly with the Congress Alukura about aspects of their care or problems as they arise.

A base radio will be placed in the Congress Alukura, and crystals bearing the women's frequency will be installed in the bush trips car and in existing radios in all communities in Central Australia.

Congress Alukura staff and rural Aboriginal health workers will hold daily schedules for consultation and co-ordination of continuing health care of women and babies in the communities, whether resident or transient.

3 Mobile bush service

The Congress Alukura will maintain an extensive bush service. A mobile team will visit all Central Australian Aboriginal communities at least once a year. They will liaise with the Northern Territory Department of Health so that communities not serviced by the Alice Springs Hospital's woman obstetrician will be visited twice a year in a culturally appropriate manner.

* This term is somewhat unsatisfactory and is being used for health funding and delivery purposes.

The mobile team will consist of a female doctor, an Aboriginal health worker and other Congress Alukura staff - ngangkari, sister, health educator or nutrition health worker.

During their visit they will camp in the community and hold clinics for antenatal care, women's health and family planning, and newborn, infant and toddler health care. They will have meetings and discussions on health education issues, collecting and showing audio-visual materials ideas in the Congress Alukura. They will also be prepared to attend bush deliveries in the area if called to do so.

4 Antenatal care and education

The Congress Alukura will play a vital role in both co-ordinating and providing antenatal care and education.

The women's frequency will enable each woman, her local health worker, and Congress Alukura staff to co-ordinate her care and travel arrangements from the beginning of her pregnancy.

Each woman will be encouraged to visit the Congress Alukura for antenatal review in both early and late pregnancy and receive care in her community from local health staff and visiting mobile teams, whether Congress Alukura or Northern Territory Department of Health.

Birth options will be discussed so that each woman's choice will be known and planned for.

The Congress Alukura will make antenatal care in Alice Springs accessible and suitable to Aboriginal women from remote communities. Flexible to their travel arrangements and minimising time away from home, it will provide acceptable and safe family accommodation.

During each antenatal visit, each woman will be reviewed by Congress Alukura staff and at the Alice Springs Hospital if necessary. She and her family group will join in and contribute to the many cross-cultural educational activities.

Local women or those travelling through Alice springs will be encouraged to make use of the Congress Alukura's antenatal service and educational activities at any one time.

Through this system, there will be no unknown pregnancies, and women who are travelling will have access to care and follow up.

5 Women's health care and family planning

Through the Congress Alukura, all Aboriginal women will be able to discuss and seek solutions to sensitive issues such as family planning and venereal disease and receive preventative and curative care.

6 Infant and toddler health care

Aboriginal women have insisted that their last child be included in the family group during all Alice springs visits, thus providing a unique opportunity for an Aboriginal family-based approach to the toddler's problems and continuing health care.

Each stay in the Congress Alukura will enable the mother and her relatives to discuss the child's problems and progress with Congress Alukura staff, have the child's nutritional status fully assessed and seek appropriate cross-cultural care.

Day-to-day observation of the child's care within the family group will enable Congress Alukura staff to identify problem areas and make appropriate suggestions for their correction, including dietary advice. The nutrition programme will be of great importance in this regard.

7 Nutrition programme

During their stay, family groups will cook for themselves. Nutrition health workers will provide daily supplies of a nutritious selection of foods potentially available in community stores and make practical suggestions about nutritious dietary requirements.

Nutrition health workers will also organise a programme of daily cooking sessions where family groups will come together to cook food from these common materials for specific groups, such as pregnant women, lactating mothers, infants and toddlers.

The combination of self-help practical cooking experiences and the Congress Alukura's cross-cultural discussions will provide one means for Aboriginal people themselves to improve their nutritional status.

The nutrition health workers will also co-ordinate audio-visual education materials on nutrition in the Congress Alukura and in the communities.

8 Normal births

The Congress Alukura will have a birth area where healthy women can give birth according to the Grandmother's Law, under the care and guidance of traditional birth attendants and Congress Alukura staff.

A list of indications for hospital delivery based upon the guidelines of the Queen Victoria Hospital's Family Birth Centre in Melbourne was discussed in general with the women and passed unanimously at the Conference. The list includes indications for elective hospital delivery (both pre-existing maternal disease and pregnancy complications) and intrapartum and postpartum reasons for transfer.

Women planning a Congress Alukura birth for normal deliveries will travel with their family groups a week or so early to await delivery there. (Women planning hospital deliveries may also do so but will transfer with their grandmothers and aunties to the hospital at the appropriate time.)

At the onset of labour, the woman with her traditional birth attendants will move to the birth area.

She will be cared for by both traditional birth attendants and Congress Alukura staff and will be free to spend labour inside the birth rooms or outside in the sun, by the fire or walking in the garden area.

Her traditional birth attendants will support her labour in every way, giving her sips of tea as required, keeping her warm and comfortable, massaging her back and her stomach in traditional ways, advising her and helping her cope with pain.

Congress Alukura staff will monitor the progress of her labour using non-invasive practices established in existing birth centres. Portable resuscitation equipment will be kept near at hand.

It is expected that within this environment, the majority of women will have a normal birth with family participation according to the Grandmother's Law, without the drugs, stress, interference, strange staff or shame associated with the hospital technological environment.

9 Support for country births

Through the women's frequency, Congress Alukura staff will be the first to know when and where a woman is contemplating a bush delivery and will play a consultative, co-ordinating and monitoring role.

If there are medical contra-indications, Congress Alukura and local health staff will talk to the woman about the implications of her choice, advising on Alice Springs delivery.

If the woman is healthy, and has had regular antenatal care, or insists on a country birth regardless, the Congress Alukura will co-ordinate local support for her. If the birth is within easy reach of the Congress Alukura or its mobile team, they will attend the birth. If out of reach, the Congress Alukura will notify local health staff and the Royal Flying Doctor Service to provide back-up support.

The fully equipped birth plane proposed by the Northern Territory Department of Health and the Royal Flying Doctor Service is greatly supported by the Congress Alukura for this purpose.

The Congress Alukura will aim to ensure that no bush births are unexpected or unsupported anywhere in Central Australia.

10 Postnatal care of mothers and babies

For several days after the birth, the family group will continue to stay in the Congress Alukura living area.

Congress Alukura staff and traditional birth attendants will keep a close eye on the mother and baby's progress. Minor complications of mother and baby would be dealt with at the Congress Alukura; major complications such as postpartum haemmorhage, sepsis or severe jaundice in the baby will require transfer to the Alice Springs hospital.

This week of supportive, cross-cultural care in the Congress Alukura will give mothers a firm basis of knowledge to continue their own and their babies' health care in their community.

When mother and baby are both well and ready, the family group will return home. Their local health worker will continue follow-up care and discuss their progress regularly with Congress _Alukura_ staff on the women's frequency until there is no further need.

The six-week postnatal check of mother and baby will be organised jointly by the family group, their local health worker and Congress _Alukura_ staff. Where possible, it will occur in the community, either with local health staff or with a visiting Congress _Alukura_ or Northern Territory Department of Health mobile team. If none of these is available, the family group will return briefly to Alice Springs for postnatal review.

11 Cross-cultural health education

The Congress _Alukura_ will be an important forum where Aboriginal women can discuss together the problems facing mothers and babies and produce cross-cultural audio-visual educational materials in their own languages.

The basis of these health educational programmes will be daily discussions at the Congress _Alukura_, where Aboriginal mothers, traditional birth attendants, _ngangkaris_, health workers, sisters and doctors will sit and talk under the bower shelters. Topics will include nutrition, family planning, venereal disease, birth options, medical and social problems, Aboriginal Law, antenatal care, postnatal care, with contributions from both Aboriginal and western points of view.

These meetings will be in Aboriginal languages, and run by the women themselves, with the health educator playing a liaison role and providing audio-visual resources. Photographs, tapes and videos of these discussions will then be used to form health educational materials in Aboriginal languages. These materials will be of enormous use both in the Congress _Alukura_ and during community visits. They may also be made more widely available if requested.

The health educator may also go with the Congress _Alukura_ mobile bush service to gather material for these programmes, and include a wider community participation.

12 Cross-cultural health worker education

Aboriginal health workers have made it clear that they want to learn both Aboriginal and western ways regarding pregnancy, childbirth and women's health.

The everyday functions of the Congress _Alukura_ will provide practical in-service training for health workers, both Congress _Alukura_ employees and those from rural areas. Alongside traditional birth attendants, _ngangkaris_, doctors and sisters, they will learn traditional and western beliefs and practices. It is planned that all women health workers in Central Australia will transfer to the Congress _Alukura_ for a two-week period each year for work experience and in-service training.

A more formally structured training course will occur regularly throughout the year, so that health workers can attend and receive some form of recognition and certification. The course content will be designed and developed within the first year of the Congress Alukura from health worker and staff participation.

The course will be predominantly in Aboriginal languages and will give a cross-cultural approach to antenatal care, pregnancy complications, care and monitoring of normal childbirth, postnatal care of mother and baby, nutrition, infant and toddler care, venereal disease, women's health and family planning, childbirth options, and the role of the health worker in her own community.

13 Orientation for non-Aboriginal health staff

An important role of the Congress Alukura will be to increase mutual respect, awareness and understanding between all health-care providers.

To broaden their knowledge of Aboriginal culture, priorities, needs and problems, female non-Aboriginal health staff will be encouraged to attend short, flexible orientation courses at the Congress Alukura.

They will be shown around the Congress Alukura and join in that day's cross-cultural discussions and activities, and will be encouraged to view the audio-visual resources of the Congress Alukura on topics relevant to their area.

14 Liaison with all providers of obstetric care

Close communication and good relations between the Congress Alukura, the Aboriginal-controlled health services, and the Northern Territory Department of Health will be vital.

Most women's antenatal care and postnatal follow-up will be provided from several sources, including local health staff, visiting mobile teams (Congress Alukura or the Northern Territory Department of Health), or Alice Springs-based services (Congress Alukura or the Alice Springs Hospital).

The women's frequency will provide invaluable day-to-day communication with the communities.

In addition, formal communication channels will be established between Congress Alukura, the Northern Territory Department of Health and rural health services to allow for mutual consultation and exchange of medical records, so that each will keep the other equally informed about details of antenatal attendances, choice of delivery place, outcome of childbirth and postnatal care.

As the Congress Alukura is only for normal births, it will rely on the Alice Springs Hospital to provide specialist care for those women requiring hospital delivery, or who transfer during labour or postnatally. Such liaison and communication will be the subject of continuing talks between the Congress Alukura and all health-care providers.

Estimation of numbers involved

The flow diagram and table represent the way in which Aboriginal women want pregnancy and childbirth care. The numbers are based on statistics in Tables 7, 8 and 9 of the Annual Report of the Northern Territory Department of Health 1983-84, and refer to pregnant women in their family groups.

Community	Congress Alukura	Alice Springs Hospital
Antenatal care and education	Antenatal care 356 and education	Antenatal care
	Antenatal care 267 and accommodation	
Normal 59 Deliveries	Normal 180 Deliveries	Complicated 117 Deliveries
Postnatal care and education	Postnatal care and education	Postnatal care

Numbers Accommodated in the Congress Alukura

Type of visit	Duration	Family Groups	Family Group Days
Antenatal	2 x 3 days	267	1,602
Delivery & postnatal care	1 x 17 days	180	3,060
Postnatal review	1 x 3 days	75*	225

* This low estimate assumed the majority of women will have postnatal review in their communities.

Rules

The Aboriginal women living in Central Australia at the final conference proposed the following rules for the Congress Alukura.

The Congress Alukura should be for aboriginal women only. Men are not allowed to visit the Congress Alukura. Women who want to have their babies at the Congress Alukura should be healthy and have had regular check-ups.No alcohol is allowed. A woman coming to the Congress Alukura can bring two women relatives and her youngest baby. The woman and her relatives are responsible for looking after themselves (cooking, cleaning, laundry and cleaning living area).

Conclusion

It is clear that if Aboriginal women were given the opportunity to express and act upon their preferences in borning matters they would not continue with the present policies, structures or funding arrangements. Equally, it is apparent that Aborigines are willing to move from passive resistance into active participation in a situation where they are in control. They are keen to have indigenous borning practices and western obstetrics in a context that allows them autonomy to explore and implement programmes that they consider appropriate. Their preferences are somewhat congruent with the trained birth assistant programmes recognised and legitimated by the World Health Organisation. It is clear that the Aboriginal women wish to retain and re-introduce the Grandmother's Law:

> We would also like our women to keep our old ways like our people before us took care delivering our kids and their kids before, and so it goes on. That's what we want to see. Keep up our old ways. Our kids should learn how it was before the white man came to this country.

At the same time, there is a strong recognition of borning problems and the need for the whitefellah way. Women distinguish between the old and young and the healthy and sick and recognise that different forms of care may be appropriate. Hence, the women strongly endorse the establishment of a women's Congress Alukura for Aboriginal women where the delivery is normal or where there are only minor complications. Borning on the ground is proposed for 'middle-aged' women having their second babies. The understanding of western obstetric care is limited, a function in part of information and communication control, but the importance of the whitefellah way is recognised. Aboriginal women understand that they will have to attend the Alice Springs Hospital if there are serious complications. The Aboriginal women, however, strongly endorse culturally appropriate changes to the hospital. It is possible that knowledge about obstetric and maternal health matters could be greatly facilitated in a culturally appropriate, non-invasive and familiar place. The women's preferences provide a clear starting point for introducing appropriate services and alleviating the borning problem.

It is clear that the two-way articulation of western theory and practice and traditional theory and practice at the Congress Alukura will involve varying compromises. Time and experience will lead to considerable negotiation and re-negotiation raising a whole range of issues. What should be the process of Aboriginal selection and adoption of western theory and practice? How should this selection be undertaken and controlled? Aboriginal control of this process will, however, assure a satisfactory resolution of the possible and inevitable conflicts.

Congress has successfully set a precedent in its operation of the two-way health clinic. Experience has shown that when the health of an individual is at risk, there is an acceptance of the most appropriate approach. The health of the person is considered paramount. Moreover, the Congress Alukura will specifically express the principle that the health of mothers and babies occurs within a cultural, political and economic context and will provide one major step in recognising this principle.

5 'LET THERE BE NO MORE SHAME'

The intention of this report has been to document the findings of this research project, which attempted to redefine the Aboriginal borning problem and to illustrate and clarify processes that might improve the infant and maternal mortality rates in Central Australia. It has recorded Aboriginal opinion on traditional borning practices, the present health service delivery and their preferences for service delivery. In doing so, it has explained the current interaction between western obstetrics and indigenous borning practice. This project has departed from previous research studies into the Aboriginal childbirth problem in that it was initiated by an Aboriginal organisation and depended on the direction and involvement of many Aboriginal women who belong to the wide community of Congress.

It is clear that white history has left the Aboriginal women a tragic legacy. In the past, Aborigines lived in clearly defined areas, hunting and gathering in small, cohesive family groups, travelling across and camping on their own country, bound to the country by strong, personal and religious ties. In the old times, women were 'big and strong' and children 'fat' on the nutritious and abundant bush tucker. Aboriginal women were free from disease, had high fertility and low infant mortality rates. They had their babies 'on the ground' in their own country, by the Grandmother's Law in the Alukura women's camp. The Aboriginal woman had control and autonomy over the sacred life processes of creation, and their ancient ceremonial rites and rituals were legitimated by timeless success.

Then the white man came. Aboriginal people were dispossessed of their ancestral lands and herded like cattle into compounds, on the missions and settlements. The pastoralists brought cattle with them, ruining the lands with bores and depleting the flora and fauna. Aboriginal Law and traditional authority patterns were made inferior and subordinated to white law, and the traditional economic base was almost destroyed. Attempts were made to assimilate people into European ways with an ideology that equated civilisation with the European way. Western modes of law, education, housing, diet and monetary exchange were introduced. Thus, Aboriginal people experienced a profound 'rape of the soul' in the midst of physical and cultural genocide.

Similarly, a white health-care system, all-powerful, free from scrutiny and oblivious to uncertainty, was exported to a foreign, powerless and essentially unknown culture to combat the diseases brought by the white man. Health care became characterised by a one-way process of medical dominance and implemented by 'indirect' force, or more politely, by 'encouragement'. Aborigines were subject to a bewildering array of screening and immunisation programmes, forced 'infant' feeding and crisis intervention. Western obstetrics was introduced as part of this programme, dedicated to eradicating the problems caused by white colonisation. Traditional births became medicalised while the women continued to return to camps without water, shelter,

electricity, washing and ablution facilities, stores, transport and communication services. The maternal and infant mortality and morbidity rates escalated.

In recent times, Aborigines living in Central Australia are actively reasserting their Aboriginality and their rights. They are returning to their ancestral lands, there are strong Aboriginal organisations representing the people, and their traditional Laws are being actively upheld. Aboriginal people have challenged the one-way process of health-care delivery. The challenge to western obstetrics parallels the challenge to land rights and the law, and these challenges are intimately related. The struggle of Aboriginal people in recent times is about rights, justice, independence, recognition and health.

The essence of the argument presented here is that the borning problem has two origins. In the first place, non-Aboriginal medical caretakers have imposed on Aboriginal women western obstetrics, which entails the projection of a whole culture, without Aboriginal women understanding the cultural context in which it developed. More than this, western obstetrics has violated fundamental traditional Aboriginal practices. Aboriginal women in their bewildered ignorance, shame and fear, present late to these culturally inappropriate services and abscond from institutions and treatments. Furthermore, the Northern Territory Department of Health in Central Australia has not kept pace with recent trends in western obstetric care.

In the second, little consideration has been given to the real impact of western obstetrics in terms of securing safety and health. Consequently and conveniently, environmental and essential 'survival' provisions have scarcely been addressed.

A review of western obstetrics and traditional borning practices has shown radical differences in the beliefs and practices of each. The approach of one is scientific and mechanistic and the pathological orientation is paramount. The approach of the other is holistic and cultural with an emphasis on nature and nurture. The practice of western obstetrics is specialised, professionalised and technologised whereas traditional borning practices are widely diffused among the women and female kin.

It has been found that Aboriginal women have passively resisted the encroachment of western obstetrics because their Grandmother's Law is strong and widely practised today. Aboriginal women, particularly in the remote Aboriginal communities, are continuing to have their babies born 'on the ground'. Tribal women who deliver in the Alice Springs Hospital mostly practise the rites and rituals of their ancestral borning Law when they return to their grandmothers and aunties on their country. The Aboriginal women have a profound faith in their traditional Law, and they have control and autonomy over their traditional borning practices. This Law, however, is not recognised by the mainstream health services in the Centre.

Aboriginal women today have a limited choice over the 'where and how' of pregnancy and the delivery of their babies. The Northern Territory Department of Health is the

mainstream health service and is responsible for the hospital and for servicing the remote communities with clinics, resident sisters, visiting sisters and medical practitioners and the Royal Flying Doctor Service. It has been shown that the Northern Territory Department of Health offers western obstetric care in an unqualified framework of medical dominance where no account is taken of Aboriginal borning beliefs and practices. In this way, the services are rendered culturally inappropriate and generate problems of late presentation and absconsion. Aboriginal women have a limited understanding of western obstetrics. They have been compelled to use these services in the absence of alternatives and in the face of their high infant mortality and morbidity rates, which escalate with the alien delivery of services.

This report has shown that Aboriginal women are 'shamed, proper shamed' in their experiences of delivering in the Alice Springs Hospital. They are 'shamed' by their ignorance and by the violations made to their Grandmother's Law. The women are shamed by the whitefellah way, which has man doctors, making legs wide, burning the baby bag, leaving women alone without the help of their aunties and grandmothers, silent without their mother's language, not knowing about drips and operations. In fear and shame, the Aboriginal women run from that white place as soon as they can. Western obstetrics represents fear and death for the Aboriginal women living in Central Australia.

The Aboriginal women, who have been systematically consulted for the first time, have clearly stated their preferences. They want to actively reassert their traditional borning Law and they want this Law to be officially recognised. Their first preference is to have their babies 'born on the ground in their own country'. The women spoke strongly for their second preference, which is to establish an Alukura to be run by the Central Australian Aboriginal Congress. The Alukura will be a women's place, where Aboriginal women can have normal deliveries the Aboriginal way. In the event of complications, Aboriginal women recognise that they will have to use the Alice Springs Hospital. Where western obstetric services may be necessary, however, the Aboriginal women have strongly called for changes that will make the services more accessible.

In this way, the Aboriginal borning problem has been redefined. At the end of the final conference, the Aboriginal women prepared a statement for the media, redefining this problem and indicating the processes necessary for resolution:

> We, the Aboriginal women of Central Australia, have all been saying the same things. We have all said that the Aboriginal beliefs and practices of childbirth are radically different to western methods. Childbirth has its beginnings in the Dreamtime and as a result we have different meanings and language for childbirth. For us, childbirth as a whole is a part of our Dreamtime and traditional Law. We have said how we feel shamed in the hospital without our Grandmother's Law, male doctors,

the strange surrounding in hospital, not knowing what is happening, being left alone with no grandmothers or aunties which would be the case in Aboriginal tradition to help us, with the lack of interpreters to explain the actions taken by medical staff while in hospitals.

We feel sad and sorry by not being able to use our traditional birthing ways, which have been developed over thousands of years and still used today.

We Aboriginal women want control over our own birth business as a whole, and we strongly ask for our Aboriginal Law and tradition to be used alongside the western way. We want the government to fund a Congress _Alukura_. The _Alukura_ means a women's place, where normal births will happen, and we can follow our Grandmother's Law, which is still strong and still used today. We want this Congress _Alukura_ to be recognised as a model for other Aboriginal communities in the future. We want this Congress _Alukura_ to have a health worker training course to train women about our traditional birthing ways, antenatal care, western obstetrics, postnatal care and provide orientation courses for white hospital workers. We are also asking for a mobile bush clinic to provide follow-up care. We have also made urgent recommendations to improve the Alice Springs Hospital, which is a regional hospital used by people from remote areas of Western Australia, South Australia, the Northern Territory and Queensland. So if there are medical problems we can still deliver in a culturally appropriate way, for example, being attended by female doctors having a full-time Aboriginal interpreter service and to provide family facilities.

We hope the federal government will listen to us and provide continuing finance for staff and resources in our attempt to improve the urgent problems which beset us today, therefore improving all levels of care under the control of the Central Australian Aboriginal Congress.

Recommendations

The Aboriginal women prepared the following recommendations at the final conference:

1 Congress Alukura

(a) That the federal government recognise our urgent childbirth problems.

(b) That the federal government accepts this Congress Alukura package immediately and permanently.

(c) That the federal government finance this Congress Alukura immediately and permanently.

(d) That the federal government recognise that the Congress Alukura will be a model for Aboriginal communities in the future.

(e) That the funding provided by the federal government be directed through the Central Australian Aboriginal Congress.

(f) That the Commonwealth and Northern Territory governments co-operate in providing a suitable site of at least five acres for the Congress Alukura.

(g) That the funding of the preparatory stage of the Congress Alukura made available from October 1985.

(h) That the Congress Alukura will have its own radio frequency to remote areas concerning its business.

2 Mobile bush clinics

That the federal government finance mobile bush clinics as part of the Congress Alukura package to provide antenatal care, attend bush births and provide follow-up care immediately and permanently.

3 Hospital improvements

That the federal government and the Northern Territory Department of Health urgently implement the following services for Aboriginal women giving birth in the Alice Springs Hospital:

(a) full-time interpreters,

(b) female doctors and staff only,

(c) access and facilities for family members assisting births,

(d) full recognition of the grandmother Alukura Law, including allowances for the adoption of traditional birthing positions, the proper disposal of afterbirth and the proper incisions to the umbilical cord,

(e) short-term orientation courses for non-Aboriginal health workers employed at the Alice Springs Hospital by Alukura workers,

(f) that all procedures be carefully explained and, where possible, choices given and that all unnecessary procedures, such as induction and the insertion of drips, be discontinued,

(g) that there be signs in Aboriginal languages in the Alice Springs Hospital.

4 Stores

That the federal and Northern Territory governments ensure that the stores in the remote communities are stocked with an abundant supply of fresh nutritious food and with a minimal supply of such foods as cool drinks, sweets, ice-cream, and so on.

5 Essential services

That the federal and Northern Territory governments ensure that the basic facilities of water, housing, sewerage, electricity, transport, radios and clinics are supplied to every remote community.

It is hoped that this report and its recommendations will be given immediate and urgent attention for its sets forth the strongly held views of many hundreds of Aboriginal women living in Central Australia. Otherwise, the maternal and infant mortality and morbidity rates will continue to be a source of international disgrace, causing unnecessary suffering and death. Moreover, there will be a continued wastage of financial resources into services which are inappropriate and inaccessible. These services have caused physical and cultural genocide.

The Aboriginal women have spoken out about their rarely told stories with pride, shame and hope. Eileen Hussen closed their sacred story at the conference with the following appeal:

> I'd like to thank all the women who have travelled as far west as Kintore and Warburton, Tennant Creek in the North, Lake Nash in the East and Indulkana in the South. This conference is only the beginning of meeting the immediate and future needs of Aboriginal women in Central Australia. So special thanks to all the Aboriginal women who have come a long way and for keeping strong the Grandmother's Law. I am happy to say I was born

and named from my Grandmother's Law and here I am, still going strong today! And I hope that younger Aboriginal women and our kids like myself will get the chance through the Congress Alukura of using the Grandmother's Law and help stop our babies dying, and help stop our shame.

APPENDIX 1

Preliminary Regional Women's Meetings

1 Ayers Rock women's meeting 10 May 1984

30 women: Senior Aboriginal women and Health Workers from the following communities:

Ayers Rock	Pitj./Yangkunytjatjara
Alcoota	Anmatjirra (Urapuntja HS)
Amblatawatja	Anmatjirra/Alyawarra (Urapuntja HS)
Alice Springs	Arranda, Loritja (CAAC)
Kintore	Pintupi (Pintupi HS)
Ernabella	Pitj./Yangk. (Nganampa)
Amata	Pitjantjatjara (Nganampa)
Indulkana	Yangkunyjatjara (Nganampa)

2 Tangentyere women's meeting 24 May 1984

52 women, with representatives from all Alice Springs Town Leases (representing all language groups).

3 Pitjantjatjara women's council meeting 29 May 1984

Kalka	Pitj./Nyaanyatjarra
Wingellina	Pitj./Nyaanyatjarra
Amata, Ernabella	Pitj./Yangk.
Fregon, Indulkana	Pitj./Yangk.

4 Bazzo Farm meeting Alice Springs 19 June 1984

150 Aboriginal women

Alice Springs	All language groups
Finke	Loritja, E. Aranda
Amata	Pitj.
Indulkana	Yangkunyjatjara
Santa Teresa	Aranda
Harts Range	Anmatjirra/Alyawarra
Lake Nash	Alyawarra
Ali Curong	Warlpiri/Alyawarra
Tennant Creek	Warl./Aly./Kaytej/Waramungu
Papunya	Loritja/Pintupi
Kintore	Pintupi
Maryvale	Loritja
Ernabella	Pitj./Yangk.
Fregon	Pitj./Yangk.
Ayers Rock	Pitj./Yangk.
Utopia	Anmatjirra
Amblatwatja	Anmatjirra/Alyawarra
Ti Tree	Anmatjirra
Yuendumu	Warlpiri
Ngurandiji	Kaytej
Mt. Liebig	Loritja
Daguragu	Gurindji

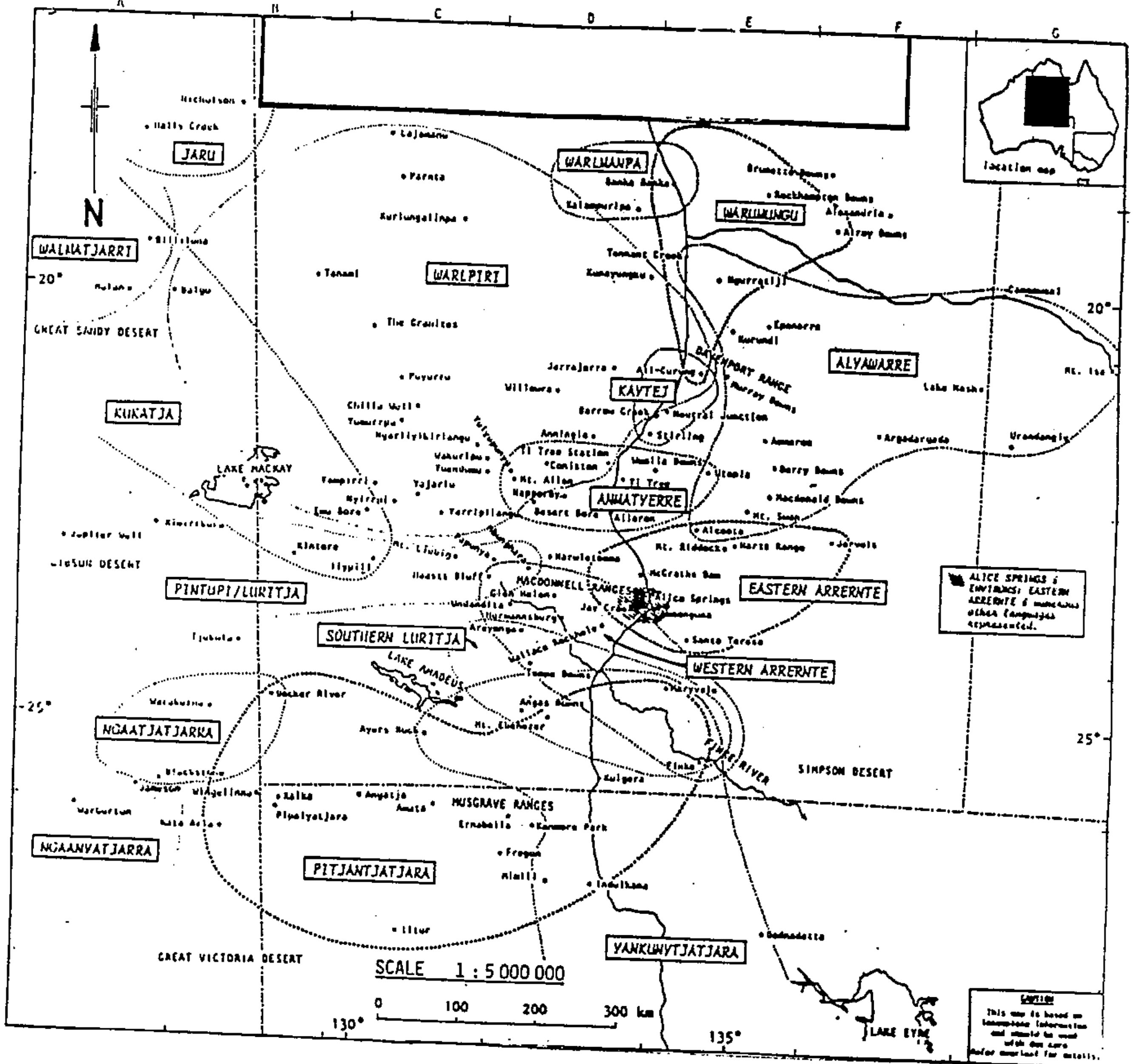
5 Yirrara High School meeting 15 December 1985

15 young girls

KEY:

Pitj:	Pitjantjatjara
E. Aranda:	Eastern Aranda
Warl.:	Warlpiri
Yank.:	Yanykuntjatjara
HS:	Health Service

Map 1



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155

Michael Hunt,
Awabakal Medical Service,
Cnr Hannel + Grey St,
WICKHAM, N.S.W.

INDULKANA A.H.S.
Private Mail Bag
Via Alice Springs
N/T. 5750

ERNABELLA A.H.S.
Via Alice Springs
P.M. Bag
N/T 5750

FREGON AHS.
P.M. Bag
Via Alice Springs
N/T. 5750

Vickie Allen
Adelaide AMS
128 Wakefield St
ADELAIDE
S.A. 5000.

Tom Walsh
C/- Adelaide AMS
128 Wakefield St
Adelaide
S.A. 5000.
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Amata A.H.S
P.M. Bag
Via Alice Springs
N/T 5750.

Ellie Gaffrey

MR S. Bellear
Nat. Trach + Eye
Health co-ord,
P.O. Box 174
REDFERN, N.S.W. 2016

Anthony Galea,
Nth Stradbroke Island Ab. &
Is. Community Health Servic
P.O. DUNWICH,
Qld, 4163.

Eric Kyle,
Bamie Community Health Serv
P.O. Box 2150,
MOUNT ISA,
Qld, 4825.

Les Collins,
Wu Chopperen,
197 Lake Street,
CAIRNS,
Qld, 4870.

Rex Marlow,
Wilcannia AMS,
P.O. Box 4,
WICANNIA,
N.S.W. 2836.

~~Daryl Wallace~~ Shane Houston
Tharawal AMS,
2 Langdon Ave,
CAMPBELLTOWN,
N.S.W. 2560.

Geoff Clarke,
Framlingham,
Purnim P.O. PURNIM,
Vic., 3279.

Merv Bundle,
Gippsland & East Gipps'
Aboriginal Co-op,
P.O. Box 634,
BAIRNSDALE, Vic, 3875.

Margaret Cole
Tasmanian Aboriginal Centre,
163 St John's Street,
LAUNCESTON,
Tas., 7250.

Thelma Rose,
Haywood Aboriginal Culture Cnt
HAYWOOD,
Vic. 3304

Kevin Cox,
Broome Regional Medical Serv
P.O. Box 49,
BROOME