Sing to Connect

WELCOMING WELLBEING

A Research Report

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ACCESS

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FUNDING AND PARTNERSHIPS

This project was developed in partnership between “Sing to Connect” at Queensland Conservatorium Research Centre, Griffith University, Logan Maternal and Child Health Hubs at Metro South Health, Access Community Services, and Logan City Council as a part of an initiative to support perinatal mental health and wellbeing and cultural vitality of new mothers from a CALD background. The project was funded by the Logan City Council Community Projects Grant 2020.

Sing to Connect and the Logan area: Harnessing the strengths of our multicultural communities in the region

The first 1000 days of life, commencing in pregnancy, are critical to long-term health and wellbeing. Poor health outcomes at the start to life manifest in chronic disease with long-term costs for individuals, families and health systems. For most women, pregnancy is the catalyst to seek health care which enables them as the matriarch to meet the long-term health needs of their families. Evidence demonstrates that women in Logan are less likely to engage with mainstream health services, have one of the lowest rates of antenatal attendance, and experience poorer antenatal outcomes than the Queensland average. Diminished engagement with health and support services during pregnancy and after birth can have negative impacts on the family and the child's physical, emotional and social welfare in ways that can have lifelong implications.

Logan Hospital is targeting some of the most disadvantaged community groups in Logan with concomitant social risk factors that correspond to this disadvantage. 31.1% of population experiences high levels of disadvantage, compared to 20% across Queensland.

- 3.2% adults and 5.8% of children identify as Aboriginal and/or Torres Strait Islander
- 26.1% were born overseas
- 12.8 % speak a language other than English at home
- Culturally and linguistically diverse women and families represent approximately 30% of the birthing cohort at Logan Hospital

To bridge this disadvantage, an approach that encompasses relationship-based care and social connection such as Sing to Connect is highly apt. The Sing to Connect philosophy works with the strengths of our CALD communities, bridging barriers of language and power dynamics to enable mutual trust and community connections to develop in a creative atmosphere.

We at the Maternal and Child Health Hubs at Logan believe that antenatal care should be women and family centred. That it should meet an individual woman's needs including her psychosocial, physical, spiritual and cultural needs, and recognise her right to self-determination. Sing to Connect utilised music, language and song, some of the most effective creative methods of engagement, highly suited for our CALD populations. We found that as the sessions progressed there was an improved uptake of antenatal classes and care, and an enhanced understanding of the lived experience of our cohort among the group. Further, such rich experiences and contextual data are useful to us as health professionals. They inform the way forward to improve care provision for this population that are marginalised. Their voices often unheard due to language barriers. Hitherto invisible or misunderstood cultural identifiers were heard loud and clear here at Sing to Connect.

Perinatal mental health and wellbeing are important in the Logan area and beyond, and Sing to Connect offers a viable approach.

The Queensland Maternal and Perinatal Quality Council Report 2015 identifies that the leading cause of maternal mortality is suicide. The report provides that 16% of women have perinatal depression; anxiety disorders are experienced by up to one third of women during pregnancy and 20% in the postnatal period. Logan community is diverse and when compared to the greater Brisbane and Queensland populations is over-representative of vulnerable populations. It is indeed likely that that the percentage of women experiencing depression and mental health problems after birth is higher than the 16% reported nationally. Moreover, CALD communities are over-represented at Logan compared to some populations and are likely to have experienced significant trauma, upheaval and loss of community resulting in social and family isolation. This vulnerability impacts on lifelong trajectory for the individual but also effects society overall.

Early interventions such as Sing to connect in the life of such families and children will likely lead to solving problems earlier rather than fixing them later in life. Antenatal and early parenting interventions have the greatest influence on a person's life success and contribution to society. Antenatal care that can bridge barriers of language and health professional power dynamics is an opportunity to bring families and health professionals together to see each other in a different capacity. Sing to Connect facilitates such connection and learning. Women that form trusting relationships with health professionals are more likely to engage in learning and antenatal care and draw significantly on the cultural connections these groups can provide. Metro South Health sees potential and hope in Sing to Connect, as we move forward towards a person-centred & community-based model of care.

Remarkable processes and outcomes

The process of being involved with Sing to Connect has been a wonderful journey of learning and discovery about what can be achieved when like-minded and motivated arts researchers and health professionals join towards a unified goal. What was striking was the ability to evolve the process during COVID-19 and still manage to remain on track and produce a successful program that could deliver the desired outcomes. Those outcomes of creating a safe and welcoming space for CALD woman and their midwives to share, sing, story-tell and connect, created enormous value for individuals and the group, and developed lasting connections that are likely to have profound effects beyond the pregnancy for the woman attending and the health professionals involved. This was particularly relevant during 2020 due to the increased isolation of our families. This project has highlighted that 'humanness' and 'connection' can be found and fostered with vulnerable communities despite the challenges of disenfranchised communities,

difficulties with language, and social barriers. It was a joy to be involved with Sing to Connect and work alongside dynamic singer/researcher Dr Charulatha Mani from the Queensland Conservatorium Research Centre, Griffith University and her A-team of music therapists, researchers, and facilitators.

Where to from here?

Programs such as Sing to Connect are vital in engaging our vulnerable populations. It would be advantageous to have the opportunity to build on the success of this edition of Sing to Connect. By word of mouth and through the compelling documentary film, the comprehensive website, and this research report, we hope to ensure that the momentum gained is not lost but continues to grow strongly into 2021 and beyond. The program has a robust research and evaluation framework and is well placed to continue to co-design innovation care with our CALD community and partners.

In Sing to Connect, we at the Maternal and Child Health Hubs at Metro South Health now have a wonderful opportunity to continue to improve on our capacity to provide safe and innovative care at Logan and improve the life trajectory of our priority populations. In this report Dr Charulatha Mani provides a compelling and humane overview of the program. As I leafed through the pages, I relived some of those moments with a sense of hope and pride. Congratulations to all and heartfelt thanks also to the Logan City Council for funding this fantastic project.

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PREFACE

Queensland Conservatorium Research Centre (QCRC), Griffith University is proud to have been a partner in this remarkable research project, Sing to Connect. This study marks a significant step forward in our collective understanding about the vital role that singing can play in promoting the health and wellbeing of pregnant women and new mothers. In particular, it deepens our knowledge of the ways in which shared music making can create a culturally safe and affirming space for social connection, bonding, and healing in Australian CALD communities.

Sing to Connect closely aligns with the values and community-engaged research that QCRC has conducted over the past 18 years. It embodies QCRC's ongoing commitment to innovative research that combines cutting edge creativity and artistry with fresh approaches to social justice, social inclusion, and broader social change. It also directly aligns with Griffith University's reputation for leading socially-engaged research, and its longstanding commitment to partnering with communities, governments, and a wide range of stakeholders in the Logan area and beyond. Sing to Connect adds an important dimension to Griffith's leadership of place-based initiatives, and work alongside a diverse range of stakeholders and sectors to bring about positive changes in this community.

Sing to Connect has come at a critical time for the Logan community. Designed and developed during the COVID-19 pandemic, it has directly responded to the social isolation and perinatal needs experienced by CALD women in the Logan area. This report documents the strong personal, interpersonal, and community outcomes which have been achieved through this unique singing, midwifery, and cultural exchange program. As this study compellingly demonstrates, there is a strong and growing need for programs that promote social inclusion and social connection in our multicultural communities in Australia.

Singing can provide a strengths-based, culturally sensitive approach that works with, and amplifies, the cultural assets of a community. The resulting findings demonstrate how music can be a powerful cultural determinant of health and contribute to broader community wellbeing.

QCRC congratulates the Sing to Connect team on these impressive outcomes. We are particularly proud of the vision the project's leader Dr Charulatha Mani has brought to the design and delivery of this project. Her unique musical identity as an internationally renowned Karnatik singer, her cultural identity as a migrant woman, and her positionality as a mother of twins has positioned her perfectly for this task. She has shown an impressive commitment to this community-engaged, interdisciplinary research and worked closely with all the team members and partners in the realisation of this vision, and I have personally enjoyed working with her on the research design of this project. In particular, QCRC recognises the creative contributions of her highly skilled co-facilitators Lynette Lancini and Daisy

Nussey. We also acknowledge the substantial midwifery and community expertise that Dr Mani's team of expert collaborators have brought to all stages of the project's development, Michelle O'Connor, Rowena de Jong, Joanna Grzybowska, Summer Hancock, Emily Ellis, Ruta Aloalii and Monica Mamea.

QCRC has welcomed the opportunity to collaborate with valued partners, Logan Maternal and Child Health Hubs at Metro South Health, Access Community Services, and Logan City Council. This has represented a unique and effective cast of cultural, social and health sector partners. This project clearly has a bright future ahead, and we look forward to continuing this important work in the years to come. I commend this outstanding report for its scholarly rigour, authorial clout, and heart-warming insights. I am sure that its impact will be felt in the field for years to come.

Professor Brydie-Leigh Bartleet
Director, Queensland Conservatorium Research Centre (QCRC), Griffith University

PERSONAL STATEMENT | REFLECTIVE SUMMARY

Sing to Connect is an ongoing research and community program aimed at enhancing wellbeing for pregnant women and new mothers through singing. In the pilot edition of this initiative (Sept-Dec 2020), women from Culturally and Linguistically Diverse (CALD) backgrounds in the Logan area of South East Queensland were given an opportunity to connect with each other, their midwives, their babies, and precious aspects of their own culture, including music and language. The program involved weekly workshop sessions featuring lullabies, folk songs and storytelling. The sessions were two hours in length and seamlessly interwove singing with health information modules and midwife consultations, creating an atmosphere that was both relaxed and creative. As participant-researcher, I have crafted this report of the pilot as a first-person narrative. I envisage this book as a reflective sharing—of the design elements, rationale, processes, challenges, reflections, findings, and inlaid narratives that, for me, quilted layers of meaning together into a coherent whole. Before you journey with me, I invite you to enjoy the short documentary film available through the QR code on the back cover. This, along with the website (www.sing2connect.com) provides a quick and accessible overview of the context and program.

I am given to metaphorical thinking. When designing Sing to Connect I likened the program to that junction of a river that entertains tributaries; that zone of contemplation where the flow slows down to allow for the gentle deposition of fertile silt. As the program progressed, I could well imagine silt-like layers of culturally encrusted knowledges pooling. Over the 12 weeks, it became clear that Sing to Connect was as much about singing as it was about cultural healing and wellbeing for the women and midwives. It was as much about native language maintenance as it was about English literacy for the women. It was about midwives finding new and culturally responsive registers of communication with their women. It was about me finding personal meaning as a migrant mother and researcher in the company of other coloured women like myself. It was about presenting real women with access and opportunity for leisure in the comforting surroundings of their immediate communities. It was also about connecting them with kindred spirits and facilitating friendships. Importantly, it was about providing an outlet for bold and creative self-expression through the voice—across physical, subjective and psychological, and social levels. Around 5 women, for instance, reported that engaging regularly with Sing to Connect helped them with keeping post-partum depression at bay and provided them with an appealing fixture to look forward to in their weekly schedules. Overall, it turned out to be a brave space rather than just a safe space for CALD mothers to share intergenerationally-transmitted cultural knowledges, skills, and practices.

Over the weeks, the program also morphed into a platform through which we could all safely understand and access the support, empathy, and networks that the communities at Logan are well-placed to offer. I believe that every single day in every person's life should be taken seriously. In this program we enjoyed 12 sessions totaling over 25 hours of human engagement with around 38 women's voices actively foregrounded. The planning phase soaked up around 100 hours of design involving collaboration with the communities. These rich moments of togetherness have provided the basis for the reflections about the program that I make here. I employed a suite of established research methods to understand the meanings that emerged here, and share some of the most striking insights in the pages that follow. As I revisited the complexities through the creative process of writing, I must acknowledge that such meaning-making provided me with further opportunities for paring back and reconsidering the project from various angles. Invariably, this report can only capture a slice of the life of this program, and I hope to shed light on those moments wherein the program truly took off—moments akin to bursts of fresh air and which most deserve more formal memorialisation.

As we march forward through 2021, I do hope that our collective voices from the Logan area will add to the complexity and criticality of the narratives being offered widely as solutions to some of the pressing questions that face society today. I also, therefore, have woven critically reflective perspectives from relevant literature across research processes, content, and context. Professor Brydie Bartleet, Director of the Queensland Conservatorium Research Centre, assisted me with the research design, particularly around questions of interview structure and other data collection models, such that the process could retain its commitment to genuine engagement with communities. Working with Prof. Bartleet on the initial planning phases also provided useful insights in unpacking why it could be worthwhile for me to streamline my own thoughts and expectations in the direction of serving the work, and not vice versa.

In sum, the intrinsic value of singing—as a biopsychosocial way of being and meaning-making using one's voice and language—was harnessed in Sing to Connect to the instrumental value of participatory music-making—as a tool for social bonding. I must also emphasise that I have delivered this program from a place of deep personal and emotional investment. The past few months have given me a level of subjective wellbeing that I had not imagined I could experience given the inexorable difficulties that COVID-19 put us all under over the last several months.

I wish to express my sincere gratitude to my host organisation, the Queensland Conservatorium Research Centre (QCRC), Griffith University, and Professor Brydie Bartleet whose care and guidance I will cherish. Without my co-facilitators and their generosity I could not have made it through these weeks—I owe Lynette Lancini, composer, singer, and mother of four, and Daisy Nussey, music therapist, a debt of gratitude. Their voices were powerful in the circle without being overpowering. They became the catalysts that often drew out the voices of the women. I am very grateful to the funding body, Logan City Council; the partnerships from the Logan Maternal and Child Health Hubs (Michelle O'Connor and the army of amazing midwives, including Rowena de Jong and Joanna Grzybowska) and community support staff at Access Community Services (Summer Hancock and Emily Ellis). Thanks are due to Kalle Kallio from Lokki Media, who patiently spent hours covering some of the key sessions on camera; the documentaries that supplement this report are ample testimony to his respectful engagement with the program. The pilot was rolled out at Village Connect auditorium at Hosanna Logan City, and my thanks go to Ruta Aloalii and Monica Mamea at Village Connect. My sincere thanks also to Dr Jack Walton, my Senior Research Assistant on this project.

It takes a village, they say; this is certainly true of Sing to Connect.

Dr Charulatha Mani
Founder and Research Lead, Sing to Connect

We need to recognise the barriers CALD communities face to healthcare including language and cultural barriers, which may affect health literacy and outcomes. We need equity in services to ensure those communities are not disadvantaged. (RACGP&FECCA, 2020 July 31)

WELLBEING AND ITS DIMENSIONS

Before I embark on describing the key aspects of Sing to Connect, I feel obliged to unpack the notion of wellbeing. The individual today is inundated with stressful situations, choices or the lack thereof, with little recourse to respite. Wellbeing, according to a burgeoning literature, is both a science and an art of living life while feeling better. It is a rapidly growing field in social science research, and over the past decade has sustained interdisciplinary interest from researchers across the disciplines of psychology, sociology, music, economics, and neuroscience, to name only a few. The word wellbeing is used frequently nowadays, and this program explored the ways in which wellbeing could be activated in those populations that not only need it the most but are also remarkably well-positioned to activate and share it among themselves due to their innate cultural strengths. Below, I set out to establish connections between culture and wellbeing to illustrate this point.

According to the recent and influential publication on singing and wellbeing, "wellbeing is an umbrella term used to describe multiple different dimensions" of human experience (Heydon, Farncourt, & Cohen, 2020, p. 3). It is frequently divided into hedonic wellbeing (subjective) and eudemonic (psychological) wellbeing (Keyes & Shapiro, 2004; Keyes, Shmotkin, & Ryff, 2002). Hedonic refers not only to the experiences of pleasure but also the absence of pain (Haybron, 2016). There is a consensus that hedonic and subjective wellbeing can be categorized into evaluative wellbeing (satisfaction with one's life), and experienced or affective wellbeing (sub-divided into feelings—positive and negative). Influential wellbeing scholars Ryff and Keyes (1995) have noted that eudemonic or psychological wellbeing pertains directly to human flourishing. It includes individuals feeling good about themselves and their identities (self-acceptance), feeling that they can shape their surrounds to meet their personal needs and desires (control and mastery), feeling a sense of self-efficacy and self-determination (autonomy), finding meaning in their efforts and challenges (purpose in life), honing their skills and abilities (competence), and believing that they are making the most of their talents and capabilities (personal growth and self-realization). These individual facets of subjective wellbeing operate in conjunction with social structures. In the Logan area, for instance, there are several programs being offered for individuals from CALD backgrounds to explore their social identities and pathways to self-determination, especially by Access Community Services. Such programs are positive social structures designed from and with the community.

Social wellbeing, importantly, stands as a related component of subjective wellbeing. Researchers such as Keyes (1998) have envisioned social wellbeing as having five dimensions: Firstly, social contribution refers to one's perceived sense of value to society. It is related to the idea of self-efficacy (belief that one can achieve objectives) and social responsibility (feeling able and willing to contribute to society). Social integration reflects the degree to which an individual feels like a part of their immediate society and has things to share in common with those around them. This aspect closely relates to the more nuanced concepts of social cohesion and social isolation which are key to this project. Social acceptance, which refers to an individual's ability to trust others (closely related to self-acceptance), social actualization of the self in relation to a positive trajectory of growth in society, and finally social coherence as an understanding how the society operates in relation to one's life. All of these factors impacting social wellbeing become amplified in the case of displaced members of society and, when influenced positively, can contribute to better health outcomes.

One of the core determinants of social wellbeing according to Keyes (1998) is an individual's involvement in activities with their communities during the past 12 months, and Sing to Connect directly activated that very space for the mothers and midwives. Further, Keyes (2005) has made an important distinction between mental health and wellbeing. Being in sound mental health refers to the presence or absence of symptoms, however, experiencing a sense of wellbeing refers to the presence (or absence) of positive indicators. Wellbeing is important for a joyful, relaxed, and balanced outlook on life. In Sing to Connect, a connection to culture, their babies, their bodies, and access to important knowledge on health afforded the mothers this very sense of wellbeing. I observed that singing activated intercultural understanding for these women and promoted intergenerational connectivity within the group (particularly when interacting with children and other elders from the family), and that when cultural and generational barriers were thus subverted, a sense of wellbeing emerged that was unique to the group and context. This project recognises that wellbeing needs to be welcomed with an openness that could only emerge from leaning into the discomfiture of vulnerability and acknowledging such a zone of uncertainty as a space of continuous individual and collective growth. Music allows for kindness, openness, and empathy to come forth and the rest is only highly likely to follow.

The model connecting singing, development, culture, and wellbeing from Heydon, Fancourt, and Cohen (2020)—drawing also on the biopsychosocial wellbeing model operationalized by singing from Gick (2011)—has informed the theoretical framework underpinning this project. I have also turned to the work of community music scholar Klisala Harrison (2019) on social cohesion and the work of Perkins et al. (2020) on participatory music-making, extrapolating these complementary ideas to inform my own practice and theorising. Figure 1 below depicts the framework that I devised based on the aforementioned stances. The notable feature of this framework is its culture-centric approach to wellbeing in a perinatal context, using singing as a tool.

This line of inquiry has been called for in recent times (see for example, by Harrison, 2019, and Fancourt et al., 2020b), however, precious little has emerged by way of research so far. It was useful for me to continue to revisit this framework as I journeyed through the weeks—singing, collecting and generating data, and trying to make sense of it all. I must acknowledge that this report includes only a cursory glance into the literature, theoretical frameworks, methodology, data collection, and analyses.

Its main aim, rather, is to provide the reader with a concise overview of the context, content, design, delivery, outcomes, and findings of this specific project. I have planned a suite of research outputs in the form of journal articles, conference papers, and creative works arising from this project which will be developed in 2021. Within each of these I hope to present a richer level of detail and nuance into each of the facets of research that informed and were informed by this project.

As I spent more time amidst the mothers and midwives, I experienced first-hand that making music together has the power to instill the quality of empathy (Clarke, deNora & Vuoskoski, 2015). Earlier in 2020, I studied and theorised empathy in the context of music making among those displaced, and those insights helped me in this instance (Mani, 2020a; 2020b). I could appreciate the value of empathy in this multicultural context; it unlocked in us the capacity to give and receive with our hearts. Through that portal of empathy engendered through singing, vulnerability could befriend strength. A description of the ways in which we achieved this is woven through the ensuing narrative.

Figure 1: A culture-centric framework for wellbeing across biopsychosocial levels

WELLBEING IN CONTEXT: CARE, COMMUNITY, CULTURE, CRITIQUE, AND COLOUR

Why is wellbeing important during and after pregnancy, and how can music help? This was the question that I had become very interested in over the last few years. My current understanding is that wellbeing through singing can be easily accessed, enjoyed, and harnessed to good health outcomes during the perinatal period. The first 1000 days of life, starting with pregnancy, are critical to the long-term health and wellbeing of both the mother and the child. Literature testifies to the fact that that poor health outcomes during this period may cause chronic disease with long term ramifications at the individual, familial, and health system level (Australian Institute for Health and Welfare, 2020). Further, a growing body of evidence suggests that in contexts where there is an early uptake of antenatal care and community-based continuity of care with concomitant allied services including socially-situated supportive activities, the long, mid- and short-term outcomes for mothers and babies can improve substantially (Wang et al., 2020).

In order to achieve a holistic model of wellbeing for the mother and baby, new approaches to connection and care that are non-pharmacological are becoming increasingly welcome. Among the recent spate of arts-based approaches that are fast gaining traction in the context of maternal and child health and wellbeing, singing has emerged a strong contender, particularly in the UK and Europe. A plethora of studies demonstrate the value of singing in mother-infant bonding (Cevasco, 2008; Fancourt & Perkins, 2017; Fancourt & Perkins, 2018a; Persico et al., 2017) and perinatal care (Chang et al., 2015b; Fancourt & Perkins, 2018b; McCaffrey et al., 2020; Reilly et al., 2019). Moreover, the previously limited literature specific to music and health and well-being of migrants and refugees is also growing (Mani, 2020a; Mani 2020b; Henderson et al., 2017; Phelan et al., 2017).

In addition to the benefits of singing for communities, the pressing needs for social inclusion in multicultural populations in Australia dictates the timeliness of community engagement programs, and Sing to Connect was no exception. The needs of communities are sometime apparent in the statistics that are available to us from the council, state and federal levels. However, it is important that these be regarded through a critical lens and explored first-hand through a ground-up strategy, not least in the context of vulnerable populations experiencing the shifting sands of policies and power structures around immigration, health, employment, and education, on a daily basis.

Today, Australia has a population of around 28 million people. Over one-quarter of Australians were born overseas and are either migrants or have been displaced from their homelands due to unforeseen circumstances (Multicultural Recognition Act, 2016). According to the latest Australian Institute of Health and Welfare report on Australian mothers and babies, over one-quarter (27%) of mothers who gave birth in 2017 were born in a non-English-speaking country and this percentage is on an upswing. Australia's CALD population speaks over 300 languages today with many families raising their children to be bilingual and culturally plural.

The country is likely to remain strongly multicultural, multi-faith, and multilingual in the coming years, rendering social enfranchisement, cohesion, and wellbeing in these communities a national priority. In the context of CALD women, social enfranchisement and psychosocial support are connected to systematic power imbalances and entrenched disadvantages that this demographic endures within and outside their families. The various factors that have been identified in the literature as impediments to CALD women's social integration and wellbeing include low English language skills, no or low literacy, minimal social support structures and familial networks, a rise in racial discrimination, insufficient partner support, economic insufficiency, and domestic abuse. These impediments assume greater proportions in the perinatal context and in the early childhood space (Miller & Mander, 2017).

One of the areas in Queensland which enjoys a high percentage of migrant and refugee populations is Logan. Logan's approximately 314,000 residents come from all over the world with more than 217 cultural groups represented. Over 3,000 women a year give birth at Logan Hospital, and around 55% of them are from CALD backgrounds (Logan Community Health Action Plan, 2020). Prof. Jenny Gamble, Head of Midwifery, Griffith University, was instrumental in introducing me to the midwifery unit at the Logan Hospital. My consultations with Prof. Gamble frequently dwelt on the potential of singing as an intrinsic means to achieve and/or maintain physical and psychosocial wellbeing in both mother and child, and the need for a robust knowledge base around this. My discussions with midwives at the Logan Maternal and Child Health Hubs, the Oversight Committee, and Access over several months importantly revealed that for CALD women in the region, the timeframe from pregnancy until a baby is around 4 years of age is a crucial period wherein they require a significant amount of social support and wellbeing assistance from a culturally sensitive perspective. Often overlooked in such discussion is the cultural strength that these women carry within themselves. Unlocking their strength in their currently challenging contexts, I believed, could be healing and empowering not only for these women but also for those around them. Time, space, care, and intent to connect and listen were determined as key requirements for this.

The Logan Maternity and Child Health Hubs at Metro South Health (2020) have been active in this space since 2018. They have been successfully navigating the multitude of challenges within the healthcare system, while boldly championing change, improvement, and innovation through their health service. The Maternity Hub for CALD women at Access Community Services partnered with Sing to Connect on this project to create a culturally rich platform for CALD women to be able to express themselves using song and storytelling while also receiving antenatal classes and health information modules from the committed midwives. This context wherein cultural knowledges and health knowledges are shared concomitantly is particularly inspiring from a health literacy point of view. The culturally-grounded knowledges of these women come forth strongly in this model. As the weeks progressed, we would witness elder women from some of the families attending the workshops with their pregnant daughters, and we would see intergenerational bonds being forged through convivial sharing of culturally relevant knowledges related to motherhood. We would also observe that knowledges thus shared in an organic and distributed manner could offset the prevalent and entrenched power imbalances in the contexts of health care; that they could trigger affective responses and reflections from other attendees, including the midwives and the music facilitators. At those times, the workshops would become highly inclusive, generative, and egalitarian forums.

In taking an integrative approach to midwifery, the Maternal Hubs adopt the Lancet Series Framework for Quality Maternal and Newborn Care (Lancet, 2016; Renfrew et al., 2020). This is a continuity of care model that addresses the holistic wellbeing of the woman and family through framing the midwifery services as a platform that also affords access to "wrap around services," including access to advice on housing, education, domestic and family violence support, and social connection. As the recent figures from Metro South Health reveal, approximately 900 to 1000 women per year have benefitted from this model between 2019 and 2020. There is a reported improvement in the uptake of antenatal visits in vulnerable women through this model, and in the context of Sing to Connect the antenatal classes were a regular occurrence that ensured weekly check-ins for the women with their midwives, punctuated by songs, stories, food, and laughter. The design of Sing to Connect was couched within this "transformative maternity care" model while also standing alone as a social engagement initiative (https://www.transformingmaternity.org.au/).

In arts-based interventions that are enacted in the context of health, a common critique has been around the ways in which the intrinsic value of the arts are eclipsed in favour of the more easily measured instrumental outcomes. In Sing to Connect, the singing was programmed for joy and leisure rather than to deliberately reduce blood pressure or cortisone levels. This approach is therefore different from more widely prevailing quantitative clinical study approaches to evaluating and measuring impact and outcomes. In this program, singing operated in the way it usually does—it gave respite, peace, and joy. The ways in which these intrinsic qualities of singing helped with the women's maternity became apparent through the self-reported experiences of the women, the impressions of the midwives, and participant observation. I elaborate very briefly on the methodologies that I applied in this study in the ensuing sections, to share key processes, ideals, and ethical concerns that arose in determining what constituted research data. This brings to bear also on the politics of ownership of cultural assets that emerged in this context.

The project addressed the following gaps in cultural studies scholarship, and I draw attention to these from a critical race perspective. Of the many studies that examine the function of singing as a psychosocial intervention in maternal care, only a handful have explored the use of voice in a culturally appropriate manner. Further, there seems to be a clear omission of representation of people from CALD backgrounds. For instance, the groundbreaking scientific research carried out by the Royal College of Music and Imperial College involving women singing in a perinatal context combined both biological and psychological data and demonstrated a 41% reduction of symptoms of postnatal depression and a recovery rate of up to 73% of those taking part in the program. However, the research team chose to exclude non-English speaking mothers from this study because they were not able to interpret the informed consent documents (Fancourt& Perkins, 2018a). The use of interpreters or alternative consent processes could have addressed this issue, however, large-scale projects conducted in Western contexts more often than not serve the majority, meaning that the margins remain excluded (though not through direct ill will). While there is a significant body of research in Australia on the benefits of music and singing in CALD communities, particularly in school-going children and youth, only a handful of them relate to women and babies (Marsh & Dieckmann, 2016). It is heartening to see that midwifery researchers are now systematically looking at music as a non-pharmacological intervention during childbirth to reduce stress (Caffey et al., 2020), and recent reports from Tasmania of music in the birthing room have been shown on prime-time news. The potential of music in the antenatal and perinatal context, however, remains underexplored in this part of the world.

To be a coloured mother in a colonial nation is challenging, and I can testify to this first-hand. Despite being educated, reasonably well-placed in society, and fluent in English, I have always been vulnerable to the systemic racial, linguistic, and ethnic prejudices that people of colour like myself are faced with in their everyday lives. The trials involved in navigating this imbalance as women and mothers has, I argue, led to a kind of training of coloured folks like myself to oftentimes accept instruction and authority in our new homes without questioning it or seeking explanation for it. We are wary of being perceived as rabble-rousers, lest we step on toes and lose favour with the more powerful white people (Trimboli, 2020). Sing to Connect created a casual intervention on the scale of an everyday occurrence. It prompted a subtle dismantling of hierarchies and power structures, even if only for moments in time—something not to be discounted according to philosopher Lefebvre (1947/1991), who declares everyday rituals and engagements a utopian reality transcending the shackles of conformance and complicity. Australian Critical Race Theory scholar Daniella Trimboli(2020) has expressed everyday multiculturalism in acts such as these to counter the prejudicial structures that weigh down culturally diverse subject in the guise of an othered multiculturalism. A conducive firmament for mothers of colour to explore and express their voice in a safe and welcoming environment—to speak, to sing, to create, to yarn, and to share, with others and their own—is a sacred space of trust and empowerment. To be able to own and value our bodies and minds through movement to music and to experience gentle contact with our babies and our breath is an invaluable experience that is a human right never to be denied. In my earlier consultations with the midwives during the co-design stages of the engagement and research, one of the midwives observed:

> *When we enter the home of our women to offer our [midwifery] consult, it sometimes feels like we are telling them what to do and they just do it without questioning or resisting us. I sometimes feel that I want to be part of those vibrant conversations where our assumptions are questioned by these women. I want to be able to understand why a certain day is auspicious for delivery; I want to be able to appreciate those little stories that they carry in their hearts from their mothers and grandmothers. I would love to make a genuine connection with them (Co-design workshop, August 20, 2020)*

I quickly understood that the midwives were keen for a window into the culture of those they were helping, to better understand and appreciate the cultural identities that these women were holding so dear. It seemed to me that they wanted to engage organically and respectfully with their women, to be in position to offer the culturally informed community-based care that they were best placed to provide. As another midwife chimed in: “Yes, we would like to flip the power of sharing information over to them so we can understand the person within—as a whole.” It was in those subtle moments that my belief in this program found affirmation. Music—as song, language, and associated sentiment—is one of the finest ways to understand the voice of a person, literally and metaphorically. The embodied voice mediated by culture is emblematic of a rich tapestry of connections waiting to be woven, given the luxuries of time, place, creativity, and care. Sing to Connect had offered us the triumvirate of time, place, and care to explore cultural expressions through voice against the backdrop of self-determination and resilience.

If everyday practices provide respite for people of colour from the calculative agendas of multiculturalism that remain tightly coiled in the guise of siloed domains of endless otherness, then the accessible ritual of singing trumps as a viable, cost effective, and respectful one. The result it has produced has been heartwarming.

PROJECT DESIGN: COLLABORATIVE FRAMEWORKS, CHALLENGES, AND RESOLUTIONS

I have been asked very often in the course of my two-decade career as a singer: What is it about singing that makes it a special means of musical communication? Why and how do singerly bodies in a physical space activate individuals, groups, and societies? To me the significance of singing lies in the materiality of the embodied voice occupying a physical space, unapologetically redeeming its right to cultural expression.

Helen Phelan (2017), a well-known singer-researcher working in the field of music and migration notes that singing operates across five key dimensions on people: resonance, somatics, performance, temporality, and tacitness, and through each of these dimensions propagates wellbeing. Wellbeing is the sense of experiencing positivity and an ability to engage with purposeful clarity in personal, interpersonal, and social activities. Reflecting on these dimensions, I believe that in my earlier research from 2010 onwards I may have explored most of the these through the lenses of music education and performance, and in doing so felt a sense of fulfilment that I describe as a warm feeling—I liken warmth to the feeling of partaking in a steaming cup of hot chocolate on a wintery night by the fire with a cat purring at my feet. Through Sing to Connect, however, I was exploring the possibility of sharing such warmth with the community, for us all to sit together by the metaphorical fire sipping chocolate—a ritual towards wellbeing.

The initial challenge that I faced in envisaging the design of Sing to Connect was in relation to being physically together in the ritual of finding warmth through singing. This challenge was directly related to the COVID-19 pandemic. In April 2020, when Brisbane was in the thick of lockdown, I sat alone in the stillness of my studio staring at a wall, feeling on the verge of an oncoming wave of hopelessness. The urge to resist this wave came as a burst of strong intent—to write a proposal for Sing to Connect to help other women more vulnerable than myself. I had been engaging with folks at Access and the Hubs even prior to this and during those initial weeks of lockdown my mind would often wander off on thoughts related to how these women might be coping with their pregnancies during the pandemic. With a view to combatting social isolation in these marginalised communities in the wake of the pandemic, I drafted a proposal which, after a few iterations of reworking, was supported by the QCRC, Metro South Health, Access Community Services, and Logan City Council.

My approach in designing Sing to Connect was to spend time with the culturally diverse communities at Logan through the support of Access Community Services. My initial conversations with the populations remain the most memorable—I made friends with some of the women and this foundation has yielded relationships and trust like no other. Likewise, with the midwives, we took time to connect on the various issues at stake. I was anxious not to reduce the complexity of the variables in play, and appreciated the midwives' guidance in matters relating to their women, the health circumstances that they were faced with, and other social needs. I also reviewed relevant literature, policy documents, and trends. What emerged was a detailed review of the literature from around the world that regarded the role of singing in fostering wellbeing, that regarded the role of music in improving self-identity and cultural healing in ethnic minorities, and research that has to date applied music in the context of midwifery. What was in paucity was research specific to the perinatal mental health and wellbeing of CALD women. Some progress is currently being made; for instance, Garry et al. (2020) have recently published a scoping review on arts-based methods to improve migrant health outcomes. Trends and policies, overall, call for further research in this niche field, notably in women's health. Turning to the communities themselves turned out to be key to refining correspondences between research trends and actual needs.

Prior to lodging the Logan City Council Community Projects Grant application, I conducted 2 scoping workshops with some of the women and midwives, and post-award I conducted 3 co-design workshops. The community engagement officer at Access Gateway at the time, Summer Hancock, was also present for these sessions and gently guided the community members into conversations. The co-design phases were also carried out with the guidance of Michelle O' Connor, Head of Midwifery at Metro South Health. The information I gathered on-ground combined with the more recent learnings from the co-design sessions clarified to me the benefit of deploying culturally relevant songs, stories, and lullabies in this complex context, and highlighted that decisions regarding how this could be done needed to come from the women themselves.

At this juncture we had a fluid framework supported by social connectedness and access to opportunities at the centre. Social occasions offering opportunities for individuals to get in touch with creative ways of cultural exploration—including song, language, and lore—have been identified in literature as social determinants of health (SDOH) (World Health Organisation, 2020). Collectively, we believed that through singing in language a culturally-led sense of wellbeing could emerge as a channel for activation of self, research, and engagement. The co-design phase involving the midwives and women was encouraging. The women made clear that they valued flexibility in participation, and preferred interviews rather than surveys as a means for data collection.

Sing to Connect has been designed based on evidence from research studies that demonstrate that singing is indeed an easily accessible, affordable, and culturally responsive way to wellbeing in a plethora of communities, including in the perinatal context. However, it has not relied on tested frameworks, but built a flexible one from ground-up. Aimed at the maternal refugee and migrant communities in the Logan area, we felt that the pilot study module was poised to adapt even more closely to the actual ways in which singing in language operated in facilitating the emergence of what wellbeing philosopher George Engel (1977), and later Mary Gick (2011) described as biopsychosocial wellbeing—positive outcomes that are apparent across physical, psychological and social levels of a person. In the short-term, the pilot initiative set out to engage with the populations through a respectful community-led design. In the long-term, our mission through Sing to Connect is to support entrenched intergenerational disadvantage in the area through a whole of community strategy, using arts and health literacy as registers of address, beginning with the mother. Through this program, my

vision is to create opportunities for care and connection for ethnic minority mothers and newborns, thereby improving the social determinants of health and community outcomes from a grass-roots level, in Logan and beyond, across a suite of dimensions including those depicted in Figure 2. Sing to Connect speaks to each of these, with the exception of the economic dimension.

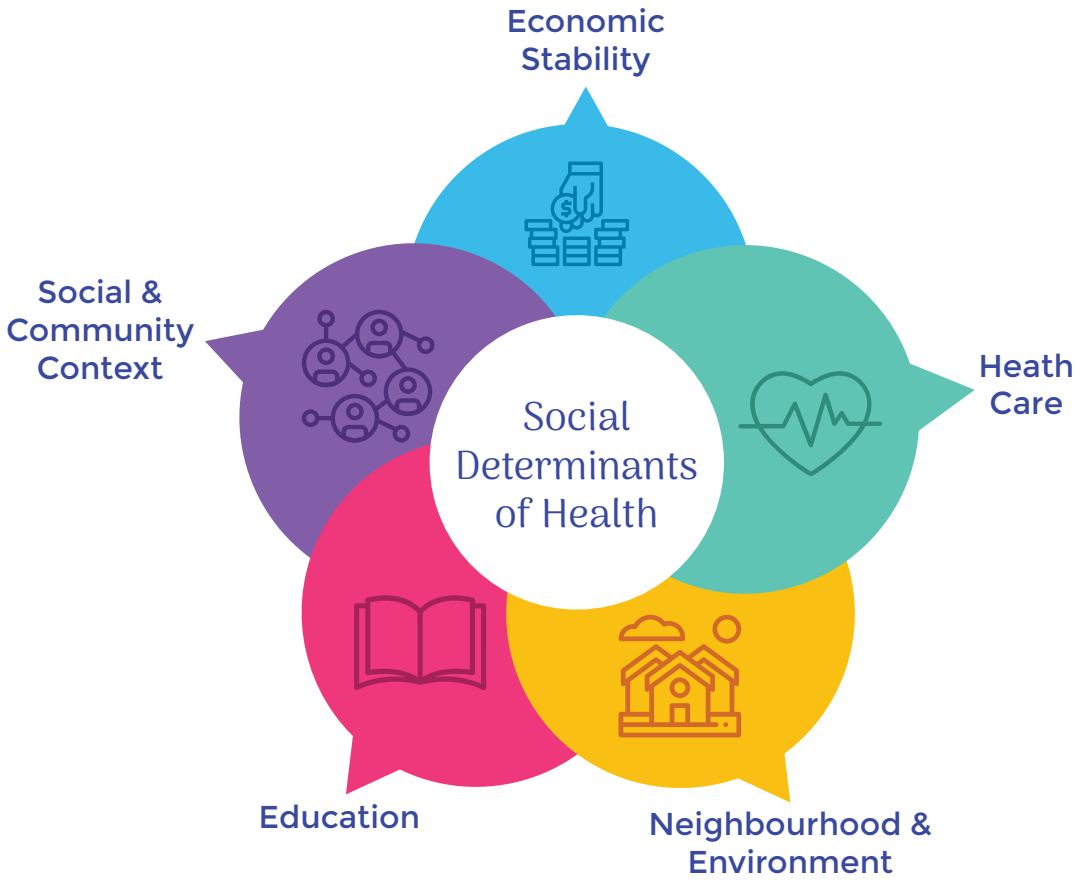


Figure 2: The dimensions of influence on social determinants of health

By May 2020, given the COVID-19 situation, Michelle O'Connor from Midwifery at Metro South Health and myself were almost convinced that if the funding were to come through, having an online delivery model would be better than having none at all. Upon the award of the grant we proceeded with meetings (between the midwives, community liaison staff at Access, and myself) to undertake co-design of the workshops. That is how and where midwifery could meet music—in programming and philosophy. We decided to keep the workshops fluid and responsive to the needs of the attendees, while having a basic structure that included beginning with music, having a module of singing, songwriting, and sharing of stories at the core of the sessions, and weaving in the antenatal classes as short tailored modules of information sharing, questions and answers, and demonstrations. We also agreed that we would close with singing. The midwives were excited about the idea of singing with women they had, until then, been meeting in a formal and consultative role.

It was during this productive phase that several problems related to the proposed online delivery model also came to light. I had designed a tool to assist in the recruitment of women for Sing to Connect, and when the midwives administered this two-minute survey to the women during their regular consult there were twenty responses. The survey revealed that sixteen of the twenty mothers and all six of the midwives surveyed preferred a face-to-face model of engagement. Many of the women (12/20) reported limited or no access to internet, data and/or equipments necessary for online connectivity, thereby reducing their chances of online participation. The survey also revealed that ten of the twenty women required interpreters, and had difficulty in procuring transportation should the engagement happen in person. In parallel, reports from research and engagement initiatives the world over were revealing that, while online singing was an interesting alternative in pandemic times, it was ineffective as a method to achieve social bonding or singing satisfaction. Social bonding, singing together, and the antenatal engagement sessions with midwives and their artefacts (toys and implements to demonstrate various aspects of child-rearing) were key to the success of our program and the organisational team were loathe to settle for reduced numbers and diminished emotional returns in adopting the online pathway. In August 2020, we experienced a difficult few weeks as we attempted to reconcile our options.

Luckily, the restrictions around COVID-19 began to ease in Brisbane, Queensland, and with strict measures of social distancing and well-structured COVID plans we were in a strong position to establish the program for a face-to-face delivery beginning September 2020. There were some initial issues. Some women (10/20) lacked transportation (they did not have a car and/or did not hold a driver's license, and public transport was not easy to access or entirely risk-free). With support from community liaison staff and the midwives, several of the women, however, quickly gained the capacity to make friends within the group and avail themselves of car-pooling options for pick-ups and drop-offs. Two of them took the opportunity to take their driving tests and pass. Some of them drew on their partners' support for transportation. We have frequently had supportive fathers and fathers-to-be excitedly drop off their wives and younger children. Sometimes, I have invited them to sing, but with a shy smile they have skipped along. Perhaps a singing program for fathers of babies and young children might also be welcome.

The challenges around transportation quickly turned into opportunities: for developing familial bonding, cultivating a sense of agency, and friendships. Belonging to the group elicited in the mothers a sense of purpose and zest that translated into seeking ways to ensure that they continued to be part of the regular workshops, in person. Out of the 30 women who did attend overall, around 9 could be considered regulars (attended more than 6 of the sessions, and across at least 3 consecutive weeks). We did not investigate the online option further for this instance of Sing to Connect. Witnessing the rest of the world go in and out of lockdown emphasised to us the relative strength and safety of our position here in Queensland. We wished to take full advantage of this position, and Sing to Connect proceeded in-person with social distancing regulations in place at Village Connect, Hosanna Logan City (a Community Faith Centre) at Slacks Creek.

The auditorium at Village Connect is worth mentioning here. A large and welcoming space designed to house around 100 people (after taking into account social distancing), Village Connect was a highly suitable venue for these workshops. Having overcome the initial obstacle of physicality, we found ourselves in a comfortable space, together. As the workshops ensued, I became aware that it was literally time for the wellbeing to unfold—this was a powerful conscious realisation. Despite the extensive prior research and planning that I had undertaken, I was not sure how this might feel, look, and sound in this context—literature cannot substitute practice, and in the context of music research that is focused on communities, I cannot overstate the transformative role of exploring cultural practices with community.

The women were informed of the program by their midwives and received information about the program through a flyer. They were given the option to attend as many as they could and wished to, with no compulsion to participate in the research. They were also free to join the project at any point. We have had around 34 women attending in all, with around 9 regulars who came almost every week. The women could join the program at any stage of pregnancy or early motherhood. Several women came with babies from as little as two-weeks to 10 months old. They also brought along their older children, including toddlers. 2–4 midwives were typically present for every session, along with 2 music facilitators and 2 community liaison staff from Access who helped with child-minding while also adding to the musical voices. Around 2–3 interpreters would join us per week. Over the course of the 12 workshops 9 languages were represented—Kirundi, Swahili, Rwandan, Somali, Arabic, Burmese, Chin Zomi, Persian, Korean, and Hindi. The women were primarily from various parts of Africa, including Kenya, Rwanda, Congo, Tanzania, Ethiopia, and Somalia. There were attendees from also Burma, Afghanistan, Pakistan, Iran, Korea, and Japan. They had lived in Australia across a range of one to ten years. Over 80% of the women required interpreters to communicate freely. Around 90% of those requiring interpreters are currently learning English language at TAFE. Those fluent in English had learned the language in their home countries.

Each week, we revised songs from the previous few weeks and collected new ones from the attendees. We augmented our repertoire as we travelled through the weeks and eventually all of the attendees had access to a collection of songs, shared stories, and memories that they could take away and cherish as a product of their social engagement and learning. As music facilitators, Lynette, Daisy and I brought along to the program our own offerings too. Lynette brought in a few indigenous songs (Innanay and Mamma Waruno) that she had learned during her years of work with Indigenous Communities in Gungarri Country (South West Queensland). I brought in some traditional lullabies and *motherese* sounds from my native village of Thanjavur in South India, and Daisy brought some exciting play songs in English. When I shared the lullaby in my mother tongue Tamil, the women could easily pick up the syllables *A ra ro A ri ra ro* and sang along while gently rocking their babies. This memory of us all moving to a meaningful song from my culture is a fond one for me. Many such memories are fresh, and I feel ready to offload them here on the page lest they are forgotten. However, the songs belong to those mothers who shared. The memories I owe to them. We also wrote songs drawing on the midwifery messages of the day, extrapolating on them to weave in the words and phrases of the women. The group found collaborative songwriting fun and spontaneous. It is notable that there is much research that demonstrates the therapeutic value of collaborative songwriting (Baker, 2016). As one of the women noted, “singing together we feel stronger”.

I wrote this poem on one of those memorable Tuesday mornings. The air was thick with stories that day. Songs signifying the shifting sands of hope, joy, loss, recuperation, and resolution had been sung and heard. I had jotted these lines down in my little blue notebook as soon as I had grudgingly climbed into my oven-like car that stood sterilising itself in the mid-morning haze:

These songs are not all mine to sing

These stories are not all mine to tell

I stand in the middle of the sharing

Gathering those flowers that just then fell.

Some memories brought the ladies delight

Some a shining tear obscuring sight

Warmth washed over moments intense

The blessing of being allowed to jump in mid-song-sentence.

For it is in those moments of light that darkness assumes meaning

In love's laboured delight sometimes we were freewheeling

I sing, I move, I listen, I soar

I allow myself the permission to give and receive – just that much more. (29/9/2020)

In understanding my role in the workshops, I tried to slow down those moments in time between which a song was first uttered by a participant for the first time and in their language, to the time at which it was realised in song in unison by the group. The intensity ensconced within those moments housed the complex processes and politics of listening, repeating, learning, teaching, and ownership, and pushed the limits of capacities musical and linguistic that were required to fulfil the immediacy of that demand. As a facilitator, I had to sustain a state of being hyper-alert, especially when a participant offered their song for the first time. They would often sing it quickly, softly, and casually. I found that I had to attend to this offering with all of my senses and open my ears, heart, and voice to the sounds of the language, inflections of tone, phrasal motifs, intonations, pitching, stresses, emotions, and pauses within, all at once. As my co-facilitators captured the tonality and key to offer support on the guitar, I would most often listen and repeat what I could hear and cognise to the woman. The women would then correct my pronunciation, complete my phrases and repeat the lines to allow me time to receive and grasp—all within a few minutes. During this time the other mothers would wait, gently hum, and watch what was unfolding. In those moments the midwives would often betray utter shock to see their shy clients flowering through song. I would then invite the woman who offered the song to come up to the centre of the circle and teach the group her song—line by line—and along with my co-facilitators I would support the group by repeating loudly at first, and then softly along with them. Meanwhile, I would also be writing the song on the whiteboard in English, phonetically capturing the sounds and text. I would then check with the woman as to whether it looked right. They would correct it, rewrite it, and tell us the meaning of it. My learning became teaching prompts for the women and flipped around the power dynamic, conferring on them increased agency, responsibility, excitement, self-efficacy, motivation, and self-confidence.

We have had some very rewarding moments when a sense of personal investment has been assumed by the women, particularly during the teaching of their own songs, and when their participating in songwriting used their own phrases. They have turned to look at my phonetic writing of their song on the board, picked up the marker and wipe, wiped off any incorrect syllables in English, and replaced them with the correct ones. There have been instances when they have decided that a certain word needed to be in the refrain of the song instead of an other word or phrase. In this way, many women who had entered the room rather shyly earlier—stating quite vehemently that they were not singers—turned out to be fabulous communicators, singers, creators, leaders, performers, and teachers of song, meaning, cultural significance, and language. The facilitators found the spirit of generosity that came through to be rather inspiring. In such moments, Sing to Connect became as much about capacity-building in literacy, creativity, and education as it was about social connection. Our claim to wellbeing here is therefore made through a quilted layering of the myriad of tasks, activities, and outcomes that accompany the ritual of singing and songwriting.

Notwithstanding our intent and enthusiasm, the midwives and us musicians both encountered challenges in the design and delivery of the workshops. The interweaving of singing and health messaging had to be timed such that neither lost their significance. This required a trial and error strategy, and our approach varied according to the number of attendees and the nature of the midwifery messages. For instance, in the first week we had a clear demarcation between the antenatal classes component of the workshop and the singing component. However, as the weeks progressed, we found ourselves beginning with song. This approach "uplifted the mood in the room", as midwife Rowena noted. In those instances, the women seemed more aligned with each other and with their own ideas, and this was clearly seen during the ensuing midwifery messaging components of the sessions. This design privileged the women's perspectives and learning styles rather than our own agendas. We also found ourselves breaking into song in the middle of the health messaging sessions, just to take a break and regroup. I observed in my journal at the time: "The joy and energy in the room sustained the engagement and interest levels better." Several women noted that through Sing to Connect they could "make friends," "have fun," enjoy "learning new things" from others ("things" included songs, phrases in language,

health tips, food and nutrition tips, etc.). For my part, I have learned that *asante* means “thank you” in Swahili, and that Somalia has a version of *dosa* (a savoury crepe) like South India!

We also encountered spatial challenges. The hall was vast and had high ceilings with good acoustics, however this meant that as any older children tore through the hall (in play) their excited shrieks left little opportunity for quiet listening. More positively, we had installed dividers to cultivate a sense of cosiness in the setting, and child minders from Access Community Services were understanding and helpful. “We did our best on any given day,” said my co-facilitator Daisy on one of those difficult mornings. I think the sense of collective commitment to the community unified us all in spirit as we worked our way through the curveballs. Research-wise, I faced some challenges. The main strands of research that I was well-positioned to engage with in this context were from music, migrant, health, and wellbeing angles. However, I was well aware throughout that there were rich insights that had emerged from a midwifery perspective that I was not able to fully fathom or capture given that my disciplinary expertise does not lie in that area. I wished many a time for my reflections and observations to be counterbalanced against those from midwifery. This seemed important given that new perspectives on the continuity of care model are being welcomed, and the discipline and practice of midwifery is seeking evidence-based approaches from a wide range of other disciplines (Renfrew et al., 2014; Wang et al., 2020). In the next iteration, I hope to engage with a midwifery researcher who can approach this study from that scholarly angle as well. This would help provide a granular view of the issues, possibilities, and solutions at stake in this complex setting.

SING TO CONNECT'S OWN LITTLE SONGBOOK

The songs that were shared through Sing to Connect were from the many mothers in attendance, the music facilitators Daisy and Lynette, and myself. They included lullabies and play songs. We also collaboratively wrote our own multilingual songs. These songs drew on the health messages for content, the phrasings of the midwives and the women for lyrical style, and eventuated in popular tunes usually suggested by a member of the group. A large whiteboard became our repository of lyrics. It was never erased throughout the 12 weeks and grew consistently. Figure 3 shows the whiteboard at its prime.

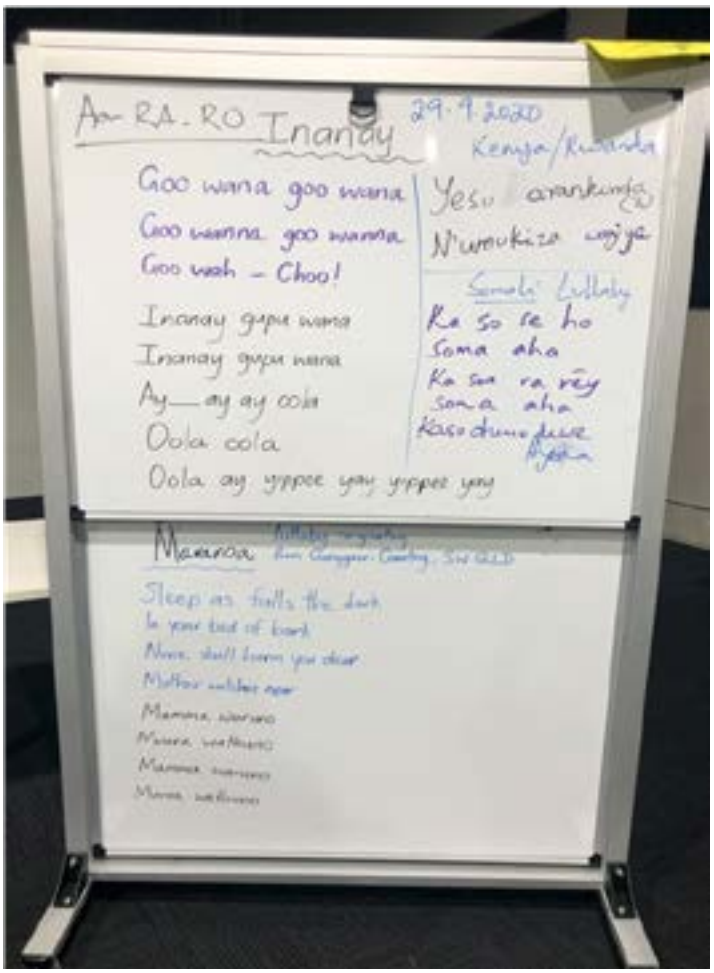


Figure 3: The whiteboard at its prime.

The following songs became well-loved and were sung regularly:

1 Inanay

Context: We started all our sessions with the well-known indigenous children's song popularised by the Tiddas band. Singing this at the outset was our way of paying our respects to the land upon which we were gathered and to the rich cultures of the Indigenous Peoples of Australia.

Inanay capuana
Ay ay oola
Oola oola oola yay yippee yay yippee yay.
Goo wana goo wana goo wana goo wana goo waa choo!

2 Yesu Arankunda

Context: This is a worship song in Kirundi and was kindly offered to us by the women from Congo and Rwanda. Their faiths and beliefs as well as spiritual values were central to how they saw themselves as mothers. Songs such as these foreground their beliefs.

Yesu arankunda
Yesu arankunda
Yesu arankunda
Nu muki za wanje

3 Ka so se ho

Context: One of the pregnant women from Somalia was accompanied by her mother, a mother of 11 children! The mother and daughter duo offered us a playful lullaby from Somalia, Ka so se ho. We all loved singing this one.

Ka so se ho
Soma aha
Ka soa ra rey
Soma aha
Ka so drumo duwe hyena

4 Mamma Waruno

Context: One of the music facilitators, Lynette Lancini, has spent much time working with indigenous communities in the Maranoa region in South-West Queensland and shared Mamma Waruno a favourite from her community. We are grateful for this gentle tune. This became the rock-a-bye song for our group. We would stand up in a circular formation and gently rock our bodies and our babies to this song. “Very relaxing” and “a lift for the spirit” were some of the comments that were made in relation to this song. We used to sing some lines for sleep in English along with this song as a refrain.

Mamma waruno
Murrawathuno,
Mamma waruno,
Murrawathuno
Sleep as falls the dark
In your bed of bark
None shall harm you dear
Mother watches near

5 Araro Ariraro

Context: I offered this Tamil lullaby. We were talking about our mothers. I recalled memories of my grandmother in Chennai singing me this lullaby. I shared it with the group. It is a song with typical motherese syllables from my culture, *araro*, regularly appearing.

Araro Ariraro
Yaaradichu nee azhudhe
Sunnambum Manjaluma
Suthi Adi Kannaakku

6 How great thou art!

Context: This famous Christian hymn became a favourite. Our women from Burma (Myanmar), New Zealand, and Congo knew it in their own languages and could sing it together as a multilingual garland. Pearl, the woman who first sang this in the group, was from Burma—a brilliant singer who still feels very shy to identify herself as one. She sang it in a mix of English and her language Chin Zomi. She was then joined by Maori and Kirundi languages. Due to the many languages it was sung in, I have elected not to present the lyrics in any one language.

7 God's love is so wonderful!

Context: Pearl's faith and spirituality were her rocks during her pregnancy (she was around 20 weeks pregnant at the time). She sang this piece with gesture. It gave our group the first excuse to stand-up in a circle and move our bodies with gentle gesture that was also meaningful. I narrate these experiences of singing and discuss the gestures in my reflective entries.

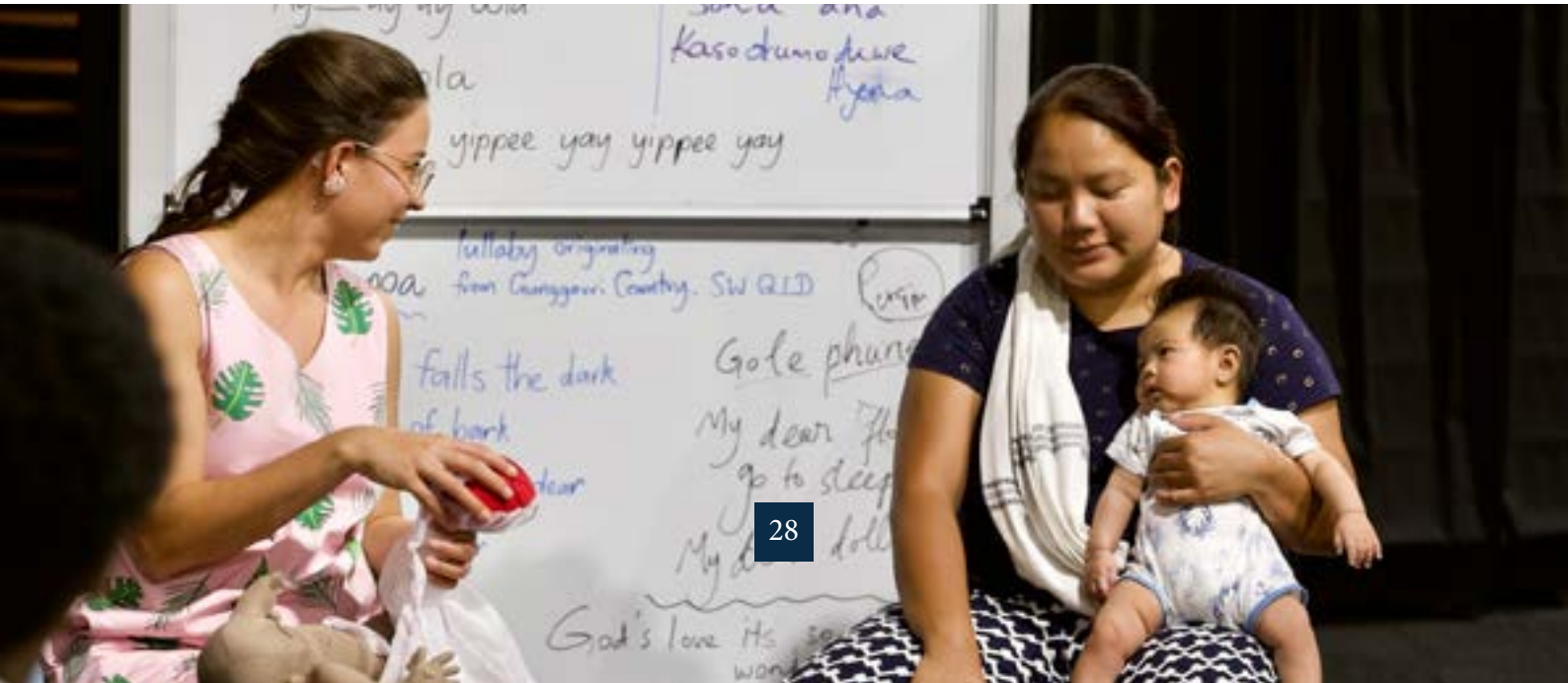
God's love is so wonderful (x3)
O Wonderful love!
So high you cant get over it
So deep you can't get under it
So wide you can't get around it
O wonderful love.

8 Yok Yek

Context: I offered this Thai lullaby to the group. This was shared with me by a friend and migrant Thai mum (Inja). I played a recording of her singing it to the group, with her permission. They loved it and were interested to learn it. She also had shared a story with it, which made the learning process remarkably interesting.

Yok Yek Ao ey
Nam Tuam Mek
Kra Taii Loy Khor
Mah Hang Ngor
Kod Khor Yok Yek

Inja's story:
Thai lullabies are usually story song for children before bed time. A poem or rhyme. Sometimes the verse may not have meaning. They may be fun words. The stories are about life and living. They reflect love and concern. They are nice for mothers and babies. The story of "yok yek" song is about a rabbit climbing on top of a puppy to escape the floods. My mom sang me this song and put me to sleep. I miss her. She also used to take me in her lap, moving my hands back and forth to the beat as she sang me this song.



9 The Placenta Song

During the antenatal class the topic turned to the placenta, and the words for placenta in Chin Zomi (Lamh) and in Kirundi (Ingobyi) were shared by the respective women. I was seized by inspiration to try our hand at collectively writing a song that reminded us all of the importance of the placenta. We co-created the song "O Placenta" using the phrases that emerged from the women and the midwife in relation to the placenta: "nourish my baby"; "source of life"; "tree of life". The sense of agency and ownership to that special part of their bodies at this special time that the women felt was indescribable. I suggested the tune of a lullaby that I had heard to couch these words. Within minutes, we were singing a song that we had generated together—it felt so participatory! Clearly the women were excited that their participation had contributed to the song itself. "This was different from our earlier experiences of listening to and learning songs that were already out there in the world. This was us creating something new from coming together on this day at this time and place in the world", said Ruby. It meant a lot to me to hear this.

The source of life, Nau Lamh
Nourish my baby, Ingobyi,
O Placenta!
My Placenta!
The tree of life
The source of life.

10 Yesuwana

This piece is a Swahili worship song offered to us by Hope. A mother of 8 children, pregnant with her 9th now, Hope mentioned that making friends through singing together was something she really valued—in church and in Sing to Connect.

Yesuwana pendawa thotho
Ni yesu Ni yesu
Ali Kufa Kwamu tini Kuwandawa makusa

11 I immunize, I exercise

Drawing on the midwifery messages of the day, safety, wellness, and immunisation, the women co-created this song. Each of them shared an activity that they engaged with during their pregnancy and with their child, and these were woven into the song. Within around 5–10 minutes we had a song ready. Daisy and Lynette came up with a lovely tune and led this piece.

I keep myself safe
I keep my baby safe
I immunize, I exercise!
I walk, I sing, I eat right,
I rest, I play, I exercise.
I care, I comfort, I repair,
I immunize, I exercise!
I work at home, and I sleep,
I spend time with family.
I keep myself safe,
I keep my baby safe

Note:
I have taken permissions from all the generous women to share their cultural and embodied cultural wealth here, and convey my heartfelt thanks to them. To share the recordings as tangible artistic outcomes is fulfilling, and these are available on the official website www.sing2connect.com. These songs were the processes through which we explored wellbeing. These pieces exemplify the cohesive nature intrinsic to music and place the findings reported here in a very human and everyday context.

The project began with engagement, and the research became embedded within it only after an essential and fulfilling period of relationship building. As per Griffith University ethics guidelines I developed an Informed Consent Package and Participant Recruitment package, both of which were formally approved (GU Ref no. 2020/267). I printed out multiple copies of these—for the women and the midwives, knowing full well that in the case of many of the women I would have to sit down with the interpreter and explain to them what the documentation was all about. In simply explaining to the participants what was happening I developed a deeper understanding of my own beliefs, research aspirations, and rationale than I began with at the outset. To obtain the consent for their interviews and for media recordings, I sat down with a small group of the women at a time over a cup of tea and told them exactly what the writings on the page meant. I was assisted by interpreters on a few occasions when the women required them. I checked with the women as to whether they were in alignment with all of the points in the informed consent document. I also gave them the ongoing opportunity to walk away from the research while continuing with the engagement. I was keen for them to reflect on their role in the research on their own time and decide if they would like to participate. I also gave them the option to sign the participant consent form immediately. All but one woman signed by the end of the two-hour session. The woman who did not sign conveyed to me later that she did not want to participate in the research, and I did not wish to push her by asking why that was.

Some of the questions posed by the women prior to signing were: How this research might help with progressing their opportunities for further social activities? How I might "get more money to continue" this after 12 weeks? One of them asked me to promise that I wouldn't leave after the 12 weeks and that I would regularly hold the sessions. She was the one who later would report that the sessions helped her with her post-partum depression. When asked directly to promise thus, I remember feeling the weight of responsibility and the strength of resolve at once. I looked into her eye and said, "I promise to keep this going, never mind the money." I remember feeling flushed and warm—she was a stranger until then, but became a kindred spirit in a split second.

In response to the questions relating to the research, I explained to them that it would be their voices, amplified through the research, that would be instrumental in reaching out—to council, state, and federal levels—to move for support, funding, and sustained investment in their wellbeing. The sense of agency that research participants ought to feel is often discounted in research, since research is sometimes seen as a machinery serving primarily the researcher, university, partners, and/or the funder. In research that decides to adopt a decolonised and participatory stance—across design, delivery, and uptake strategies—the contributions, intentions, and priorities of the participant communities is centralised, and the research serves to disseminate this further for and with the communities. There are several examples of such research in Australia, including the work of Bracknell (2020) and Bartleet et al. (2020). Research can be as activist and ideals driven as it seeks to be, and in this context I recognised the potential of the women's voices, often in awe and sometimes in overwhelm, as I contended with the gravity of responsibility that rests upon us folks who call ourselves researchers. We seek to add knowledge, find knowledge, and advance knowledge—however, our positions, beliefs and intentions as qualitative and artistic researchers influence that which we advocate for. We have an ethical responsibility towards critically viewing situations, and this may not always be pleasant for all involved. I sought courage from the fact that I was standing on the shoulder of several committed researchers and musicians who have come before me.

I sought explicit permissions for the usage of the recorded media in publications. The women were given feedback as to how the research was progressing every few weeks in the context of the workshops. In relation to the midwives, I sent out a formal participant recruitment email and obtained permissions through consent forms that were in certain cases handed to me during the sessions and in others mailed to me post signing and scanning. I undertook the interviews in-person and online, allowing full flexibility for their busy schedules that usually involved home visits, hospital visits, 24-hour on-call profiles, and birthing. I reflected on the way in which data collection avenues and opportunities so widely differed for the CALD mothers and midwives. It is incumbent upon those conducting research in such contexts to remain aware of their position of power and ensure that the power is not misused while dealing with those who are disadvantaged and marginalised. I ensured the presence of interpreters for those who required them to ensure rightful representation of their and my words. While it is true that much semantic content is lost during interpretation, the ethics of communication and intent were better preserved when interpreters were around.

Drawing on the framework of decolonisation theorist Kakali Bhattacharya (2013), my research design used a qualitative approach drawing also on arts-based research principles. An Interpretative Phenomenological Analysis (IPA) philosophy was adopted throughout. The IPA approach to examining data, in brief, is one that takes into account the needs, experiences, and perceptions of the participants and allows individual voices to emerge in rich detail. This experiential quality also rendered IPA conducive to unpacking the artistic processes experienced through and as song, story and language. Further, IPA allowed for the interpretations of the participant researcher (myself) to emerge and co-construct meaning in that context. The embedded approaches from Artistic Research (which can be simply described as research as and through artmaking) softened the divisions between engagement and research, melding them through process and act rather than product and text. The methods of participatory creativity and embodied collaboration as evidenced in the songs and stories and documented through rich media (video and audio) contributed to rich artistic data. The qualitative data gathering that ensued in the context of sing to connect yielded the following: the actual lyrics of songs; the narratives that emerged from spending time with the mothers (and interpreters), midwives, and singing facilitators (in the form of my field notes and reflective diaries); the notes of my co-facilitator (Lynette Lancini); and detailed interviews with the mothers and midwives (8 mothers, 6 midwives).

A challenge to the research presented itself in the form of access to the women. The women attended these sessions with limited time at their disposal, and I felt that I couldn't bother them with long interviews after the already long two-hour session blocks. Commuting for attending independent interviews was also a challenge for the women. Online interviews using devices were not an option and many of them required the presence of interpreters. I also decided not to administer surveys due to the technological and literacy challenges involved. Face-to-face conversations and singing itself became the most conducive and organic ways of conducting research. I am also grateful for the fact that this approach to research did not take away from the engagement—rather, it drew on it, centralising the artistic engagement. I took the opportunities during and briefly after the sessions to have reflections and candid conversations with the women, drawing out their ideas on some of the key themes that I wished to tease out through this pilot.

Broadly, the questions that I was attempting to investigate were: How did the women feel physically and emotionally during singing? How does singing connect to motherhood, if it does? What did they feel about meeting each other and their midwives in the informal context of the Tuesday morning sessions? How did the midwives feel about conducting the antenatal classes in the context of singing? What would the women and midwives like to see continue and/or change in these sessions? I revisited the two meaningful consultations that I undertook on structuring interviews with Prof. Brydie Bartleet

in listing out and prioritizing the questions for the women. Brydie had told me to keep the questions direct and ask of descriptions of their experience first and perception next. She advised me to pare back layers without preempting, to make space for physical and embodied experiences to be heard and felt in their own time by offering prompts rather than leading statements, and to converse rather than interrogate. Having worked with culture bearers all her life and in community settings, Brydie's insights came across as a useful set of guidelines to follow for good measure. I resolved to be with the women and for the women in seeking to find out more about what singing meant to them in this unique context. A couple of times I requested them to lead the interview/conversation. One of them began unsurprisingly by asking me about my experience as a mum of twin children. We ended up talking for an hour—laughter, tears, and ruminations all rolled out unfettered. There were a few instances when the interviews were cut short due to crying children, noisy and/or playful older children, or pick-ups arriving earlier than scheduled. I remained flexible and worked with what I received.

I critically evaluated the multimodal data—including recorded soundscapes of songs and stories, video clips, transcripts of interviews, transliterated transcripts, and journal entries—in relation to the literature, theoretical frameworks, and the key research questions. The approach to analysing the qualitative data was inductive and exploratory, and undertaken using the popular analysis software NVivo. Units of meaning identified within the data led to codes and categories, thus yielding sub-themes and overarching themes. Detailed layers of meaning emerged through the process of thematic analysis (Braun & Clarke, 2006). I have chosen to share a suite of the top-tier findings in this document. There remain several angles through which the data interpretation could occur in the future studies that emerge from this project, and for these possibilities I am very excited. In research that is primarily inductive, such as this, the findings are data-driven rather than theory driven, and the inquiry often yields insights least expected and/or not directly sought through the research questions themselves. The ethical concerns around data collection and sharing including participant recruitment, information, informed consent gathering, interview protocols, and ownership of songs generate questions around vulnerability and complicity in extraction of knowledges. These processes were complicated, mostly due to the language barriers and power imbalances at play.

I also needed to be mindful of the health situations of the women during the workshop. There have, for instance, been days when a few of them have said that they felt tired and wished to remain observers rather than active participants. Working with singing in a health-based and culturally sensitive setting came with multiple responsibilities and risks. My colleagues and I tried to be mindful of topics that came up during the sharing circles and remained alert to sensitive issues. When some of the women spoke about their refugee camps, they often trailed off, lost eye contact, or changed the topic. On those occasions, we took the cue and veered away from these topics. It was invaluable to have the midwives by my side as we together tried to ensure that wellbeing was indeed being welcomed as we had originally envisioned.

OUTCOMES, KEY THEMES, AND FINDINGS – THE MOTHERS' PERSPECTIVES

Sing to Connect combined health messaging and cultural vitality in the context of singing and language. The analysis reveals multiple lines of impact and these are evidenced through the following key findings:

- The women turned to their cultures as the bedrock; everything else flowed from that – music, language, mothering, attitudes, behaviours, beliefs, and hopes.

- In being together, they acknowledged the feelings "being in Australia", "safe and welcome", and "hopeful for the future."

- The women felt "connected" to each other, their baby, the place, their midwives, and their bodies, through the singing.

- They felt connected with "spirituality" through the rite of singing – this they uniformly felt was important to their wellbeing and "healing."

- They reported feeling "comfortable" and "warm" in their "body" while singing, as if "everything was going to be okay."

- They were able to "teach each other coping" skills – this they recognized as the "power of being in a group."

- "Meeting" and "sharing stories" post the COVID-19 isolation brought about a "big positive change in mood" for many.

- "Learned about life from each other" and "made friends also from other cultures," so "every week was exciting."

- Gained agency and "confidence" as mothers and migrants – this was reported in the context of sharing songs in their language and "teaching it to others," as well as in the context of sharing experiences from the past in those teachable moments within the circle.

- Gained respite from often "everyday schedules" through being "creative," "dressing up" and "turning up with the children."

- Developed capacity also in the "English language" – this was reported in the context of discussions, reading the lyrics from the whiteboard, and writing/correcting the writing on the whiteboard.

- Developed motor-mimetic, visual, and oral-aural bonding with their baby: through lullabies, rocking songs and play songs – "I feel like my baby is singing with me – when I look into the eyes, I feel a pull!"

- Continued to "stay connected with the midwives" through and after pregnancy in a social context.

- This program allowed them the chance to see their midwives "differently" – as "ordinary humans" like themselves, and "friendly" and "fun."

• Felt a sense of “unity” and “strength” of “purpose” as they “come together as mothers”.

• Felt “joyful” to connect with those from other cultures and “listen to stories”.

• The program gives them the “feeling that they are not alone” and a sense of being “supported” by each other and the midwives.

• They women felt more open to receive antenatal health messages in the “gentle” and “relaxed” context of music.

The above findings have been offered from a qualitative research perspective—that is, based on the self-reported and lived experiences of the participants and the researcher. In future upscaling of this research, I would like to delve into a systematic evaluation of the ways in which these findings unfolded (through broader data sets over longer periods of time) and a measurement of the extent of the impact, using also research methods from midwifery.

Overall, the findings from this pilot can be categorized across the following five themes under the umbrella of an overarching lens of inquiry, namely, connection with culture as song, language, and stories. Figure. 4 depicts the five dimensions of culture-centric wellbeing in this perinatal context.

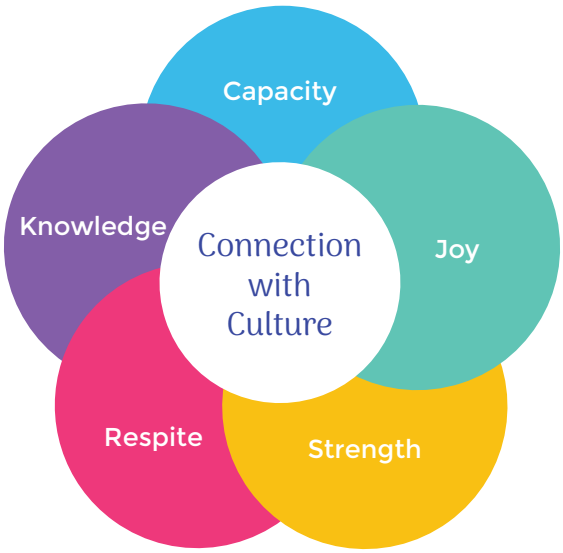


Figure 4: Dimensions of culture-centric wellbeing in a perinatal context

These themes demonstrate a correlation with key factors in literature that have been identified as conducive to wellbeing—across physiological, psychological, and social levels. The need for literacy, education on health issues, agency on health choices, and social and cultural capital among these populations to activate and strengthen the key social determinants of health also emerges strongly. The themes are drawn from the first-hand experiences of the women as reported by them and drawn from observing and being with them, rendering their voices powerfully foregrounded in the research. Research on health and wellbeing of displaced lives has often silenced their voices and has dwelt on measurements of stress-levels, observations, and reports from others as Garry et al. (2020) have demonstrated. While such studies are indeed valuable, studies that do centralise lived experience in a culturally respectful manner in the context of health are important to have, particularly in the context of vulnerable members of society.

There is a need to be wary of dehumanising approaches to researching health. Research in light-touch approaches (as in Sing to Connect) stems from acknowledging human qualities that are seen within the community. Such research, I proffer, is well-placed to offer empirical insights into the ways in which phenomena reported through dominant scientific research paradigms actually operate. For instance, there is much research that shows us exactly which parts of the brain light up while singing and how the activity of singing release the feel-good dopamine chemical in the brain—activating the reward centre of the individual and therefore promoting wellbeing. The words which the women have used here to describe their experiences of singing dovetail remarkably with such findings, galvanising the ownership of the rich evidence-base around singing and wellbeing in favour of the communities. Since the women in this program expressed themselves in relation to their bodies and mind, their perspectives also shone light on those social determinants of health that have worked for and/or against them. For instance, many of them reported that they wished to study but could not afford the fees, needed jobs but lost out on or failed in job interviews due to lack of English skills and other job-ready attributes that were technology-based, and failed in some of the social necessities such as driving tests due to lack of sufficient support, information, everyday racism and/or communication. Some expressed financial concern for their families due to disruptions in their businesses due to COVID-19. Poor education and employment opportunities coupled with economic disadvantage and systemic and everyday racism are clearly indicated across the demography. While many of them noted that singing offered them respite—"we forget all our worries at this time and come together" (Don, personal interview, 24/11/2020)—programs such as Sing to Connect also draw our attention to urgent and pressing issues

of our time that need systematic addressing across health, cultural, and socio-political registers, and across council, state, and national levels.

The women valued the space for learning from the midwives about important aspects of maternal health, indicating that health literacy is a key determinant for these populations. Several of them noted at various points in time that post-partum, when they have felt a "bit low", turning to medication made them feel dependent on prescriptions and less self-sufficient. They felt singing and meeting friends gave them the upliftment in mood that they were seeking. A few of them (n=5) requested that this program happen bi-weekly. "My mood is lifted on Tuesdays, and I stay positive through the week. I wait excitedly for the next Tuesday", one of them noted. Through this pilot it is immensely clear that the women see the value in singing, especially as a way to meaningfully be together. As a low-cost, sustainable, inclusive, and mood-uplifting activity, they appreciate being given access and opportunity to it enjoy it.

In order to ethically undertake research that aims to improve the conditions of those at a disadvantage, those impacted must have the biggest say. Within twelve weeks, there was only so much we all could do, but this foundation I believe is invaluable for future iterations of this program. Through Sing to Connect, our team have learned that women value the opportunities to:

- **Connect and make friends.**
- **Build capacity across health, literacy, and maternity.**
- **Share aspects of their own culture through song, language, and lived experience.**
- **Seek out happiness through social activities.**
- **Enjoy respite and relief from often mundane daily routines.**
- **Experience strength as a collective of women and mothers.**
- **Find knowledge within oneself and through the experiences of others.**

I have also learned that community-led models for research make for robust projects. In the near future, I hope to take the insights borne out of this attempt at co-design, identify areas for growth, and develop them further, with active participation from the community and colleagues from health.

OUTCOMES, KEY THEMES, AND FINDINGS—THE MIDWIVES' PERSPECTIVES

This book has been written primarily from my own perspective—as a singing facilitator and participant-observer-researcher. I did, however, conduct interviews with the midwives to gain insights into the following aspects: Did they women respond to the antenatal messaging any differently when they were enfolded in the context of singing? Did the midwives feel that their relationship with their women was impacted positively due to these singing sessions? Did singing help the midwives with their wellbeing—if so, how? Based on an analysis of these interviews, there emerged interesting insights which will, in due course, lend themselves to further unpacking, in collaboration with midwives, across practice and scholarship.

The following insights are noteworthy:

- The midwives felt that the women were "more open to receiving from them" and "less self-consciously" in the context of sing to connect.

- They learned about their women's "cultures, families, talents, and personalities" through this program and this helped them in giving their women culturally responsive care.

- They saw a "side of their women that they'd never seen before" – this was an "ice-breaker" in many cases and "improved communication."

- The program cultivated "friendships" with their women and learned about their cultures and beliefs – this was something they had been wishing to see for a while with their CALD women.

- The program offered them variety and freedom to explore new ways to connect with their women.

- It offered a context to "flip around power" in the interactions with the women – as in, midwives giving them a few choices rather than instructing them on what to do, and sometimes learning things from the women rather than vice-versa.

- The program offered them a "space to be creative" in "health messaging" models.

- The "women asked more questions", "were curious", "listened to each others' questions", "learned from each other", "were less inhibited", and "more forthcoming with the concerns" during these antenatal sessions.

- The program offers a "pathway for future antenatal engagement" that is "bold, fun, and productive."

- The midwives recognize that the program shines light on the "power of non-pharmacological interventions" that are arts-based; in doing so, it has drawn attention to the "potential of singing for wellbeing in this maternity space."

In this report, I have foregrounded the voices of the mothers rather than the midwives in order not to take away from the primary purpose of this engagement and research—to study the impact of singing on mothers in a multicultural perinatal context. In the future I hope to see joint publications emerging from colleagues from midwifery and music, affording further spaces for delving deep into the complex impacts, processes, and challenges that unfolded here.

RECOMMENDATIONS AND FUTURE DIRECTIONS

Based on the inputs received from the multiple participants and stakeholders, and my own impressions, I would like to present the following recommendations for the future of Sing to Connect and such music interventions, more broadly. These recommendations and goals pertain also to the future of research in and through music for seeking better outcomes in the context of perinatal mental health and wellbeing.

- To seek and succeed in receiving funding across council, state, and federal levels to sustain, critically reflect upon, broaden through extensive and interdisciplinary research, and upscale, Sing to Connect.

- To continue to develop and sustain meaningful engagements, across research and practice, between music and midwifery and music and ethnicity in engendering an ethos of shared wellbeing.

- To firmly instate the value of culture and music in promoting health and wellbeing, especially in those marginalised.

- To continue with the vision of Sing to Connect by way of regular engagements beyond this 12-week period.

- To ideate on further ways to creatively intertwine singing, yarning, and antenatal classes.

- To ideate and implement deep focus times within the session so that the health messages or singing experiences do not lose their gravity.

- To develop and sustain council, state level, national, and international networks and partnerships that share similar focusses and visions.

- To make timely, interdisciplinary, and evidence-based submissions to policy makers at Council, State, and Federal levels in matters relating to health and wellbeing in CALD populations.

- To draw in related organisations such as Logan Together, Settlement Council of Australia (SCOA), Ethnic Communities Council of Australia, Federation of Ethnic Communities' Councils of Australia (FECCA), and Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT), to collaboratively and systematically address the need for steady and purposive wellbeing models for women and families from ethnic minorities, particularly in the perinatal context.

- To preserve the integrity of the grass-roots and one-to-one relationship aspects of this program, and to avoid over-therapisation, assumptions, role-patterning, stigmatisation, systemic and everyday racism, white-saviour mentalities, and the familiar trappings of one size fits all approaches in dealing with persons of colour.

- To champion diversity, equity, and inclusivity through centralizing those voices lurking in the margins, and thereby consciously divest from dominant narratives of power.

CONCLUDING MESSAGES

In this section of the report, I have shared special messages from each of our key team members, including myself. The messages stem from our experiences in Sing to Connect and present multiple perspectives. As we gaze upon what we achieved, we strive to reach higher, together.

I was a young girl in Congo once. I then got married. Now I'm happy to be a mum. I have five children. This is my sixth pregnancy. I think I grew up only when I became a mum! When you have children you are never separated from joy. When you are a mother you are another person. Our family are happy here. I thank my midwife. I sing at church here and I love to sing. My children sing. My husband sings. Singing is healing. Everything has a time and place. I learn the value of time being a mum. I am happy to attend Sing to Connect. I wear my nice clothes. Dress my children and come. An occasion for all. ***(Aline, Participant, Rwanda)***

It's great when the midwives to come to our places, our homes, but it's even much better when we come here. We meet other women and they tell you their experiences and you get to know everyone, share song and stories – that makes it even better! When we sing, I think we all feel like we're doing the same thing, unity, and we have one intention – to be strong. ***(Granessa, Participant, Congo)***

[T]his program of coming, singing, and meeting together is actually helping us more. It gives us the opportunity to meet other women and that will help us to also improve our English and we will be able to communicate with others better. ***(Esperanz, Participant, Congo)***

I thought I just come and see what's happening and what you guys do. When I came, I really felt – it's a lovely thing to connect with other people. I don't feel alone. Other women share stories. We are going through the same journey. I was in refugee camp earlier. I have seen hardship. It is good for us all to have care and happiness. Here I see that. ***(Dative, Participant, Tanzania)***

I have a very spiritual connection with my heritage, and I feel all of that spirit coming through. I feel proud that I can share my culture with other people. I'm happy that they are embracing my culture and my language, as well, just as much as I'm embracing theirs. For me, wellbeing defined in the sing to connect context is being present in the moment, no judgements, no biases or anything, all of that is left at the door, and you're just there, you're that person, and you're just open to receiving and giving with hope and optimism. That is the kind of physical and spiritual wellbeing that I felt. ***(Emily, Maori mum, Community Liaison at Access)***

I feel happy and relaxed when I sing with the group. This program, it's very nice for – you see – you meet a lot of different people. You learn different things, different languages. Children take that time to play. Also, when we go home, we discuss on how the connections happened. We take this excitement to our homes. Hold it in our hearts and families. ***(Saado, Participant, Kenya)***

When I am at home I feel alone. After I gave birth to my babies I went into depression. I have negative thoughts – like, what will happen to my babies when I die. When I come here, when I join with others, I feels more secure and more safe. I meet lots of people and feel happy. When I sing, I forget about my worries. The negative thoughts go away. They stay away. I look forward to the next week. This keeps me going. Please don't stop this. ***(Cing, Participant, Burma)***

When I feel sad or when I feel worried, then I will listen to songs and sing songs. This program forced me out of my worries. When I sang here, I feel happy. When I shared stories with women, I got relief from that. Coming together, talking, and singing makes me feel confident, trust in myself. It makes me feel safe. And it gives me friends. Yes. And I think I am a healthier person now than before. ***(Don, Participant, Burma)***

Sing to Connect has further enhanced the relationship that the midwives already have with the women and that brings us midwives so many wonderful experiences and positive results, not least of which is better outcomes. It directly impacts mental health and speaks to things that we're trying to achieve in our communities here. It's this cheerful atmosphere when you've got people coming together in a trusted space to share and care – lots of oxytocin here! The relationship-based care model is where it's at in the hubs and this for me, is just the way we should be moving towards doing things - unlocking creative spaces for nurturing. ***(Michelle, Midwifery Manager, Logan Maternal and Child Health Hub)***

I got goose bumps and literally felt the endorphins happening! And I feel quite proud of the women when they want to sing by themselves and share what they've got to the group. Today, we were singing a song... one lady started singing a song, and we all joined in. We didn't know what the song was originally, but we just kind of went, "Oh, actually, we could join in, sounds familiar!" And it was really lovely to be able to support them in this spontaneous way. This program is a unique one where health and culture are cemented through music. ***(Jen, Midwife)***

[w]hen [Petronia] was birthing, we actually sang the song [learnt at sing to connect] which was really lovely. Her husband and I were like listening to the prayers she was saying in her own language in the birthing room; she was really going into that spiritual space for her zone of birthing. And it was really magical that I could understand what she was saying, you know, that she was asking for help from her God through gentle song and it was really beautiful. I could join in the song. So, thank you very much for opening up that space. It's not something I would have been able to do had we not done Sing to Connect and I felt like we were able to connect through on a different level and I mean for midwives that is huge. So, I feel like we have access to a whole new world of possibilities, a set of different equipment, through sing to connect. This is fantastic. ***(Rowena, Lead Midwifery Facilitator at Sing to Connect)***

Sitting in circle with migrant and refugee women within the context of their midwifery care has been a precious gift for me. With my half-size pink guitar 'baby' held close by guitar strap 'sling', I've been privileged to wholeheartedly accompany women from many language groups in the sharing of birth stories, songs and poetry. Through shared aesthetic experiences, we have established intercultural spaces of empathic connection, with the literal meaning of midwife - to be 'with woman' – becoming a regular and directly felt group experience. Over the weeks of the pilot project, I have observed increased levels of authentic engagement between participants and midwives around vital health messages. The union of group antenatal and perinatal classes with Sing to Connect's woman-centred and culturally sensitive approach to music making has birthed a model which yields powerful intercultural, health and wellbeing outcomes. ***(Lynette, Music Facilitator and Consultant)***

I think, probably one of my favorite moments comes from last week [week 11], where one of the women shared a special thank you song with us saying hallelujah for our group. And everybody joined in for a loud chorus. It was just so beautiful and powerful. I felt very, very honored to learn from so many women with so much life experience. And I felt that my role was really to step back and help people to give their voice. ***(Daisy, Music Facilitator and Consultant)***

Over the last 12 weeks, we have been singing lullabies in many languages and sharing stories of love, courage, loss, kindness, empathy, and resilience. We have witnessed new conduits of connection blossom, care and consideration unfold, knowledge dissemination and uptake rise, and an infectious enthusiasm pervade. I do believe there is much work to be done here – together. I have made friends with some very inspiring women – mothers and midwives. Findings from this pilot will hopefully lead us to greater levels of research and engagement which can empower women and children from ethnic minorities in the context of perinatal care. Culturally respectful care at this crucial time will determine the quality of health and wellbeing in these populations. Singing is one fantastic way to unlock culture and care at the same time. ***(Charu, Founder and Chief Investigator, Sing to Connect)***

CAPTURING EPHEMERALITY: SELECTED JOURNAL ENTRIES

I offer below a suite of raw and largely unedited journal entries from across a few key weeks. These entries were all written on Tuesday nights. I would sit down with a cup of tea and try to relive the morning. I would flesh out field notes that I took in a little blue notebook that I kept with me at most times. The field notes would be scarce—scribbles. I usually am a creature of the moment—tearing away to the confines of my notebook from my social place of connection, I felt, was a betrayal of those I was physically with at that point in time. I had therefore avoided detailing within the blue book. But even the few words shaping the notes would trigger powerful memories, allowing for space to revive them. There were some very interesting weeks and some less remarkable ones—ordinary only in comparison to very eventful others.

Week 2

In my mind today was a reflection of Lefebvre's notion of the utopian everyday multiculturalism. Cultural hybridity was seamlessly woven into the daily tasks thereby dodging the familiar trappings of structural power, and artistic exploration became a natural way to unpack cultural differences. The women were consulting with their midwives – however, in a setting where their relationship to song, language, and culture, were valued.

At the Village Connect auditorium in Hosanna Logan City, myself and co-facilitator Lynette Lancini began with the well-known Indigenous song Innanay Capuana. (My daughter) Kuyili Karthik had joined me that morning and had written the song on the whiteboard for the women to refer to, should they need (and be able to benefit from) lyrical support. Many of the women sang along – first slowly then with greater confidence – just by listening to the sounds and the tune. We taught them through repetition, line by line. We began with the catchy chorus phrase "goowanagoowana etc..". They learnt the tune quite quickly (around 2 repetitions) of Innanay and started to sing with us.

Then the antenatal class started. During that time, I helped with giving out some snacks, and with relaying messages to and from the interpreter for two women from Congo (speaking Swahili). Kuyili and Summer (from Access Gateway) took care of the younger children in the playgroup setting nearby. Following the antenatal session, we began singing Innanay again – this time the sound was louder. The women had been able to remember the tune and looked like they were enjoying themselves. For the benefit of the many children (toddlers to around 10 years of age), we sang some fun playsongs – like "the wheels on the bus". Mums sang along, swayed along.

One woman from Ethiopia demonstrated two songs (one in Ethiopian and another in Arabic). She and her son did a clapping song. The woman clapped on her chest and then clapped on her child's hand and the patterned clapping complemented the rhythm of the song and the emphases of word. The song and accompanying gesture, she explained, signify that maternal love flows from the heart to the child through sound and language – I was struck by its profoundness. With a dulcet voice, she shared two of her favourite songs while the midwives and other mothers listened in admiration. She reflected, "In my culture there is a song for everything – for rocking baby, sleeping, eating, making jokes with friends, and courting the woman. It is our way of life – music". We have asked her to teach a few of these to us next week – but her midwife Jo noted that was due to give birth within the next week or so – exciting!

Following her, another woman from Congo (Aline 4 months pregnant) sang a few of her favourite songs after narrating the story of her village, in Swahili (we used an interpreter). As Lynette gently supported her on the guitar with chords, Aline's voice soared, and a lullaby from a land and peoples that were hers to speak of and others to imagine rolled out almost effortlessly. As she sang, her eyes grew misty. Her midwife Jo exclaimed, "I didn't know you sang – you sing so beautifully!" Aline blushed. Brushed it aside as she busied herself with her older child.

We sat around sharing stories of our countries, foods, grandma's restorative remedies and recipes during pregnancy and childbirth, and lullabies. I sat on the floor, at the centre, wheeling around the group. When my turn came, I shared that my grandma used to regularly give me a pudding (halva) made with garlic, milk, butter, and sugar to promote breast milk. The chatter with the midwives, to me, showed that there were friendships being nurtured.

One of the Afghan women, when questioned if they had any song from their childhood or country they would like to share with the group, noted without skipping a beat: "We don't have such songs". I wanted to ask why – but she had to leave. I later learned from another Afghan woman that in certain countries, including some parts of Afghanistan, women (and in some cases even men) were not permitted by religion to sing or undertake musical activities.

Week 3

I went in with a few objectives in mind:
- To eliminate external noise and scattering by effective use of the divider screens.
- To begin with song and end with song.
- Also, to punctuate the antenatal messages with song.
- To invite women to stand up and move gently with song.
- To invite women to share songs.

When people talk others don't always listen. When they sing, others do listen. After singing the focus in the room is deep. Jo noted, "the women are more open to our topics of conversation after singing because they are relaxed and happy". They are riveted to the space. The feeling in the song. The collective energy when they sing. The transformation and unity are remarkable. While speaking, some of them were aloof - checking their phones or checking on their older babies. The difference that singing brought about was so profound. Unmissable.

After singing we began the sharing circle.

"I'm very tired.. sometimes we miss home – the farming in Burma and fresh fruits and veggies from our garden. I'm very tired sometimes," said Cing suddenly. We started talking about what she missed. Together, some of the women made plans to visit a farmer's market in the area. I listened. One of the grandmothers (from Somalia) shared their story of raising 10 kids. "Women are very strong", she started. "Women are amazing", she went on. Lovely way to lead, I thought to myself. There is "lot of wisdom being in tune with the body" said the interpreter, and I wondered how lovely it might have sounded in her own language. "You know only from lived experience about babies. Experience of living life", she concluded.

Aline jumped in and started speaking in Kirundi language. I made notes from what the interpreter conveyed: "This is my sixth pregnancy. I was a young girl in Rwanda. I then got married. Now I'm happy to be a mum. I grew up when I became a mum. When you have kids, you are not separate from joy. When you have kids, you are another person. Our family are happy here. I thank my midwife (Row). I sing at church and I love to sing. My children sing. My husband plays mbira. Singing is healing". The song she sang was about a loved one who had passed on and that we meet them someday in another realm. It was surreal. We sat silently for some moments.

Interpreter Immacula was in a refugee camp when she was pregnant – "I didn't know I had twins," she started. "No one was looking after you - in refugee camp". Meanwhile, I kept thinking I was going to cry as I listened to her. "Two to three days in labour. The second twin was still birth. I have a picture of my son in my mind. I have no photo. I asked for a box to bury him – they gave me a shoe box. I tell my other kids that they have a brother in heaven". The weight of the words fell thickly. We took time to reflect. To regroup. Sing to Connect is not all laughter.

Petronia extended a hand to Immacula and began: "You go through so much being a mum. Being a mother you don't know what to expect. After having the baby, you forget all the pain and you become happy. When you have a baby the way you sleep changes. In this country even though I don't have my family, my kids are my family".

The Somali grandmother Amina shared a traditional lullaby – I picked up the tune and had her dictate it to me as I wrote it down on the whiteboard. The women have some level of literacy and despite a lack of fluency in speaking they very quickly learn the tune and sounds with the help of the text on the board and sound of the facilitator singing. With around 2 repeats they picked up the tune and words. Amine came up to the whiteboard and led the group. Initially she was shy to come up. I found her wanting to sing yet wanting to step away from the "leadership" role. But she found herself singing and conveying the musical and lyrical meaning to the other women, very naturally. Amina said that in her village in Somalia they had to walk everywhere (hours and hours) and sometimes they would sing songs while walking. Ten minutes later we were singing those two songs together as a group. We sang the two songs a few times.

The topic of the day was safe sleeping and the midwives had bought props of babies, crib, etc.We wound up with Innanay again. Next week Aline said that she would sing and teach her song to us. The women felt that it was great to have the playgroup integrated with the antenatal class and the singing. It felt like a "whole".

Week 4

The women helped write on the board and could read the phonetic manifestations of their language in English. This session was noisy due to the children running around and poor acoustics. Maybe we need microphones? Perhaps children could be present for singing but not during the midwifery instructions? The discussion on the midwifery education topic of the day, breastfeeding, was robust, with many mothers chiming in with questions. I learned from the midwife that many of them were usually very quiet. But since we began with singing, they seemed relaxed. Perhaps the creative act had rendered them more expressive – emotionally and idea-wise, charged with greater levels of agency and inquiry, and had enabled them to be receptive listeners, active participants, and enthusiastic questioners, shaping the message and its impact rather than shy onlookers of the message. Some of the women, over the weeks, had grown to be more outspoken and more comfortable with being in the group and in the company of their midwives and myself. The children were settling into a gentle rhythm at play, allowing space and silence for the singing/antenatal sessions to proceed.

Neema is an example. During the first session I hardly got a moment's eye contact – I could feel her shutting off to the outside. In this session however, she came dressed in a lovely green frock and had a radiant smile. She even told her interpreter to tell me that she was sorry she missed the last week and that she was happy to be here this week. She was feeding her baby, singing, and having a nice time. I was wondering if this was indeed the same tacit Neema from earlier. I could see firsthand the confidence and sharing spirit in her having grown. Midwives Jo and Row noticed this too.

Week 5

Then we started going around the circle introducing ourselves and that's when the stories and songs of motherhood came out from the different women in the circle.

Don sang "how great thou art" so beautifully. Midwife Mary said that music was her language of love to her son when she was pregnant with him in Scotland. She sang the hymn she used to sing to him every day. She said that she would stroke her belly as she sang and would be delighted to feel the baby move as she sang. "Just singing made me feel good and connected with my spiritual side and my baby", she said. We discussed the benefits of singing for the woman and the baby. Immediately, we also discussed the benefits of breastfeeding for the mum and the baby. Reinforcing these associations - between the good feelings brought about by singing and the messages and health advice from the midwives – I noticed, brought about a greater sense of receptivity, interest, and "buy-in" into the health messages and as well as the musical messages. As soon as Don (just one year in Australia yet!) sang How great thou art, Emily got excited – she sang the Maori version of the hymn. Emily sang the verse and Don sang the chorus. Faith, belief, music, and hope cemented all of us in those moments of togetherness.

We bid goodbyes.

So many mothers sing so beautifully. Their journeys through motherhood has influenced and has been (or is being) influenced by singing in many ways. Neema's voice is getting louder and she is leading the Kirundi song these days. Many of them who were earlier quite reserved are seen to be speaking with other ladies – making friends, and exchanging meaningful glances. The children in the room always

add joy to the situations. They play with each other and when singing some of the women rock their babies to tune. I had a nice time introducing A –ri-ra-ro to the group. Kannana Kannukku song tune (Neelambari raga melody type). They loved it! We clapped the 7 beat – ta-dheem-ta-ka-dhi-mi. I didn't verabalise the syllables or anything theoretical – just the claps. It was fun. A-ri-ra-ro has joined our repertoire now. The regular repertoire keeps increasing every week.

Week 7

There were four women from Myanmar today. Cing, Don and two others. Three of them were pregnant and Cing came as usual with little Abigail who is literally growing week to week as we check in at Sing to Connect.

Also, there was a new woman speaking Swahili from Congo (and her interpreter – Rosalia).

Although the four women were from Myanmar, they came from different parts of the country and spoke different dialects. When requested to share a song one of them (Don – 16 weeks into pregnancy) sang an English worship song beautifully! They spoke with each other in their language, and one of them translated what was said but it seemed to me like they perceived music as a form of global communication that would render them somehow "understood." They did mention that they couldn't think of any "simple enough" songs from Myanmar. I did wonder – how might a complex Burmese song sound? I told them that I would love to listen to a Burmese song – whenever any of them might be ready. It is week 7 so there is still time!

I called upon Don to song knowing that she would be keen to sing – she was emerging the "voice" to look out for! She had just then asked me if we would ever use the stage. [I had told her that we would certainly have a celebration on week 12 and that she would have the opportunity along with the group to sing on stage]. Don sang a song that she had learnt in her employment in a playschool here in Brisbane – "God's love is so wonderful…". It was a song with gesture – gestures that engaged the body – as stretches, turns and heart shaped formations. Everyone jumped up and participated – I could feel the mood lift in the room. I quickly approached the whiteboard and wrote the words with Don's help. Lynette figured the chords out. Within seconds we were singing. The decibel level in the room rose, smiles occupied faces, and I felt a warm familiar feeling of performance coursing through my veins. That ritual of being together in the rite of song – as if our very existences were predicated on the uncertainties and depths of those moments in creative time. We all followed her gestures and song as though we had it sung together for years and years. The mothers are all very fast learners - they are used to being agile! Just a few times of singing and they picked it up. So did I! Being a mum of twins helped – in spades – to be able to manage all forms of disaster, uncertainty, joy and surprise!

As I wrote the words on the whiteboard, an African woman said she was going to TAFE to learn English. For many of the women, literacy and the English language were points towards which they were working. Seeing these words on the whiteboard made it easier for them to follow.

Jo and the other midwife Jen had a chat to the women on choice in birthing and opened the floor for any questions. Through this time several questions emerged. Women were listening to each other's questions and were responding to all the information that was shared and heard naturally and

without coercion. It appeared to me as if the health-related information sharing and health literacy was proceeding seamlessly due to the relaxed atmosphere fostered by the music. The connections between the women were also becoming more palpable and the links between them and the midwives were strengthening.

Importantly, midwives are in the practice of usually visiting women in their homes and giving them advice and check-ups. However, during Sing to Connect, some women were given check-ups in the context of the antenatal classes. Also, during the singing sessions and the chats with the midwives, the women met other CALD women like themselves and made friends while also exchanging stories and songs, thereby creating a platform for empathy, cultural connection and vitality. There was an atmosphere of kinship and support – not only through words but through music and action. The midwives sang with the women and assumed the role of friends, connecting to the women through the conduit of the culture. A kind of "meeting midway" created a shift of balance of power in the scenario. The women were able to express their queries and concerns in a free and empowered manner. One of the midwives mentioned that this was an amazing outcome.

I found myself recognising the importance of singing for the cognitive and language development in the baby and telling this to the women. I actually wished for them to sing loudly and deliberately create those connections to the baby and themselves.Emily and Don then decided to do their duet of How great thou art in Maori and English – it was beautiful – as usual. I felt the expectation of the week-12 performance rising in all of us. I invited us all to stand up and complete the circle that were seated in. In the standing position we sang two songs to include on the day of the public performance – Innanay and God's love.

Cing said: "God's love is a great song because the gestures – hand movements signifying so high, deep, and wide– engage the body entirely in simple stretches and movements. It is a nice song for physical exercise while also singing. When we sang this together, I found that we actually had fun. I could jump out of my serious zone and started having fun with music". Literature in music does tell us that a state of creative play is activated during singing and moving and this is the state of being wherein everything seems possible and the music-making subject feels powerful, well, creative, spontaneous, expressive, and intuitive. Able to tackle the challenges of the world. Cing saying that she felt "confident and capable – like she could handle and ace all things after singing" reinforced this theme from the literature on music, creativity, and mood. I asked her if the feeling of joy and power endured through the day – and she replied "sometimes... if I feel myself getting down, I would look at some of my old albums and think of my mum's recipes... always picks me up!" I relate to this too – I think we all might! Music, food, memories of loved ones and beloved spaces, cultural artefacts, and language are integral to our existential wellbeing as migrants and/or refugees carving out our own spaces in a new land.

Two outcomes (unanticipated) have unfolded already.

First, the antenatal sessions had begun for the women at Access due to the impetus from Sing to Connect	*Second, bridges are being built between two hubs in the Logan area – the Access and Pasifika – through this program.*

Week 11

We opened with the Placenta Song to revise it from last week and then the antenatal class began.

The topic of the day was safety of the child and mum. Immunisation came up as the topic of the day and so did exercising and safety during exercising. The need for care, both of the baby and the self, was discussed. I took notes of the phrases that popped up from the conversations between the midwives and the mothers: keep safe with exercise, listen to your body, maintain energy levels, do deep breathing, eat right, keep on top of immunisation schedules and dates, don't lift heavy things etc. I then wrote a basic structure for a song titled "I immunise, I exercise" on the whiteboard as the discussion progressed. Daisy and Lynette joined me in bringing their ideas and tunes into the songwriting.

Daisy then suggested we ask the women what they each do to keep well. It was a great idea to hand over the ownership to them rather than telling them what to do. I then whipped around the room. The women gave a list of some very lovely things that they engaged with to stay well – walking, playing, eating right, working at home, regularly exercising and sleeping. The midwives Jen and Farhia said that their wellbeing was related to spending time with their families and finding time to rest their bodies and minds. Pooling these ideas together, the group co-created a song – it was a democratic and fulfilling process. The women were thrilled to be part of this fun exercise. We then sang the song a few times together – just following from the whiteboard. This helped with their reading too – I called this music-TAFE and we all laughed! Here is the song in its final avatar:

I keep myself safe
I keep my baby safe
I immunize, I exercise!
I walk, I sing, I eat right,
I rest, I play, I exercise.
I care, I comfort, I repair,
I immunize, I exercise!
I work at home, and I sleep,
I spend time with family.
I keep myself safe,
I keep my baby safe,
I immunise, I exercise!

After this song, we sang some of our favourites from our usual songlist – Mamma waruno, God's love, and YesuArankunda. Emily, Cing, and Esperanz and Granessa together did the most moving version of "How great thou art" in Maori, Chin Zomi, and Swahili. We wound up with goosebumps as our voices rose into "then sings my soul". Closed eyes, head tilted skywards, babies in hand, unified through pitch and rhythm. If those captures in time could be distilled and collected in a jar, they would be the droplets of the elixir of peace.

There was a short silence after. Granessa stood up and thanked me and the crew of Sing to Connect in Swahili – the interpreter assisted. She said that she was going to offer a song as a gift to us all. We got excited – cheers rang out as she wished us all a Happy New Year too! She then started singing

"Alleluia" – the tune was that of Amazing Grace – one of my favourites. Christmas is upon us and the moment couldn't have been more suitable. As she sang, we all found ourselves joining in first slowly and then will gusto. As alleluia rang out, I felt every muscle in by body relax and a warmth spread through my chest. My eyes smarted with tears and I made little effort to hold them back. Quietly they rolled earthwards pulled down gently by the gravity of the moment. It was so kind of Granessa to offer her thanks through song. The mums initiated "three cheers" for us all. I felt proud of what we had collectively accomplished in those 12 weeks. It was truth in song.

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About the author

Dr Charulatha Mani is a world renowned vocal performer of Indian Classical music and a researcher and educator with expertise in intercultural musical practices and global histories of music. She currently lives and works in Brisbane, Queensland. Charu is the Founder and Research Lead on Sing to Connect, and a passionate advocate of cultural wellbeing, increased agency, and enhanced opportunities for Culturally and Linguistically Diverse (CALD) populations here in Australia.

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"Sing to Connect" is an ongoing research and community program aimed at enhancing wellbeing for pregnant women and new mothers through singing. In the pilot edition of this initiative (Sept-Dec 2020), women from Culturally and Linguistically Diverse (CALD) backgrounds in the Logan area of South East Queensland were given an opportunity to connect with each other, their midwives, their babies, and precious aspects of their own culture, including music and language. The program involved weekly workshop sessions featuring lullabies, folk songs and storytelling. The sessions seamlessly interwove singing with health information modules and midwife consultations, creating an atmosphere that was both relaxed and creative. Sing to Connect was delivered in partnership with Metro South Health, Access Community Services, and Logan City Council. Research Lead and Founder, Dr Charulatha Mani has crafted this report in the form of a moving, first-person narrative. Before you embark on this journey of stories and songs, do take a moment to enjoy a 10-minute documentary film on Sing to Connect - just scan the QR-code below.

Sing to Connect: Welcoming Wellbeing

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