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How do midwives learn about, understand, and integrate Cultural Safety into their care of First Nations women and families? A qualitative exploration

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ABSTRACT

Problem: Midwives are required to provide care based on Cultural Safety for First Nations women and families. Recent literature has suggested that midwives' understanding of Cultural Safety and how it translates into their practice differs widely. This disparity requires further exploration.
Background: The Australian professional midwifery codes and standards state that there is a requirement to provide care based on Cultural Safety. It is critical to understand how First Nations people's history and culture impacts their health and wellbeing, requiring midwives to recognise how this may impact care.
Aim: To determine Australian midwives' knowledge and understanding of Cultural Safety and how this translates into their practice when caring for First Nations women and families.
Methods: A qualitative study was undertaken. Data were collected via semi-structured interviews with 12 midwives practicing in Australia. Data were transcribed and thematically analysed.
Findings: Three themes were identified: 'Society and Systems', 'Knowingness versus Understanding', and 'Personal Qualities, Engagement and Partnerships' which highlight the strengths and deficits of Cultural Safety education and its integration into midwifery practice in Australia.
Discussion: Health systems providing maternity care remain rooted in Western biomedical philosophies, which influences the practice of Cultural Safety at all levels. Midwives are beginning to understand the ongoing impact of colonisation on the health and wellbeing of First Nations families, but still face challenges when striving to provide culturally safe care.
Conclusion: Cultural Safety must be valued at an organisational level, in which midwives can engage in authentic, maternity-based educational programs led by suitably prepared educators.

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Statement of significance	
Problem or Issue	Midwives' knowledge and understanding of cultural safety and how this translates into their practice differs widely. This means that care provided is inconsistent
What is Already Known	Midwives must provide culturally safe care to First Nations women and their families if we are to work towards closing the gap.
What this Paper Adds	There is a disparity in midwives' knowledge and understanding of cultural safety. Midwives desire Cultural Safety education which is authentic, engaging, and maternity-specific. Midwives' knowledge acquisition and integration of Cultural Safety vary, shaped by the broader sociocultural system and its dominant discourses and cultural norms. Midwives desire authentic Cultural Safety education that is engaging and maternity specific.

1. Introduction

Aboriginal and Torres Strait Islander (herein, First Nations) women accounted for 5 % of birthing women in Australia in 2021 [1]. According to the 'Australia's Mothers and Babies' report [1] between 2012 and 2021 an increased number of First Nations mothers presented for antenatal care during the first trimester of pregnancy and attended five or more antenatal visits. Additionally, more First Nations mothers reported that they did not use tobacco during pregnancy, with the number increasing from 87 % in 2011 to 91.3 % in 2021[1]. Despite these positive trends, a substantial gap in health outcomes remains between First Nations and non-First Nations mothers and babies [2]. In 2020, the Australian Prime Minister's Closing the Gap Report [3] highlighted the ongoing need for strategies to improve the health outcomes of First Nations families. Key to this is ensuring access to culturally safe and respectful maternity care [2], which aligns with Australian professional midwifery codes and standards [4]. However, for midwives to fulfil this requirement, they must first understand the concept of Cultural Safety, and how this translates into their practice.

1.1. Background

1.1.1. Cultural Safety defined

The authors acknowledge Cultural Safety as a dynamic and reflective practice that involves critical self-awareness and a commitment to addressing ingrained assumptions, biases and privileges [5]. It requires deep questioning of how personal and systemic factors, shaped by colonisation, decolonisation efforts, power imbalances, and racism, impact relationships, decision-making, and outcomes. Cultural Safety is inseparable from broader sociocultural contexts, encompassing social discourses, health system structures, and systemic power dynamics [6]. It challenges individuals to comprehend their own power and privilege and address the ways these factors shape experiences and outcomes for various populations [7].

1.1.2. Cultural Safety & the midwife

Cultural Safety emphasises the responsibility of the midwife to critically reflect upon how their attitudes and beliefs impact the care they give, with the recipient ultimately deciding if the care is culturally safe [8]. For midwives to provide culturally safe care, recognition of the impact that First Nations peoples' history and culture has upon their health is essential [9], and they must understand their own power and privilege [10]. Whilst contemporary Australian midwifery curricula must encompass 'Aboriginal and Torres Strait Islander peoples' history, culture, and health' [11], midwives who have completed older programs, or have migrated from overseas may have had little opportunity to undertake Cultural Safety education. Furthermore, despite the recommendation that all midwives undertake mandatory Cultural Safety education [12], there is ongoing debate about how it should be provided [13].

A recent literature review [14] highlighted that midwives' understanding of Cultural Safety and how it translates into their practice differs widely, with some perceiving that 'woman-centred care' meets the needs of *all* women, regardless of their cultural identity. Some midwives struggled to provide specific examples of how they apply Cultural Safety and/or were unable to demonstrate an understanding of the history that underpins the specific cultural needs of First Nations families. Other research has found that midwives can feel challenged to differentiate the Cultural Safety needs of First Nations Families from those of culturally and linguistically diverse (CALD) families [15]. These findings highlighted the need for further research to better understand midwives' knowledge, understanding and approaches to Cultural Safety, and to ascertain whether they are supported to provide a culturally safe approach for First Nations families.

The new knowledge gained through this study has potential to inform the development of effective educational strategies for use in entry-to-practice midwifery courses and post-registration professional development programs.

1.2. Researcher positionality

The researchers acknowledge the necessity to share about the position from which they have engaged with the research project and the lens through which they have approached the subject matter. One of the researchers is a registered nurse and a proud First Nations woman. Another researcher is a midwife registered in Australia of mixed European and Chinese ancestry. The remaining four researchers are registered midwives in Australia who are primarily of white European ancestry.

The researchers also acknowledge the inherent power imbalances and the potential for this research process to feel like an unsafe space for the First Nations team member. As a predominantly non-Indigenous research team, the risk of unintentionally reproducing inequities was recognised by all. To mitigate this, open collaboration was fostered and given the research topic, the cultural perspectives of the First Nations team member were prioritised.

1.3. Aim

This study aims to determine Australian midwives' level of knowledge and understanding of Cultural Safety and how this translates into their practice when caring for First Nations women and families. It aims to explore the nature of this knowledge and understand how it was gained, consolidated, and translates into contemporary midwifery practice.

2. Methods

A qualitative descriptive research approach [16] was taken. Qualitative description is an appropriate methodological approach for midwifery research, particularly when seeking to understand the knowledge and experiences of others through the eyes of the participants, rather than the researcher [16]. Additionally, qualitative

descriptive research lends itself to obtaining straightforward answers to questions that are important to informing policy, procedure, and effective educational strategies [16]. Approval for this study was granted by the Central Queensland University Human Research Ethics Committee, approval number 23573.

2.1. Participants and recruitment

The participants, Australian Health Practitioner Regulation Authority (Ahpra) registered midwives were purposively recruited using a social media advertisement on Facebook, LinkedIn, and X. The advertisement was shared via the research team's personal and professional social media networks.

Interested midwives accessed the information sheet and the consent form by clicking the link provided in the advertisement. The information sheet and consent form were hosted on the Qualtrics platform. Once consent had been obtained, the researchers contacted participants via email to arrange an interview.

2.2. Data collection

Semi-structured individual interviews were conducted with 12 participants by four members of the research team (RC, MW, KH, BF) at which point data saturation was reached. Interviews were conducted in accordance with ethical requirements. Participation was open to registered midwives and did not specifically seek First Nations individuals; therefore, the data collection methods did not specifically incorporate Indigenous cultural preferences. Participants selected their preferred method from either Zoom, Microsoft Teams, or telephone. Their demographic information is in Table 1. The interview questions (Appendix A) were developed, underpinned by Williamson's [15] study and a literature review by Capper et al. [14], who are members of the present research team. The questions were developed in collaboration with and deemed culturally appropriate by a First Nations member of the research team (KL).

2.3. Data analysis

The interviews were deidentified and transcribed to Microsoft Word.

Table 1
Participant demographic data.

Participant	Age Group	Gender	Cultural background as stated by participant	Country of birth	Country where midwifery qualification was gained	First year of midwifery registration	Type of qualification	Years of practice	Work location	Midwifery practice setting
P1	30–34	Not stated	South African/ Indian	Not stated	Australia	2017	Bachelor of Midwifery (3 years)	6	QLD / Regional	Public hospital: Rotational midwife
P2	55–59	Female	Caucasian Australian	Australia	Australia	1990	Postgraduate certificate 1990 Upgraded to Bachelor of Midwifery 2011	33	SA / Regional	Public sector: Midwifery educator
P3	55–59	Female	English heritage/ Australian	Australia	Australia	2012	Bachelor of Midwifery (3 years) Postgraduate endorsement – Private practice.	11	WA / Rural	Aboriginal Medical Service. ***And*** Private practice – antenatal and postnatal midwifery
P4	55–59	Female	European	New Zealand	New Zealand	2004	Bachelor of Midwifery (3 years)	18	NT / Remote	Aboriginal Controlled Community Health Organisation
P5	40–44	Female	Anglo Saxon	Australia	Australia	2008	Graduate Diploma of midwifery	15	NSW / Regional	Public hospital
P6	40–44	Female	Australian/ American	Australia	Australia	2008	Graduate Diploma of Midwifery	15	QLD / Urban	Public university educator, private practice midwifery
P7	65–69	Female	Caucasian Australian	Australia	Australia	1976	Certificate	47	QLD/ NSW Rural, Regional, Urban	Public university educator, public hospital, private hospital, private practise midwifery, MGP, Indigenous communities
P8	60–64	Female	Caucasian/ Australian	UK	Australia	2000	Master of Midwifery	23	Regional	Public hospital, Private hospital
P9	45–49	Female	Caucasian/ Australian	Australia	Australia	2012	Bachelor of Midwifery (3 years)	10	Regional	Public Hospital
P10	40–44	Female	Caucasian/UK	UK	UK	2013	Bachelor of Midwifery (3 years)	10	QLD/ Regional / Public	Public hospital: Clinical facilitator
P11	55–59	Female	UK	UK	UK	2004	Advanced Diploma in Midwifery	20	Regional/ rural	Public sector
P12	55–59	Female	Caucasian/ Australian	UK	Australia	2012	Bachelor of Midwifery (3 years)	12	Urban	Public sector

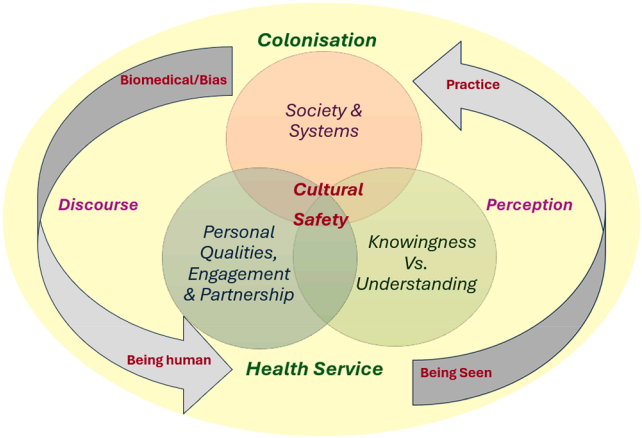

Fig. 1. Overarching themes.

The transcripts were read multiple times by all members of the research team before analysis commenced. Thematic analysis was conducted using Braun and Clarke's original 2006 six-step process [17]. Whilst it is acknowledged that there is an updated reflexive version of this process [18], the research team held frequent collaborative meetings throughout all stages of the process to reflect upon and consider their pre-existing knowledge and cultural differences, which cultivated reflexivity during data analysis.

3. Findings

Thematic analysis revealed three overarching yet interrelated themes. Fig. 1 illustrates the three central themes: "Society and systems", "Knowingness versus understanding", and "Personal qualities, engagement, and partnership". Each theme then includes sub-themes – social discourse, health system structures, being human and being seen. These interconnected elements are positioned within a broader temporal and contemporary context shaped by colonisation and the health system. These themes and subthemes will now be explored in detail.

3.1. Overarching theme one: society and systems

Contemporary Australian society remains rooted in a dominant culture and discourse of Westernised and Anglo-Saxon origins due to colonisation [19–21]. Social influence permeates all sectors, including health systems rooted in a biomedical model [22]. Despite efforts to adopt a biopsychosocial model, health services have incorporated Cultural Safety with varying degrees of success. This was articulated by participants in the study who relayed how this affects care. The following example highlights how the persistence of a dominant Western, Anglo-Saxon culture and a biomedical health system perpetuates biases and inequities for First Nations people.

> *The dominant Caucasian Western culture says, "These people [First Nations] think they're special". They [Australian society] still don't think that First Nations people are owed anything. The way we treat First Nations women in health care is terrible.* (Participant 1)

Dominant social practices and discourses significantly influence large-scale systems and the individuals within them. A negative social discourse towards First Nations Australians hinders care based on Cultural Safety [23,24], and inadvertently affects the way an individual health care professional perceives Cultural Safety. The example below illustrates how dominant societal discourses influence individual health professionals' understanding and application of Cultural Safety depending on personal reflection and engagement with historical context.

> *I think… learning from history is always a good thing, so that helped to inform me to go "this is what's happened to [First Nations] People". Have some empathy. But I don't think that message gets through to everybody…. I think it depends on how you take in the information and apply that to your own practice.* (Participant 6)

Bias and discrimination in healthcare result in unequal treatment and poorer health outcomes for First Nations women [24]. Although institutional practices aim to be inclusive, dominant discourses often render these efforts as tokenistic. Negative discourses in healthcare and negative perceptions persist.

> *No one mentioned anything about the fact that she was Aboriginal and might have some preferences. In fact, everybody's attitudes were derogatory towards this woman.* (Participant 6)

Participants noted that women are viewed through the system's lens, focusing on their ability to fit in rather than adopting a Cultural Safety approach.

> *Health is not just the physical body; it's also the spiritual body, and health is about family. As a health professional, when… that [First Nations] person doesn't come to the appointment, people [sic] will say… "well, they just don't care about their health"… of course they care, but they care very differently from how we care.* (Participant 4)

Health professionals' interactions and communication styles are influenced by dominant cultural values, impacting consumer experiences and outcomes [25]. These interconnected factors hinder delivering healthcare based on Cultural Safety for First Nations Australians [26].

3.1.1. Subtheme one: social discourse

Social discourse around First Nations Australians has evolved from initial conflict and dispossession during the colonial period, marked by assimilation policies and portrayals of First Nations Australians as "savages" [27,28]. The early to mid-20th century continued with segregation and protectionist policies, perpetuating negative stereotypes [29]. The 1960s and 1970s brought activism and legal reforms, increasing recognition of First Nations people's rights, however this was also marred by the Stolen Generation [29] which continues to impact on First Nations women.

> *Understanding Aboriginal history, a basic understanding of the real history of this country and First Nations people, not the whitewashed version and… The Stolen Generations, it's important to understand that mistrust with public institutions and health.* (Participant 12)

The late 20th and early 21st centuries saw reconciliation efforts, formal apologies, and cultural revival, yet significant disparities persist [2,30,31]. Recent discourse focuses on cultural empowerment, constitutional recognition, highlighting ongoing challenges, and the need for systemic change [32]. Since the Voice referendum in Australia in 2023, negative social discourse around First Nations Australians has increased [33]. Key points of contention include concerns over exacerbated racial divisions, with a "them versus us" mentality [34]. One of the participants recounted colleagues' discourse about their perceptions of this mentality.

> *I've heard people [sic] say "…why should they get special treatment? Aboriginal women seem to get 'special treatment'."* (Participant 6)

Misinformation about the referendum reinforced negative stereotypes [33] and political polarisation fuelled inflammatory rhetoric and stifled constructive dialogue [35]. Social media harassment and racist commentary, with public backlash against the Voice as unnecessary has added to the tension [33]. One of the participants articulated their feelings about the outcome of the failed Voice referendum.

> *The referendum outcome indicates that society has not moved forward. I've been fooling myself about how far we've come as a culture. Some of*

my Aboriginal colleagues say it's normal for us. I thought we had moved a lot, but no. (Participant 7)

However, participants acknowledged intergenerational trauma and the Stolen Generations, noting that treatment and recognition of First Nations peoples is evolving. They believed that their colleagues' knowledge of historical and contemporary truths for First Nations people varied based on factors such as their age, cultural identity, and their education, particularly regarding when, how and where they completed their schooling and midwifery education. This may reflect a current transitional state of Australian society. While colonisation was once pervasive and unconscious, recent efforts in decolonisation and truth-telling may mark a shift towards greater awareness.

I mean, I do remember a couple of years ago having a hard conversation with… a midwife that I work with and she's from England … she didn't know the history of our Indigenous people and the horrendous treatment that they've had at the hands of white Australians… they're still way below us [First Nations Australians] like in terms of the way that they've been treated and the huge gap in healthcare outcomes. And once I explained it to her, she was like, oh my god, I actually didn't realise. (Participant 9)

3.1.2. Subtheme two: system structure of health services

Healthcare systems often adopt a "one size fits all" approach based on a Western biomedical model, influenced by social discourse, which can marginalise alternative ways of knowing, such as cultural practices and First Nations knowledge. This adherence to traditional biomedical methods maintains the status quo, potentially overlooking the validity of diverse healthcare approaches [36,37]. This limits healthcare inclusivity and perpetuates health disparities among Australian First Nations populations, rendering them invisible or forcing them to conform to the system.

We're not doing enough to change. We're not doing the bare minimum to look after women who identify as being Indigenous [sic]. Our environment and the people we work with have a huge impact. (Participant 1)

Health services, driven by demand and constrained by limited resources, often have rigid structures that struggle to meet the unique cultural needs of First Nations people. Participants noted feeling constrained by these system limitations.

We need to be less structured and more flexible. Just open up. I think our Western world relies on tick boxes and structure, whereas working within the Aboriginal [sic] *community is much more fluid.* (Participant 3)

The authority of the system and its inflexibility often funnels women into standardised care pathways that may not align with their cultural practices, values, and priorities. For First Nations people, whose healthcare needs are closely tied to cultural connections and relationships with time, the macro-scale health system can feel impersonal and disconnected. Participants found this mismatch hinders the application of Cultural Safety in care provision.

She's [the woman] declined a procedure and has the right to decline, but we make them sound non-compliant and naughty because they're refusing. It's a huge power imbalance. I've seen a lot of inappropriate and unsafe care for First Nations women; it's because that's the culture of the place you're working at. (Participant 4)

3.2. Overarching theme two: knowingness versus understanding

'Knowingness' refers to understanding the cultural habitus and social capital or power dynamics within a context [38]. In contrast, 'understanding' pertains to grasping academic content and completing assessments, which may not reflect a deeper comprehension [39]. Knowingness involves experiential learning, reflexive practice, and emotional intelligence [40].

Participants with experience in Aboriginal Community Controlled Health Organisations (ACCHOs) or models of care (MOCs) demonstrated a deep, immersive understanding of Cultural Safety through their daily engagement with First Nations families. For those without regular engagement with First Nations families, Cultural Safety was more of an occasional "hat" to be worn, rather than an integrated aspect of their practice. This "hat" sometimes became stereotypical and not specific to First Nations Australians, demonstrating a lack of understanding of diversity within cultures and of the meaning of Cultural Safety.

I better understand cultural sensitivity in terms of other cultures. So, when I birthed with Asian women, I knew they liked hot water. Arabic women don't like a male caregiver in the room. I know these things, but when it comes to Indigenous cultural sensitivities and safety, I have less understanding. (Participant 5)

Women who have migrated to Australia or who are refugees experience many challenges. However, these experiences are different to the injustices and oppression that First Nations people have experienced [15]. Midwives may not ask the woman what they would like, rather they may base their care on their perceived views of cultural traits.

3.2.1. Subtheme one: knowing

Humanistic methods of gaining knowledge involve direct interaction and empathy. Participants described understanding First Nations perspectives through personal contact and research, listening to oral histories, building meaningful connections, and appreciating cultural contexts and lived realities.

Cultural safety is about self-awareness. It's about listening, appreciating, valuing, and supporting… all those elements of Cultural Safety. (Participant 6)

Participants also demonstrated an openness to self-awareness when apprehending the different life experiences of First Nations people. These methods and qualities emphasise a holistic knowingness of human experiences through direct engagement and empathetic connection.

I feel very compassionate towards our First Nations women… but I understand that there is also trauma. I take an approach of - what can I do to improve this? (Participant 6)

Their preferred approaches to learning that might develop these qualities involved collaboration with First Nations people and communities. Ideas about collaboration were described in various ways, including direct educational delivery by a First Nations facilitator, immersion into First Nations communities and having midwifery students complete a clinical placement in First Nations continuity of care models.

It's really important to listen to Aboriginal [sic] people and to have the learning come from them. Having educators from a First Nations background and working with Aboriginal [sic] health workers is fantastic. (Participant 9)

Those who learned through methods reflecting more First Nations ways of learning, such as yarning circles or storytelling, and immersive clinical placements expressed these as highly valuable.

Conversations help people understand the incredible generosity, humour, and extraordinary kindness of Aboriginal [sic] people. I love learning about their culture… and seeing how it created this extraordinary social fabric. I now know Aboriginal [sic] people have profound capacities. (Participant 7)

The participants also demonstrated their comfort with reflecting on self-perceptions, inherent biases and limited knowledge.

It is helpful to have reflective strategies for acknowledging your biases or misconceptions and how they might influence somebody. (Participant 1)

3.2.2. Subtheme two: understanding

Most participants agreed that their employer provided a program of education related to Cultural Safety and the health care of First Nations people. The requirements for these programs were either mandatory or non-mandatory, and varied in the mode of delivery, duration, and required frequency of completion. Many participants stated that mandatory education was often generic, box-checking activities and none were tailored to maternity and newborn care. A significant identified gap in mandatory education was a lack of translation into practice.

> *The hospital has an online program. The first one is mandatory, and anything beyond that is optional. It's lip service; I don't see it reflected in practice. The hospital cultural awareness program doesn't include women and children, so we're unsure of our role in Culturally Safe [sic] practice.* (Participant 5)

Participants noted that while online education programs exist, they lack authenticity, thereby minimising genuine engagement.

> *I had to do some training, but it wasn't in-depth. I clicked through to the answers and could answer the questions, so…* (Participant 5)

In contrast, direct communication with First Nations people was valued for its depth, offering transformative learning that could address broader social issues and drive systemic change.

> *I've done cultural competence in different organisations… They're all very superficial. The deep immersion comes with talking to Aboriginal people and answering difficult questions.* (Participant 6)

Some participants noted a general lack of appreciation for Cultural Safety among leadership and staff. However, others said that when the organisational leaders visibly committed to Cultural Safety and included First Nations representation, frontline staff valued it.

> *We did a yarning circle. Aboriginal Elders sat down and talked, and those sessions were crowded. They weren't mandatory, but the staff would walk out of the room just bouncing.* (Participant 4)

3.3. Overarching theme three: personal qualities, engagement and partnerships

Participants recognised that their organisations should support Cultural Safety, but those with a deeper understanding saw that personal responsibility and genuine commitment were crucial. They actively engaged in their learning journey, reflecting and learning continuously rather than passively receiving information. They acknowledged that asking First Nations women about their needs was the just the beginning.

> *It's been a steep learning curve and very much self-directed learning. I had a bit of an "aha" moment, realising I needed to educate myself, and that's been helped by… Aboriginal friends and colleagues who helped me find where I needed to go to find information.* (Participant 12)

Most participants acknowledged that asking First Nations women about their needs is essential for Cultural Safety within midwifery practice. However, some recognised that promoting self-determination in a woman's care must be approached carefully, as it may inadvertently burden the women to educate or guide the midwives, whose responsibility for Cultural Safety is ultimately their own.

> *I know the answer isn't to burden the client. It isn't their responsibility to educate us. I'm not entirely sure what the right pathway is, but it's not right to expect every Aboriginal woman to be training her carers.* (Participant 2)

3.3.1. Subtheme one: being human & being seen

Understanding differences without judgment and possessing emotional intelligence enables healthcare professionals to recognise First Nations women's fear, vulnerability, and reluctance to trust the healthcare system, even if they haven't experienced these [41,42]. Those with sensitivity can appreciate universal human experiences, such as grief or acceptance, which influences their practice [43]. Participants who demonstrated empathy and avoided biased or institutional perspectives could better address the broader circumstances of First Nations families without imposing a Westernised approach.

> *I'll tell the woman - it must be hard for you to come here. I try to understand things from the woman's perspective so that she feels welcome and knows she won't get told off.* (Participant 4)

Comprehension of the human experience and how this is informed by history, and traditional and generational experiences was identified as painful transformative learning. Still, it was not shied away from by those participants who integrated knowledge into practice on a deeply humanistic level.

> *By revisiting, rereading, rethinking, reflecting, such big processes, you're remapping your brain, which is why it hurts, and you get headaches because your neurons connect in new ways. By making those pathways and creating the grey matter that holds them, you get a deeper understanding that becomes an embodied reality.* (Participant 7)

3.3.2. Subtheme two: engagement and partnerships

One element of inquiry this research sought to address was how midwives can cultivate and demonstrate authentic understanding of Cultural Safety when engaging with First Nations women. Participants reported they highly prized working alongside First Nations individuals.

> *I worked for a few weeks on the Ngaanyatjarra lands. That was amazing. I learned more about Aboriginal culture there. It was a great learning experience that helped to inform my practice.* (Participant 3).

Building genuine relationships with the healthcare system is crucial for First Nations people [44]. Participants who regularly worked with First Nations families demonstrated self-awareness, reflection, and a deep understanding of their circumstances. They explained that ongoing learning came from active listening and immersion in meaningful communication, which sometimes required relocation to rural and remote areas.

> *I've learned how connected Aboriginal people are to each other, to the earth, to the sky, to the waters… we are so disconnected from that… Communication takes time to have a little bit of a yarn.* (Participant 3)

Participants also noted that cultivating professional partnerships with First Nations colleagues offered insights and education beyond traditional Western methods. They valued the reciprocal partnerships which could be forged with their First Nations colleagues to optimise Cultural Safety in maternity care. Whilst many participants spoke of the immense value brought to their practice by working with First Nations colleagues, one participant highlighted the success of partnering with First Nations colleagues who have unique, formal training in maternal and infant care.

> *A midwife partners with an Aboriginal health practitioner… and it's that one is bringing clinical expertise, one is bringing cultural expertise, but they actually both cross over and the benefit to that is that the [Aboriginal health] practitioner has… an increased capacity for clinical work, the midwife has an increased capacity for cultural work, and I think by working together we're showing the clients… that this is a way forward.* (Participant 2)

Whilst the participants' First Nations colleagues worked in a variety of roles, including as Aboriginal health workers, educators, and managers, they consistently expressed appreciation for the value their First Nations colleagues contributed to Cultural Safety, regardless of their role.

4. Discussion

This study explored how midwives acquire, understand, and apply Cultural Safety, providing insights into how their knowledge is consolidated and implemented in midwifery practice. It specifically highlighted how the pervasive influence of dominant Western culture within societal attitudes and health systems hinders midwives' ability to be culturally safe and prevents First Nations families from experiencing Cultural Safety. Despite these challenges, the findings indicated a progressive understanding of Cultural Safety among midwives since a previous study completed in 2008 [15]. They exhibited varying degrees of personal commitment and awareness, demonstrating a positive approach to Cultural Safety despite the obstacles they encountered.

However, in some cases the participants applied the concept of Cultural Safety to both First Nations women and to CALD women. This indicates that they may not understand the intent of Cultural Safety as first developed by Ramsden [8], who articulated that Cultural Safety was derived from the need for health care professionals to recognise the ongoing impact of colonisation on the Māori population and the need to address the inherent power relationships within health care systems. Cultural Safety has now also been applied to marginalised ethnic groups [13]. However, the injustices endured by First Nations populations must be heeded by midwives when providing care as these have engendered ongoing 'intergenerational trauma' for First Nations women [45]. This distinction is paramount to the pursuit of Cultural Safety in midwifery care.

Most participants in this study did demonstrate an understanding of the lasting effects of colonisation on Australia's First Nations people, including intergenerational trauma and widespread health disparities, and recognised how these impacts manifest in the daily lives of the women in their care. This finding contrasts with those of Williamson [15], whose similarly designed research revealed that many midwife participants had limited knowledge of the impacts of colonisation on First Nations people. In Williamson's study, the few participants who did understand these impacts worked in an Aboriginal Medical Service. In the present study, participants working in MOCs for First Nations women demonstrated knowledge of the impacts of colonisation. However, unlike Williamson's participants, this understanding was not limited to those settings, as some participants working in other contexts also comprehended this. The increased availability of MOCs for First Nations families may, in itself, indicate progress over time in recognising the need for Cultural Safety and reflect a gradual shift in societal views following the Apology to Australia's Indigenous Peoples in 2008 [46].

Although this study revealed that midwives have some understanding of the impact of colonisation on First Nations families and its implications for Cultural Safety in maternity care, there is an application-to-practice gap which is compounded by programs of education which are insufficient or not fit-for-purpose – a finding noted in existing literature [47,48]. Hickey et al. [49] highlighted the need for organisations to endorse the concept of Cultural Safety to enable midwives to practice effectively; this is also true of the organisation's capacity to deliver education and professional development. However, on an individual level, non-First Nations educators who are responsible for providing education find themselves ill-prepared to do so and question the accuracy and authenticity of their teaching [50]. Like the participants in the present study, they value the contributions of First Nations People to Cultural Safety education and view this as a strategy for more effective education [50]. However, this approach can overburden First Nations people, who are often simultaneously navigating working in a system that is not culturally safe for themselves [51]. Relying on First Nations colleagues for this education also risks placing undue burden on them [52] and may lead non-Indigenous educators to avoid the difficult but necessary critical reflection and reflexivity required to achieve culturally safe practice.

4.1. Limitations

A limitation of this study is that all of the participants completed midwifery qualification programs prior to the Australian Nursing and Midwifery Accreditation Council's requirement for a discrete subject focused on First Nations people history, culture, and health in 2021 [11]. Consequently, it was not possible to explore midwives' perceptions of current approaches to providing education on Cultural Safety in entry-to-practice programs.

4.2. Recommendations for future research

Future research should aim to explore midwives' understanding of Cultural Safety in the care of First Nations families from the perspective of midwives who have undertaken a discrete unit of study in their entry-to-practice course. Additionally, to further understand the integration of Cultural Safety in midwifery practice, the experiences of First Nations families, the end-users of the service, should be encompassed in future research.

5. Conclusion

The findings of this study offer insight into Australian midwives' knowledge and understanding of Cultural Safety, as well as their ongoing professional development. It has confirmed that the pervasive influence of embedded Western biomedical philosophies persists as a barrier to Cultural Safety at organisational and individual levels. Whilst the midwife participants in this research verbalised their acknowledgement of the need to be culturally safe, there were varying degrees of understanding and belief in their capability to achieve this. The study found that contemporary educational strategies employed by health services are diverse and can be inadequate in developing midwives' knowledge. This may serve as a barrier to becoming a culturally safe practitioner, and therefore in building a culturally safe organisation. The research identified that comprehensive and authentic maternity-focused education, delivered by appropriately prepared educators, is needed.

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Author agreement

This article is the authors' own original work.

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Declaration of Competing Interest

None.

Appendix A. Interview Questions

1. Can you tell me why you chose midwifery as a career?
2. Why do you continue to practice as a midwife?
3. Given that the Australian professional midwifery codes and standards now reflect the role and responsibilities of the midwife in

ensuring that their practice is culturally safe, how do you feel about that?

4. In what ways do you incorporate Cultural Safety into your everyday practice?

- o Prompt 1: Do you find this successful?
- o Prompt 2: Can you give an example?

5. Have you had any challenges incorporating cultural safety into your practice?

- o Prompt 1: Can you tell me about them?

6. What strategies have you used when caring for First Nations women?

- o Prompt 1: You gave an example of caring for First nations women where you incorporated strategies. Was this successful and was it challenging for you to do?

7. Did your initial entry to practice midwifery program cover the importance of cultural safety and understanding First Nations Peoples' history and culture?

- o Prompt 1: Could you tell me about this?

8. Since you became initially registered as a midwife in Australia have you undertaken any type of professional development about the importance of cultural safety and understanding First Nations Peoples' history and culture?

- o Prompt 1: Could you tell me about this?

9. Can you describe any professional development opportunities your current employer has provided about the importance of cultural safety and understanding First Nations Peoples' history and culture?
10. How do you think is the best way for midwives to learn about cultural safety and providing culturally safe care for First Nations women and their families and why?
11. What do you think should be included in entry to practice midwifery courses?
12. Do you have any other comments about your experiences of learning about First Nations Peoples culture and the provision of culturally safe maternity care?

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