Birthing on Country

Workshop Report

Alice Springs, 4 July 2012
Birthing on Country Workshop Report 2012

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Meaning of front cover illustration

Circle in the belly depicts the baby in the womb.
Symbolises the Aboriginal flag

Foot prints in the centre circle represent unity with the woman, her family and the maternity carers all walking together on the same journey with her and her family

Small horse-shoe shape inside a larger horse-shoe depicts a baby in the womb

Depicts the connection to country. Shows balance between family and the land. Shows strong relationships keeping the family culture strong

Shows only men sitting around. The absence of women means there is an unbalance and this is supported in the ATSI culture. Straight lines mean people coming and going

Illustrates that respect for family involvement is better. Shows pregnant women and their men sharing the stories. Means happiness for all and the connection to their culture and lands.

Two-way learning, the foot prints on the arms illustrates the journey forward. Onside carers and the other ATSI people

Represents an organised, holistic approach to maternity services with all health needs met. The ATSI has all the team working with her and her family, recognising her cultural, clinical, psychological needs.

Represents the professionals, ATSI midwives, ATSI staff, other midwives and Drs/Nurses

Shows restoration of skills & pride and continuing sustainability of the ATSI culture

Artist Margaret Larkin: 2012
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EXECUTIVE SUMMARY

BACKGROUND

The Birthing on Country (BoC) workshop, held in Alice Springs on 4 July 2012, was the first national workshop of this kind in Australia. The workshop was a key deliverable identified in the National Maternity Services Plan\(^1\) under Action 2.2: *Develop and expand culturally competent maternity care for Aboriginal and Torres Strait Islander people* (Appendix 2). As stated by Ms Djapirri Mununggiritj, a Yolngu elder from Arnhem Land who presented at the workshop, “we gather at these sort of conferences to talk about... to set up something... for twenty years time and we on this table can look back and learn... and participate... in what I have to offer to make this people or this generation something they can be proud of”. The Maternity Services Inter-jurisdictional Committee (MSIJC), in collaboration with the Central Australian Aboriginal Congress (CAAC), (an Aboriginal Community Controlled Health Organisation (ACCHO) in Alice Springs), hosted the workshop. The objectives were to:

- Obtain agreement regarding progressing Australia’s commitment to BoC programs
- Establish jurisdictional steering groups to support the implementation of BoC programs in Australia
- Develop an implementation and evaluation framework for the BoC program, and
- Identify potential pilot sites for the BoC program to be trialed.

THE WORKSHOP

Key stakeholders were invited under the guidance of the facilitator, Ms Anne Marie Hayes (Director within South Australia (SA) Health, experienced in clinical and strategic planning for women’s health), to explore these objectives and their understandings of BoC: what it meant to them; the key principles; what might underpin good practice; and the risks and barriers to implementation. Stakeholders were also invited to discuss and to provide guidance on how best to identify and engage other stakeholders; and sites for implementing BoC models of care. The workshop was preceded by a session for Aboriginal and Torres Strait Islander women that aimed to ensure the workshop was conducted in a culturally safe manner. Ms Leshay Maidment, an Arrernte woman from Alice Springs and Acting Deputy Director of CAAC, facilitated this session.

In total, 50 participants (Appendix 3) from across Australia attended to address the workshop aims. Lhere Artepe (Native Title) representatives Ms Janice Harris and Ms Felicity Hayes delivered a powerful Welcome to Country, which established the importance of Country to Aboriginal people and set the scene for the day. Ms Bonnie Fisher, the Chair of MSIJC, provided an overview of the National Maternity Services Plan in relation to the BoC agenda. The cultural guidance for the day was provided by Ms
Leshay Maidment who asked participants to be respectful of cultural sensitivities and protocols, whilst also recognising the need to be inclusive of others, including male participants, in order that all present could work effectively together for the best outcomes for mothers and babies. She indicated that specific cultural details, in particular ‘Women’s Business’, would not be discussed during the day and that there would be an opportunity to have women only discussion groups at any time, on request.

Several presentations provided the participants with background information. Ms Donna Ah Chee (Acting CEO of CAAC) and Ms Leshay Maidment co-presented on the journey and learnings from 25 years history of the Congress Alukura¹, CAAC’s Women’s Health and Maternal and Child Health Care Centre. This service has seen the development of several different service models over this time. Importantly it has retained strong community involvement with an overarching governance framework that includes an Aboriginal Cultural Advisory Committee comprising senior women from across Central Australia. Insufficient funding and periodic difficulties with staff recruitment and retention have provided a challenge to offer the most desirable model of care. Despite these setbacks, several evaluations have found that Congress Alukura has made marked improvements in maternity care for the women it serves and in the maternal, infant and child health outcomes for families in Alice Springs and beyond.

Ms Hazel Keedle and Ms Tracy Coles, from the Orange Aboriginal Medical Service (OAMS) in NSW, provided an overview of their newly established primary maternity, service, that includes an on-site birthing facility. Prof Sue Kildea followed with an overview of the results of a literature review on BoC maternity service models for Aboriginal and Torres Strait Islander mothers, babies and families.² The results of the Inuulitsivik maternity service evaluation of primary maternity units in several very remote communities in Northern Quebec³ were presented and distributed to participants. A framework for a service delivery model, developed from the literature review (which had been distributed to all participants), was highlighted and participants were asked to consider this during the afternoon session. The formal presentations concluded with Ms Djapirri Mununggirritj, an invited guest speaker and Elder from Yirrkala in East Arnhem Land, providing an overview on the importance of BoC to the Yolgnu people. She emphasised that “birthing is the most powerful thing that happens to a mother and child ... our generation needs to know the route and identity of where they came from; to ensure pride, passion, dignity and leadership to carry us through to the future; BoC connects Indigenous Australians to the land.”

¹ Alukura is an Arrernte word meaning ‘women’s camp’
A modified World Café research methodology was used to engage workshop participants. The morning session concluded with participants having identified the key principles underpinning a BoC model of care. The afternoon session covered different topics, which included: the key elements of a BoC model of care; the governance structure; training and education requirements for a skilled workforce; participants understanding of two-way learning and working; understandings of ‘risk’; and community engagement.

In the morning World Café session, participants were encouraged to rotate through all the Café tables (n=6) to meet a variety of people discussing BoC definitions. In the afternoon sessions, participants were asked to pick one of the six topics to work on and each of the six groups presented back to the whole group at the end.

Tables were facilitated by ‘hosts’ who ensured discussions remained focused. A volunteer 'scribe' took notes at each table for all sessions. The notes, together with those taken by the authors, were compiled into the one document and a thematic analysis was undertaken. A draft report was circulated amongst a group of participants who had agreed, in advance, to provide feedback. Additionally, the draft report was circulated to MSIJC members and further feedback was incorporated.

**RESULTS**

The results of the BoC workshop are presented against the objectives, which are numbered 1-4 below.

1. **Obtain agreement regarding progressing Australia’s commitment to BoC programs**

There was clear agreement from the participants that the BoC program should be progressed, that it ideally should be a national program, and that a long-term view is required. Participants were also mindful that a successful BoC program would be a radical and groundbreaking milestone in the delivery of maternity care for Indigenous women and their families. For that reason one participant stressed the importance of “not about setting ourselves up to fail … we’d have to pick out, you know, one or two remote communities that have got some reasonable amount of infrastructure, that have got a clinic that can support that … hopefully, an Aboriginal midwife that could support that. … a community site that will be able to support (the initiative).” The term BoC was described as a metaphor for ‘the best start in life’ for Aboriginal and Torres Strait Islander families because it provides an integrated, holistic and culturally appropriate model of care. Participants agreed that the term ‘pilot sites’ should not be used, to avoid the customary association with short term, inadequately funded, projects. One participant stated candidly: “I actually don’t think we should pilot (original emphasis) anything. I think we’ve had pilots … They’ve never done anyone any good. We have to talk about system reform. We have to use research or political strategy or infrastructure to support system reform. We have to evaluate it. We don’t do pilots”. Participants agreed that the system-wide reform required is not possible within a short-
term ‘pilot’ program; hence, the term ‘initial sites’ or ‘exemplar sites’ were suggested as acceptable alternatives. The BoC initial sites should be funded for long-term success with a commitment to further rollout the BoC program after the initial sites have been established. The sites should have a strong ongoing research and evaluation framework embedded which includes regular assessment of socio-cultural elements of the program, in addition to clinical indicators. Initial sites should include several that are established in remote and very remote regions of Australia with at least one in an area that is non-English speaking. A BoC assessment tool that can measure critical factors underpinning culturally safe environments could monitor the program activities and impact. An appropriate tool will need to be devised and validated.

2. **Establish jurisdictional steering groups to support the implementation of BoC programs in Australia**

The establishment of jurisdictional steering committees was not discussed at length as funding concerns had been highlighted to the MSIJC Chair just prior to the workshop. In general, however, participants indicated that it would be important for MSIJC to work with the National Aboriginal Community Controlled Health Organisation (NACCHO) to consider establishing a National Steering Committee rather than individual jurisdictional committees. As NACCHO does not represent all Aboriginal and Torres Strait Islander communities or ACCHOs it was recommended that there was a call for nominations more broadly to ensure the widest possible consultation. Recommendations included across all Aboriginal and Torres Strait communities and to advertise through NACCHO, Land Councils, and both national and local Aboriginal and Torres Strait community. This issue had also been discussed in the pre-conference cultural guidance meeting where participants stressed the importance of transparency throughout the process of selecting a Steering Committee, which must have strong, and majority, representation from Aboriginal and Torres Strait people, particularly women.

3. **Develop an implementation and evaluation framework for the BoC program**

Key points that need consideration in the implementation of the BoC program are noted in the following two paragraphs and have been further articulated in the Recommendations and the body of this Report. As the BoC program is introduced, it will be important to take a long-term, capacity building, approach that recognises the importance of Aboriginal and Torres Strait Islander culture. Each mother and her family must be able to define their own cultural practices. Participants also stated that the BoC services have a responsibility to play a role in the maintenance and reclamation/revival of cultural practices, as successfully achieved by Congress Alukura who embed cultural education into their services.

Continuity of care and carer throughout pregnancy, birth, and the immediate postnatal period, was identified as essential for all women. Ideally, some degree of continuity would also continue for mother
and infant through the first year of her baby's life. Where continuity of carer was not possible there should be a direct, timely, verbal handover of care between care providers. There was broad agreement that choice was an important aspect of care provision and that Aboriginal and Torres Strait women should not feel that receiving care through a particular model, or in a specified place, is their only option. Informed consent is essential. Aboriginal and Torres Strait Islander people must be instrumental in explaining how risk is perceived locally and hence must be actively engaged in discussing how this concept is best applied to pregnancy, birth ‘on country’, and throughout the postnatal period; ownership over how the definition is interpreted and ‘actioned’ in practice is crucial.

Community engagement will be an essential component of the BoC project. The significance of identifying and incorporating the voices of Aboriginal and Torres Strait Islander elders, and other holders of cultural knowledge, was repeatedly emphasised. However, community engagement should not be limited to ‘just’ the voices of selected individuals; it is important to involve the wider community, and especially to ensure that women and mothers have a legitimate voice, and a recognised role, in providing direction for the BoC service.

4. **Identify potential pilot sites for the BoC program to be trialed.**
Participants acknowledged that several ‘initial or exemplar sites’ for BoC could be identified on the basis of previous consultations; however, there was clear agreement that further national consultation was necessary before any final decisions were made. This would ensure that everyone concerned had the widest possible opportunity for involvement.

**RECOMMENDATIONS**

The following recommendations are presented under the objectives of the workshop and are numbered 1-4 below.

1. **Obtain agreement regarding progressing Australia’s commitment to BoC programs.**
   A. Workshop participants agreed that the BoC program should progress and that:
      i) a long-term view of this work is important
      ii) it be seen as a program of work that is leading system-wide reform
      iii) it include the establishment of initial exemplar sites which are funded for long term success with the view that there will be a further roll out after these initial sites have been established and evaluated
      iv) the BoC program requires a strong ongoing research and evaluation framework embedded into it that includes:
         a) regular assessment of socio-cultural elements of the program, in addition to clinical parameters
b) a BoC assessment tool that can monitor critical factors that facilitate culturally safe environments, program activities and their impact is to be developed

B. The term BoC be retained and that:
   i) the term is understood as a metaphor for the best start in life for Aboriginal and Torres Strait Islander babies and their families, an appropriate transition to motherhood and parenting for women, and an integrated, holistic and culturally appropriate model of care for all.

2. Establish jurisdictional steering groups to support the implementation of BoC programs in Australia.
   A. Representatives from jurisdictions and NACCHO will seek members for a BoC Steering Committee to progress the BoC work and that:
      i) the BoC Steering Committee will have a majority of Aboriginal and Torres Strait Islander members on the panel and a majority of Aboriginal and Torres Strait Islander women
      ii) membership includes representatives of urban, rural, remote and very remote regions of Australia and from a community that is primarily non-English speaking
      iii) consumers are represented on the committee in equal proportion to non-consumer members
      iv) nominations from across the Aboriginal and Torres Strait Islander communities to be sought through advertisements via NACCHO, Land Councils, workshop participants, Aboriginal and Torres Strait Islander newspapers and community-based organisations.

3. Develop an implementation and evaluation framework for the BoC program.
   A. The implementation framework should aim to develop initial exemplar sites whereby the BoC model of care is:
      i) a woman-centered service that encourages:
         a) each mother and her nominated family to define their own cultural practices
         b) a philosophy that normalises birth
         c) informed choice
      ii) a service that aims to maximise social, emotional, spiritual and cultural wellbeing, i.e. a holistic health model and:
         a) has a significant role in the maintenance and reclamation/revival of cultural and spiritual practices as a service responsibility (similar to Congress Alukura) and offers cultural education and activities as part of the service
         b) is inclusive of diverse Aboriginal and Torres Strait Islander cultural and spiritual beliefs and practices
c) enables women to identify their own risks within an Aboriginal and/or Torres Strait Islander cultural framework and ensures equal weight is given to risks associated with spiritual, emotional, and cultural disenfranchisement as is given to clinical risks

d) leads discussions on what degree of risk is ‘acceptable’

e) includes mechanisms for effective and timely responses to adverse events

f) has a recognised complaints procedure (or equivalent) that is accessible and appropriate for all community members

iii) a ‘hub and spokes’ model:

a) which is developed and managed within a community engagement and cultural framework:

i. that identifies and incorporates the voices of Indigenous elders and cultural knowledge holders

ii. that prioritises an inclusive process for community involvement

b) that has robust Governance structures including:

i. regular governance training for committee members

ii. transparent processes, accountability and clear reporting lines

iii. a means for reporting against key outcome measures identified in advance (these would be expected to evolve over time)

iv. commitment to regular community consultation and engagement

c) where midwives have skills, knowledge and flexibility to attend women during labour and birth in various locations e.g. at home, at hospital, on a sacred site or in a birthing centre (not all births outside will necessarily be on a recognised sacred site). A pragmatic approach to BoC viewed this simply as “allowing Indigenous women to birth where they live or at their chosen cultural location”. Of central importance, was that “women feel comfortable and are proud ... most of all it's their choice where to have their baby to be born on country or hospital .... But to me personally I would see our young Indigenous women birth on country”.

d) that incorporates continuity of care and carer for all women, including women with identified risk factors:

i. with the proviso that direct communication between care providers occurs when woman require transfer of care (individual hand-over of client information both to and from higher level care)

ii. and that consideration is given to providing case conferencing facilities between primary and tertiary units for women who require transfer

E) where women feel safe and have choices
f) which has well recognised partnerships with other service providers and includes overarching governance arrangements that allow sharing of resources to maximize effectiveness across agencies

iv) encompasses a community capacity building approach and:
   a) works rapidly towards establishing and maintaining a largely localised Aboriginal and Torres Strait Islander workforce which:
      i. includes Aboriginal and Torres Strait Islander student midwifery positions with scholarships that equate to a living wage
      ii. develops alternative pathways to learning and skill acquisition
         (i) for example, traineeship/apprenticeship models with onsite education, including in remote areas
         (ii) with supportive structures (may be short courses) to ensure potential students are prepared for higher education
      iii. enables formal educational programs to be much more flexible and acknowledges the family, community and cultural responsibilities of Aboriginal and Torres Strait Islander students, which may include unplanned and unexpected leave from the workplace/educational environment, whilst also ensuring professional and educational requirements are fully met by all students
      iv. recognises the contribution provided by mothers and grandmothers and the importance of “ancestors to bring ... into today’s world of what they’ve left behind and carry on the legacy ... you may not be a midwife but at least you are carrying on that culture of knowledge to your ... daughter's children and your grandchildren.”
   b) where possible, employs more Aboriginal and Torres Strait Islander staff than non-Indigenous staff
   c) includes a ‘Strong fathers/dads’ program
   d) includes Aboriginal and Torres Strait Islander parenting programs designed and run by Aboriginal and Torres Strait Islander people
   e) considers health literacy programs
   f) is community controlled and sits within an ACCHO or has overarching Aboriginal and Torres Strait Islander governance and control through other structures; e.g. Aboriginal corporation, Cultural Advisory Board

v) ensures cultural safety/security training and education for all staff which:
   a) is designed, defined and where possible delivered by local Aboriginal and Torres Strait Islander people who are remunerated for doing so
   b) includes trauma informed practice and care (see glossary)
   c) includes racism awareness training

B. encompasses a strong evaluation framework
i) that reports against clinical indicators and those that measure the social, emotional and cultural wellbeing of women and families
ii) that includes measuring health system performance from the consumer perspective
iii) that incorporates a continuous cycle of change and quality improvement.

4. **Identify potential pilot sites for the BoC program to be trialed.**

A. Initial exemplar sites should be identified by jurisdictions and where possible established in a variety of regions (very remote, remote, rural, urban) and
   i) be funded for long term success with the view that there will be further rollout after these sites have been established
   ii) sites are identified by the jurisdictional steering committees following widespread dissemination of this Report and that
      a) several sites are located in remote and very remote Australia
      b) at least one very remote or remote site is in community that is primarily non-English speaking.
The National Maternity Services Plan\(^1\) (the Plan) was endorsed by the Australian Health Ministers in November 2010 and released in 2011. The Maternity Services Inter-jurisdictional Committee (MSIJC) has been delegated responsibility for implementing the actions in the Plan and reporting to the Australian Health Ministers’ Advisory Council (AHMAC), through the Health Policy Priorities Principal Committee (HPPPC) which was re-structured in 2012 to the Community Care and Population Health Principal Committee (CCPHPC) for strategic direction. Action 2.2 of the Plan aims to develop and expand culturally competent maternity care for Aboriginal and Torres Strait Islander people. A key deliverable from the Plan is Action 2.2.3 (Appendix 2): To undertake research into international evidence-based examples of BoC programs to inform the development and implementation of a national BoC service delivery model that is culturally competent and improves health outcomes for Aboriginal and Torres Strait Islander mothers and babies. This work commenced with a literature review\(^2\) with inclusion criteria defined as ‘maternity services designed and delivered for Indigenous women that encompass some or all of the following elements: are community based and governed; allow for incorporation of traditional practice; involve a connection with land and country; incorporate a holistic definition of health; value Indigenous and non-Indigenous ways of knowing and learning; risk assessment and service delivery; are culturally competent; and developed by, or with, Indigenous people’. The review was completed in early 2012 at the time that the middle years implementation plan of the Plan was released (Appendix 1).

The next step in the process of developing a framework for BoC programs was to hold a national workshop. The MSIJC in collaboration with the CAAC, held the workshop on 4 July 2012 in Alice Springs at the Crowne Plaza Hotel. A committee of representatives from these organisations planned the workshop and a wide range of stakeholders were invited (Appendix 3). A contingent of the attendees were from the National Maternity Council which held their regular meeting in Alice Springs on the 5\(^{th}\) July, to coincide with the workshop. This meant some of the lead maternity representatives from across Australia were already in Alice Springs. The MSIJC received funding from AHMAC to bring Aboriginal and Torres Strait Islander representatives to the workshop and invitations were distributed through NACCHO and their state affiliates as well as targeting expert individuals in the field.

The objectives of the BoC Workshop were to:

- obtain agreement regarding progressing Australia’s commitment to BoC programs
- examine the establishment of jurisdictional steering groups to support the implementation of BoC programs in Australia
- develop an implementation and evaluation framework for the BoC program
- identify potential pilot sites for the BoC program to be trialed.
THE WORKSHOP

The workshop program (Appendix 4) consisted of a Welcome to Country and several presentations including: a formal welcome from the Chair of MSIJC who provided an overview of the aims of the workshop; a history of Congress Alukura, the Aboriginal Medical Service in Central Australia which incorporates a primary maternity service (Appendix 1) for mothers and babies; an overview of the results of the aforementioned literature review; the importance of BoC to the Yolgnu; an overview of the Primary Maternity Service that has recently opened at the Orange Aboriginal Medical Service in New South Wales; and interactive sessions with participants. The workshop was facilitated by Ms Ann-Marie Hayes, Director of the Health Informatics, Planning and Performance Outcomes (HIPPO) Unit of the Women’s and Children’s Health Network in South Australia.

The workshop employed a modified ‘World Café’ methodology as a practical way of enhancing human capacity for collaborative thought. The aim of the World Café methodology is to generate small scale and intimate conversations, and to facilitate multiple interactions between a wide range of stakeholders, as participants move between tables and groups. Key stakeholders gathered together to explore their understandings of BoC: what it meant to them, the key principles, what might underpin good practice, the risks and barriers to implementation; to discuss the outlined objectives and to provide guidance on how best to engage other stakeholders and identify sites.

In the morning there were three sessions of Café-style interactions, all of which commenced with an initial table of participants discussing a given topic for 20 minutes. Participants were then asked to rotate around the other tables taking with them core ideas generated by their initial group for discussion with the next group. One or two participants remained as table ‘hosts’ who agreed to ‘scribe’ the key points raised. The first topic ‘open discussion about the definition of BoC’ was discussed at all of the tables with the aim of mixing as many participants together as possible. In the afternoon session, the world café tables were given different topics to discuss which included:

- Key elements of BoC
- Governance
- Training and education requirements for a skilled workforce
- Participants understanding of two-way learning and working
- Risk, and
- Community engagement.

The process facilitated the cross-pollination of ideas and enabled new connections between participants, many of whom had not previously met. As this ‘living network’ of conversations evolved through several rounds of exploratory conversations, knowledge-sharing increased, differences of
opinion were voiced and explored, and a deepening sense of the complexities underpinning the notion of BoC began to emerge. Innovative possibilities for working together more cohesively as a large group also began to emerge. As was witnessed in the workshop, the unique structure of World Café style of learning enabled large groups to think together creatively as part of a single, connected conversation. However, as this was a modified World Café style workshop, the tables were all given topic areas rather than specific questions and table facilitators. Notes were taken by the report authors and from 'scribes' at every table and session. A thematic analysis was conducted from the notes taken during the workshop. The draft report was then circulated amongst a group of participants who had agreed in advance to provide feedback, which was incorporated into the final version.

CULTURAL CONSIDERATIONS

Prior to the commencement of the workshop, Ms Maidment facilitated a separate discussion. This session was specifically for Aboriginal and Torres Strait Islander women. The participants granted permission for Ms Hayes, and Prof Kildea, as the only non-Indigenous participants, to attend this session. Ms Maidment provided participants with an overview of the MSIJC and the National Maternity Council, and the aims and objectives of the workshop. Prof Kildea provided an overview of the recommendations for improving Aboriginal and Torres Strait Islander maternity services in Australia highlighted in the Plan. Specifically, a history of the BoC Project was provided to the participants, with explanations of some of the consultations and processes that had occurred to date. Ms Hayes provided an overview of the plan for the workshop and discussions about the cultural considerations ensued. Clear directions were given to the facilitator with agreement from all participants.

The pre-workshop meeting was a very important part of ensuring the workshop was culturally safe whilst also providing specific directives to the facilitator. The meeting was not recorded; however some of the concerns regarding discussions about women’s business and other private issues, in front of men, were explored. Strategies were developed to ensure these discussions could take place, for example separating men from the main group if necessary. This situation did not arise at the workshop. The participants raised a number of other concerns:

- Who decided who should be invited to the BoC workshop and who would speak and facilitate at the workshop?
- Why weren’t there more Aboriginal speakers and facilitators?
- Who will make the decisions about the location of pilot sites and the make-up of the steering committees?
- Will Aboriginal and Torres Strait Islander communities get the final say?
• What strategies are in place to ensure more Aboriginal and Torres Strait Islander people, and more Aboriginal and Torres Strait Islander communities, will be involved in the process with an ability to have a say in the decisions made?

Participants in the pre-workshop meeting discussed their responsibility when providing feedback to elders and community women and their need to fully understand the process. The need for transparency was acknowledged, for the provision of realistic information to local communities and outlining the scope communities will have in planning and decision making when developing the BoC model. An outline of the findings from the literature review on BoC maternity service delivery models was requested by participants, and provided by Sue Kildea, to assist in the preparation for the national workshop being held the following day. The importance of this national workshop, and the need to document proceedings, was also considered. Permission was granted to have a roving video-camera operator present for the day to interview consenting participants. The wording of consent forms for this activity was discussed. It was agreed that Sue Kildea and the camera operators would waive ownership of overall production and recording rights, with an affirmation that all intellectual property rights would remain with the interviewee/storyteller. However, it was also agreed that Prof Kildea would carefully retain all media files for possible future use, when individual consent would be secured. Participants could contribute their opinions via video if they wanted to, with the understanding that Prof Kildea would keep the footage and that the footage would not be used without prior permission from each individual. Direct quotes have been used in this report to illustrate participant understandings.

WELCOME AND PRESENTATIONS

The following section provides a brief overview of each of the presentations and the results of the interactive sessions. See Appendix 4 for the workshop program.

WELCOME TO COUNTRY

Lhere Artepe (Native Title) representatives Janice Harris and Felicity Hayes provided the welcome to country; it provided an excellent introduction for the day.

WORKSHOP WELCOME AND PURPOSE

Ms Bonnie Fisher, the Chair of MSIJC and the Maternal and Neonatal Clinical Network in South Australia, provided a brief overview of the relevant recommendations from the National Maternity Services Plan; the aims of the workshop; and the work plan for the next six months for the BoC Project. This included the completion of a workshop report, the establishment a national steering committee, agreement on a process of identifying sites for a BoC program, and the development of an evaluation framework for such a program.
CULTURAL GUIDANCE FOR THE WORKSHOP

The cultural guidance for the day was provided by Leshay Maidment, a local central Arrernte woman and as noted above, one of the co-organisers of the workshop. She thanked the Aboriginal and Torres Strait Islander women for attending the pre-workshop session and for providing guidance on how best to facilitate the national workshop to ensure that participants were respectful of cultural sensitivities and protocols whilst also accepting the need to be inclusive of others, including men. She stressed the importance of having a culturally safe and comfortable space for all participants and established some ground rules acknowledging that for many participants there are cultural sensitivities and cultural protocols associated with the topic of birthing, whilst acknowledging that these discussions were vital to progressing the vision. She outlined that specific cultural details were not necessary at this point but instead broader descriptive statements would be sufficient and appropriate, such as the commonly used term ‘Women’s Business’, or the term ‘Grandmothers Law’, which is well known and used by women in central Australia. The workshop facilitator, had been briefed on these important aspects and the need to tailor and structure the workshop accordingly, highlighting that there may be women-only groups if individuals preferred. Participants were asked to discuss any concerns they had with the facilitators as the day progressed.

PRESENTATION OF THE BOC PAINTING

Ms Margaret O’Brien (Aboriginal Health Worker, Danila Dilba Aboriginal Medical Service) presented the BoC painting on behalf of the artist Margie Larkin, an Aboriginal Maternal Infant Care worker living and working in Alice Springs, who was unable to attend for the day. She explained the meaning of design which can be seen inside the cover of this report.

CONGRESS ALUKURA AND COMMUNITY CONTROLLED ABORIGINAL ORGANISATIONS

Ms Donna Ah Chee (Acting CEO of Central Australian Congress) and Ms Maidment co-presented and described 25 years history of the Congress Alukura birthing service which incorporates: antenatal and postnatal services including: home visiting; family planning; young women’s education; cultural liaison services; transport; pharmacy; midwifery education; and women’s health services, including an obstetrics and gynaecology outreach clinic. Birthing services have been established and operational several times over the 25 years including 1993-97 (17 births) and 2002-08 (88 births); each time under different governance arrangements and agreements with the tertiary service. Recent negotiations have seen a revised Memorandum of Understanding (MOU) with Alice Springs Hospital (ASH). The MOU enables midwifery-led care whereby the midwives employed by Congress Alukura can provide care in ASH with Alukura midwives:

- Under the direct clinical supervision of the ASH Obstetricians
Taking part in ASH orientation, induction and professional development opportunities

- Birthing women with and without risk factors which ensures skills maintenance
- Providing a higher level of continuity of care as many more women are now eligible for the service
- Who can become eligible midwives and claim Medicare for the services they provide (though the potential for midwives to claim Medicare funding has yet to be realised).

Key points included the way the service had evolved over the years to adapt to available funding, recruitment challenges and community directions (identified by the grandmothers, consultation, research and service reviews) and included the following:

- The service was premised on a very high level of community control and community input
- Ongoing community direction and involvement included many women’s meetings and cultural camps with elders and younger women organised by Congress Alukura over many years
- The service was designed around women’s cultural spirituality, cultural practices and women’s business, and maintaining women’s business and women’s law/lore.
- Providing cultural education to pregnant women and mothers is also part of the service
- The underlying philosophy includes:
  - Aboriginal people are a distinct and viable cultural group with their own cultural beliefs and practices, law/lore and social needs
  - Every woman has the right to participate fully in her pregnancy and childbirth care, and determine the environment for, and nature of, such care
  - Every Aboriginal and Torres Strait Islander woman has the right in pregnancy and childbirth to maintain and use her own heritage, language and customs, language
- The importance of maintaining good relations with the local maternity unit
- The positive impact on maternity care, in particular antenatal and postnatal care, and the way maternity care has integrated with child health services (currently participating in the family home visiting program)
- The challenges of recruiting and retaining adequate numbers of skilled staff, particularly for birthing service provision and Medicare billing capacity
- The challenge of ensuring adequate recurrent funding to provide an appropriate and sustainable model, given the shortage of midwives who can attract Medicare funding
- The importance of being based in the primary health care setting and having appropriate clinical governance frameworks and integration with tertiary services
The inevitability of unpredictable, adverse, events and the need to develop a critical and enquiring ‘no – blame’ culture†.

A copy of the PowerPoint presentation is at Appendix 5.

YOLGNU BIRTHING YARN

Djapirra Mununggirritj gave an overview of the importance of BoC to the Yolgnu people. The full transcript of her speech is at Appendix 6.

Key points to consider included:

- Birthing is the most powerful thing that happens to a mother and child
- BoC brings spirituality to the modern world, it lies deep and wide from the ancient to the future
- Our generation needs to know the route and identity of where they came from; to ensure pride, passion, dignity and leadership to carry us through to the future
- BoC connects Indigenous Australians to the land
- I may have been born without a hospital but I had Aboriginal midwives, grandmothers and aunts with me.
- Connecting ourselves to our roots is the key to opening doors in the modern environment
- We are here at this workshop to set up something for 20 years time, so that we, on these tables, can look back and say we were proud of what we did.

OVERVIEW OF THE BOC MODELS OF MATERNITY CARE LITERATURE

This presentation was provided by Prof Kildea and included an overview of the Plan which was endorsed by the Australian Health Ministers in 2010.1 Action 2.2 of this Plan, aims to: Develop and expand culturally competent maternity care for Aboriginal and Torres Strait Islander people (Appendix 2). A key deliverable is Action 2.2.3: to undertake research into international evidence-based examples of BoC programs in preparation for developing and implementing a national BoC service delivery model that is culturally competent and improves health outcomes for Indigenous mothers and babies. For the purposes of the literature review BoC was defined as: maternity services designed and delivered for Indigenous women that encompass some or all of the following elements:

- Are community based and governed
- Allow for incorporation of traditional practice

† For example: through advocating reporting systems for ‘near misses’ and adverse events, case review (and facilitation), acknowledging mistakes, transparency and transparent systems, open forums to disseminate information, ongoing education/information sessions for maternity service providers users, consumers, their families and the wider community.
• Involve a connection with land and country
• Incorporate a holistic definition of health
• Value Indigenous and non-Indigenous ways of knowing and learning; risk assessment and service delivery
• Are culturally competent, and,
• Are developed by, or with, Indigenous people.

This review was restricted to models of care used in the provision of birthing services in Indigenous communities of developed countries such as Australia, New Zealand, Canada, and the United States of America and sought to answer the following questions:

1. What are the components of maternity service delivery models that have been implemented for Indigenous mothers and babies?
2. Which of these models have been most effective? And why? (Only include models that have been evaluated).
3. What have been the barriers and facilitators of the successful implementation and sustainability of these models? And why? Were the barriers resolved?

Key points described in the review included the lack of high quality research in this area with most studies limited by small numbers, short-term evaluation data and a lack of comparison data. An overview of one of the most successful models (the Inuulitsivik Midwifery Service), based in the Nunavik region of far north Quebec, was provided as an example of what has been achieved in a remote Indigenous community. A key factor supporting the establishment of the service appears to have been the open dialogue and debate around risk in childbirth. Additionally there was acknowledgement and a recognition that: “Culturally appropriate health care requires respect for the choice of community-based child birth and may also challenge the world view of medically trained health professionals who are concerned with access to medical technologies and medico-legal liabilities” Indigenous doctor, Janet Smylie MD. A key principle underpinning the model is that “the cultural aspect of birth is not a mere ‘nicety’ that can be appended to the care plan once all other acute obstetrical techniques are in place. It is essential to perinatal health... it is from within the culture and community that real positive changes in the health of the people begins”.

Birth in communities is perceived as part of community healing from the effects of colonisation and rapid social change whereby: “women are cared for in Innuittut, [their own language], and children are born into their culture, in the presence of family. Inuulitsivik’s maternity service builds local capacity, reclams meaningful roles for Inuit midwives, empowers childbearing women and involves fathers and other family members in childbirth”.

The principles and factors that underpin successful service include:
Providing women with the knowledge they need to understand the risks and benefits of giving birth in the community so they can make an informed choice
- Respecting women’s right to choose where they give birth
- Ensuring the support of community leaders and elders and ensuring that women are part of the planning and implementation of birth plans
- Creating policies and procedures to facilitate optimal communication, planning, trust-building, and overall collaboration between caregivers within the community and in the supporting referral centres
- Developing protocols for clinical care for the community birth initiative and the referral centre and in collaboration with all health care providers
- Ensuring that continuous monitoring and evaluation of risk during pregnancy and labour are understood to be critical and are in place at all times
- Ongoing documentation and annual review of experience
- Reporting back to the community on the successes and challenges
- Developing a campaign to inform Society of Obstetricians and Gynaecology of Canada members, governments, communities, and the population at large about the benefits of birth in the community.\textsuperscript{10p,1186} A copy of the PowerPoint presentation is at Appendix 7.

THE ORANGE ABORIGINAL MEDICAL SERVICE: MURUNDHU DHARAA

Hazel Keedle and Tracy Coles from the Orange Aboriginal Maternity Service (OAMS) in NSW co-presented on the newly established primary maternity service, which includes a Birth Centre and other maternal infant health services (immunisation, child and family health, well women’s screening, colposcopy and paediatric clinic, home visiting, postnatal care and child health services up to 12 years). During 2008, the Federal government conducted a National Maternity review and in January 2009, the service received ‘New Directions’ funding from the Commonwealth Government. A comprehensive risk assessment process was completed in November 2010. The OAMS secured capital works funding and the Birthing Services opened on 14\textsuperscript{th} November 2010. Three births occurred before the birthing service was suspended, in response to advice from NSW Health, that OAMS required a License as a private hospital to continue offering birthing services. The Licensing procedure involved a quality control review of all clinical, governance, financial and administration policies, procedures and processes. Additionally, the OAMS received accreditation from the Australian General Practice Accreditation Limited (AGPAL). The midwives working at OAMS have Medicare eligibility that contributes to the sustainability of the service; insurance was secured through the Medical Insurance Group of Australia (MIGA). If a woman needs to be transferred to hospital, the primary midwife accompanies her in the ambulance and upon arrival at Orange Health Service her care is transferred. The OAMS midwives do not have visiting rights at the tertiary hospital although discussions have taken place regarding this matter. The Aboriginal
Maternal and Infant Health Workers support women across the continuum in either setting. A general practitioner works with the team two days per week.

The Birth Centre reopened in February 2012 after the private hospital License was granted. Hazel and Tracey indicated that the Birth Centre is available to both Indigenous and non-Indigenous women to ensure a critical mass and funding viability. In the four months between reopening and the workshop being held, a further 11 births had occurred, bringing the total number of births to 14. Four of these births were to Indigenous women and 10 were to non-Indigenous women; 100% of women accessing the service received follow up within 24 hours of discharge from hospital and within 12 hours of discharge from the Birth Centre.

During the discussions that followed this presentation, one participant questioned why Murundhu Dharraa didn’t ensure they had at least one Aboriginal community speaker at the workshop given the nature of the workshop. They responded that the Aboriginal health worker was asked if she would like to attend but was not available on the date of the conference. One participant raised concerns about the services’ unwillingness to be inclusive of diverse Aboriginal cultural and spiritual practices and also highlighted a lack of diverse cultural input into the development of the service stating no Aboriginal community women’s gatherings had been called to help design or create the service or to give advice as to how it could be run. It was suggested that if Aboriginal community women had been able to help choose the name they may not have chosen the word ‘Dharraa’ which means ‘mansion’ or ‘house’ but they may have chosen a more familiar word less associated with non-Aboriginal buildings such as ‘ganya’. It was also raised by one participant that no cultural education services regarding cultural birth or cultural parenting were available through Murundhu dharraa.

In summary, participants recognised the importance of a second Aboriginal controlled primary maternity service being established in Australia. Additionally, the participants felt that the administrative progress in three years was impressive given the need for accreditation as a private hospital and the challenges midwives currently have had in obtaining Medicare eligibility status in Australia. Participants supported the service remaining open for birthing but stressed that Aboriginal community women have an ongoing voice with regards to decisions about the service for example through a separate Women’s Board and that the service must cater for the cultural practices of all Aboriginal women living in the region.

The following key points were highlighted:

- The importance, and challenges, of ensuring Indigenous families and other stakeholders have been appropriately consulted in the establishment and ongoing running of a Centre, and ensuring staff continue to receive ongoing cultural guidance
• The benefits of having a comprehensive primary maternity service that is an ACCHO
• The challenge of recruiting and retaining staff who are eligible to claim Medicare and the benefits that this brings, including an additional income stream for Aboriginal and Torres Strait Islander Maternal Infant Health programs
• The importance of including Aboriginal cultural and spiritual beliefs within the service including providing a service to all Aboriginal people
• The importance of maintaining working relationships with all organisations that have assisted in the establishment or running of the birthing service (including Aboriginal Cultural Birthing and Parenting NSW).
• The importance of providing Aboriginal cultural birthing and parenting educational workshop opportunities to allow Aboriginal people who may not have had previous access to culture to learn about culture and to then make an informed decision as to whether it is something they would like to experience at their births and in their lives or not
• The time necessary to make partnerships work needs to be acknowledged and embedded into the model
• The considerable time it takes to gain the confidence of community members as new services commence in a small community
• The challenge of establishing and maintaining a service when funding is not ongoing.

MORNING SESSION: IDENTIFYING KEY ELEMENTS OR PRINCIPLES

INTRODUCTION: SETTING THE SCENE

Participants engaged in consecutive rounds of discussions to identify the key elements or principles for a BoC model of care. Although discussion points are numbered, this does not suggest any hierarchy or prioritising of the topics.

OVERVIEW

BoC may be understood as a metaphor (Djapirri) for the best start in life for Aboriginal and Torres Strait Islander babies and their families because it provides an integrated, holistic and culturally appropriate model of care; “not only bio-physical outcomes ... it’s much, much broader than just the labour and delivery ... (it) deals with socio-cultural and spiritual risk that is not dealt with in the current systems”. It is important that the BoC project move from being aspirational to actual. The BoC agenda relates to system-wide reform and is perceived as an important opportunity in ‘closing the gap’ between Indigenous and non-Indigenous health and quality of life outcomes.
Any BoC framework should have State/Territory and national application and agreement; regional/local arrangements would not be sufficient to generate nor sustain the substantial improvements needed in maternal and neonatal health and well-being. Innovative, well-designed programs that are adequately resourced, and embedded within research evaluation frameworks, are needed. All Aboriginal and Torres Strait Islander women, as with all women, have the right to learn/revive/maintain/reclaim their cultural practices and to follow their beliefs during pregnancy and birth. A culturally safe assessment tool is imperative to any BoC model. Investment in a BoC model of care will need to take into account the long-term program needs and ensure structures are in place to guarantee stability and sustainability. A long-term capacity building approach is therefore essential and must be underpinned by cultural inclusivity, which recognises the importance of Aboriginal culture, spirituality, law/lore and cultural practice.

Whilst some aspects of BoC were thought to be general principles with wide application (the role and importance of the maternal grandmother), others would be local and highly specific. A key consideration is the acknowledgment of local diversity within Aboriginal communities that are composed of a mixture of people with different family clans, different religions, different tribes and differing cultural practices and beliefs. Each mother and her nominated family will define their own cultural practice. Participants also stated that the BoC services have a responsibility to play a role in the maintenance and reclamation/revival of cultural practices; as Congress Alukura has done. As such, cultural education services need to be part of the design of any BoC service, with workshop participants believing these contribute to community and individual healing through cultural practices. Continuity of carer throughout pregnancy, birth, and the immediate postnatal period, was identified as essential for all women. Ideally, some degree of continuity would follow the mother through the first year of her baby’s life. However, there was broad agreement that choice was an important aspect and that Indigenous women should not feel that receiving care through a particular model, or in a specified place, is obligatory. Informed consent is essential for all processes and procedures, especially those of a clinical nature.

Indigenous people should be instrumental in explaining how risk is perceived locally and how this concept is best applied to pregnancy and ‘birth on country’. Ownership over how the definition is interpreted and ‘actioned’ in practice is essential. Descriptions and classifications should be fluid and flexible, taking account of socio-cultural and linguistic diversity amongst and between Indigenous people. This means it is unlikely that there will ever be a ‘one size fits all’ definition as BoC is likely to be understood differently by different Indigenous groups. There will be diversity in practices, protocols, spirituality and identity.
1. Connection to country/land is crucial to Indigenous identity and must be central to the BoC agenda; recognising however, that country is everywhere. Recognition of the links to one’s ancestral land is an essential element in any definition; it is what keeps Indigenous cultures strong and connected to their ancestors. As one participant commented: “We need to bring the mothers that carry the younger generations back to culture ... to be connecting the child back to earth and it's environment ... you don't lose your culture and your language ... ”.
   a. An understanding that no matter where women birth across Australia, it will always be on Aboriginal country
   b. BoC will contribute to healing from the intergenerational trauma resulting from historic injustices, colonisation, removal from, and dispossession of Aboriginal and Torres Strait Islander land. BoC will assist to revive and reclaim cultural knowledge and practices, strengthening links to land and culture, resulting in improved social, emotional and cultural wellbeing.
      i. The cultural revival will come from those who have the knowledge and are willing and able to share it. The cultural knowledge/practices that need to be part of BoC services will be part of cultural education programs where women who want to learn (i.e. make an informed choice) can attend. Cultural women’s camps like those regularly run by Congress Alukura, are examples of how women getting together can share their cultural practices and knowledge.
      ii. The loss of connection to ancestral land as experienced, for example, by some stolen generation Indigenous people, was acknowledged. However, it was described that even if stolen generation members do not know where their home ‘country’ is the BoC services may further enable them to create connections to country, via kinship connections within the community. The BoC models may assist Aboriginal and Torres Strait people to reconnect with family, culture, spirituality and country by providing cultural education and the ability for individuals to connect with cultural knowledge holders.
      iii. Some Aboriginal and non-Aboriginal people believe that Urban Aboriginal people are less connected to country than Aboriginal people living in rural or remote areas (Appendix 1 - Glossary: Cultural Connections). In reality, many Urban Aboriginal people maintain strong connections to both their country of residence and their home country. This includes participation in local cultural events and connection through local kinship and returning ‘home’ to their ancestral country for cultural
events and funerals. Many urban Aboriginal people have created their own strong cultural connections to kin and country in their urban homes as well. Sometimes this is known as historical custodianship or being historical caretakers instead of “traditional owners”. Many Aboriginal people in urban locations are strong in culture including regularly participating in ceremony and ritual, language, law/lore and other cultural practices.

c. Culturally safe and secure care, as described by BoC, should be available in all locations; from remote communities through to tertiary, metropolitan settings.

d. It was generally agreed that ties to one’s ancestral land had powerful significance to Indigenous people; it is commonly understood as an embodied aspect of identity. In addition, the place of birth (regardless of whether it is your ancestral country or not) may also be culturally and spiritually significant. For example if a Wiradjuri child is born in Bundjalung country then there may also be a spiritual connection with regard to Bundjalung country even though the child’s bloodline is Wiradjuri.

e. Indigenous people are likely to engage with a diverse range of cultural practices and may be expected to hold diverse views about the meaning and significance of such practices and all views and practices should be respected.

2. Spirituality, connectedness and identity (Appendix 1 - Glossary: Identity) are likely to be recurring themes which should be integrated into a BoC model of care.

   a. The pregnancy and birthing environment would need to engender a sense of ‘the sacred’ (however defined), as well as enabling women to feel safe and secure physically, culturally and emotionally.

Choice and the Environment

3. Choice is an important factor and each woman should define her own birth plan.

4. Final decisions about the setting (or location) of the BoC site must be acceptable to local women who need to be involved from the beginning; “our mob need to be aware there is a service” (workshop participant).

   a. Women must feel safe; the setting must be acceptable to them. Participants were of the opinion that most hospital environments will require major modifications for pregnancy, birth, and the postnatal period to be considered culturally safe; the present ‘clash of cultures’ was portrayed as a real and divisive issue. Creating cultural safety and security in hospitals is essential because birthing in hospital is still BoC, and women who birth in hospital also have the right to practice their cultural beliefs surrounding birth.

   a. The following issues were raised as topics for further discussion:
i. One participant questioned whether the siting of a BoC ‘facility’ should be limited by the distance to the nearest hospital. However, others said location is not important, noting Inuulitsivik’s maternity service has shown that BoC services can be provided in very remote locations.

ii. A question was raised concerning a possible conflict between the notion of pregnant women self-defining ‘risk’ and exercising ‘choice’ regarding their birthing environment, and labouring/birthing ‘on country’ where skilled support and emergency facilities may not available. Participants highlighted again, the Inuulitsivik model, stating it is about community control, and that outcomes will be better if women are able to exercise informed choice.

iii. Risks associated with unattended births (i.e. in the absence of a trained maternity professional) were discussed in conjunction with a range of potential problems that might arise if women were choosing to labour/birth alone. One participant reminded the group of the earlier presentation when Prof Kildea cited estimates of 5-25% of women in some communities did not disclose their pregnancy, or are ‘disappearing’ around the time of planned transfer to metropolitan hospitals (36-38 weeks gestation) and birthing in the remote communities. Noting that when you don’t ‘let’ women birth in their communities with support and assistance, some women will choose to do it anyway, therefore respecting women’s cultural choices and providing medical support as appropriate (like Inuulitsivik) is a better alternative.

iv. Many others echoed one participant’s opinion: that the “myth about distance” tends to silence BoC discussions almost before they get started with wide agreement that the Inuit (Canadian) model “blows all the fears about distance as a barrier”.

v. BoC services need to be adequately funded to fulfill women’s needs; if women require higher level services they need to have funding for an escort to accompany them, as recommended in many reports and reviews of maternity services and patient travel.

vi. Women whose preference is their local hospital, must still be able to make this choice and BoC aspects such as inclusiveness of diverse cultural and spiritual beliefs and practices must also be available to women birthing in hospital.

*Men and their Contribution to their Families*

5. The significance of men, and their contribution to their families, is integral to defining BoC
a. In some places pregnancy and birth are understood as exclusively ‘women’s business’ with many women continuing to regard birthing in this way. These women have a right to their cultural safety. However, there is great diversity in cultural practices across the country and for women who want their partners to be present, it must be acknowledged that this is their right, and their choice. Several groups highlighted that some younger women in particular valued the presence of their partners whereas others only want women elders and sisters around. There should not be any restrictions on the number of people women have with them when accessing maternity services or during birth.

b. Men have always held cultural roles in relation to pregnancy, childbirth and parenting though these roles differ across the country.

c. ‘Strong fathers/dads’ programs will need to be developed and resourced, either based on the ones that already exist and are known to be successful, or new ones that are specifically designed and evaluated.

**Skill Acquisition, Training and Education**

6. Skill acquisition training and education for Indigenous midwives and other key health staff was identified as a priority area, as was their long-term retention in the workforce. This is supported in the National Maternity Services Plan 2010 Action 3.2: ‘Develop and support an Aboriginal and Torres Strait Islander maternity workforce’. It was suggested that achieving a ‘critical mass’ of Indigenous staff would be a significant milestone and one which should be seen to be achievable

7. Cultural safety/security training for non-Aboriginal midwives and other health staff must include trauma informed care and practice training because staff will be working with Aboriginal and Torres Strait Islander people who suffer from ongoing trauma and/or intergenerational trauma

   a. Capacity-building would be an important issue for any BoC model; an initial needs assessment may prove to be beneficial

   b. Clinical practice must be evidence-based wherever possible; however, it was acknowledged that the word ‘evidence’ is highly contested

   i. The recently published study from the National Perinatal and Epidemiology Unit in the United Kingdom reporting on perinatal and maternal outcomes by planned place of birth was cited as an important contribution to debates in this area (see Appendix 1 - Glossary: Birthplace study)

   ii. Deficits in core skills amongst maternity providers in rural and remote areas were thought to be linked to closure of services – these would need to be built up to ensure staff were competent and confident to provide high quality care. This may be an aspect of a bigger issue concerning the loss of/reduction in maternity service provision in rural and remote areas of Australia, such that “there's no birthing
services in Tennant Creek ... they were taken out a few years ago ... women have to travel to Alice Springs, 500 kilometres away .... at least a month that the mother's away from home ... the other children that get left behind ... that puts a lot of strain on families as well. It's a lot of hardship.”

iii. Consideration was given to models of care operating elsewhere in the world (NZ, Canada, UK, Holland) which offered women a greater range of choices than were available in Australia. Whilst some thought “they wouldn't work here” many participants felt we could learn from them

c. Training in Western practices should acknowledge and integrate the law/lore of grandmothers and/or cultural understandings. Biomedical understandings must not be allowed to determine the knowledge base nor the orientation of care provision

d. The mental health risks associated with disregarding cultural practices should be emphasised and better understood by health care providers

e. The importance of improving health literacy programs for Indigenous women and their families was identified as another important element of the BoC model.

Perceptions of Risk

8. Different and/or opposing notions of ‘risk’ was thought to pose a genuine threat to progressing the BoC agenda. Western societies are typically very risk averse and this is likely to be problematic in the context of formulating a BoC model of maternity care. It is vital that there is community engagement to determine how risk is defined and what level of risk is acceptable. It was likely that the terms of any such agreement would differ between communities and between different stakeholders.

a. Pregnancy, labour and birth are normal life events for most women and should be perceived as such. Review of the literature on social models of health and well-being might be helpful in this context. It was noted that Indigenous women have significantly higher normal birth rates and that their risks were not necessarily around the birth itself

b. Notwithstanding, some Indigenous women and their infants do have higher risks of poorer outcomes and this cannot be ignored. Culturally safe/secure care should be made available to these women, some of whom will require specialist medical care throughout pregnancy

c. Participants considered it important to acknowledge that some Indigenous women perceive themselves as having been damaged by their previous encounters with mainstream maternity services and hence will wish to protect themselves from further exposure. Hospitals were not necessarily viewed as safe places and nor could they guarantee protection against death or disability. Women and their babies also die in hospitals and spiritual death to some Indigenous people may be as significant as physical death.
d. Women and representatives of local communities (grandmothers and elders/cultural knowledge holders) would need to be closely involved in defining risk and contributing to discussions about how best to accommodate it in the maternity context.

e. The medical model of risk assessment, entrenched in a culture of fear and defensiveness, was felt to be too restrictive and needed to be challenged; ideally in a BoC setting. The prevailing medical model was widely understood to have become “normalised in terms of accessing acute settings for a normal process of life” although this was not without consequences: “we are ripping off the community, family members including dads, and younger kids, siblings, from being a part of such an important … momentous occasion for them and their families … This is an opportunity for that to be put on the table and noted quite clearly: This is not acceptable and doesn't have to be the norm.” A social model of health and well-being, which assumes a holistic approach to health care provision, and which puts “Indigenous knowledge’s and grandmothers law on parity” with medical approaches, should be incorporated into any BoC model of care

   i. Social, cultural and emotional risks need to be included as important measures and awarded the same significance as medical risks. This may require the development of special tools and/or validation processes

   ii. An important point to bear in mind was that service providers, and the obstetric profession more widely, will need to be more accommodating of other factors contributing to Indigenous understandings of risk

   iii. All health professionals must be encouraged to regard pregnancy, labour and birth as normal events, however it was also acknowledged that this is difficult for many given the current Australian maternity context

   iv. Midwives may need additional training to rebuild confidence in facilitating birth in primary settings. Although participants recognised that this was problematic due to the low numbers of primary units in Australia which has resulted in a gradual diminution of core skills (e.g. managing undiagnosed breech presentation and birth).

Working in Partnership

9. Working in partnership was generally considered essential to the establishment, viability and longer-term success of any BoC model. Identifying appropriate partners would be an early priority, as would how best to maintain (and dissolve) partnerships. Maintaining, and growing, relationships with the wider (non-Indigenous) community was also considered to be crucial to the success of the BoC model. Encouragingly, medical support for the initiative was forthcoming from the RANZCOG Chair of the Indigenous Women’s Health Committee: “we support a well-funded … well-staffed, well-audited pilot project in an appropriate community or several appropriate communities. And we
remain open-minded ... we want to collaborate with midwives. We want to open doors and not close them.”

a. MOUs with referral services were viewed as an important element of the BoC model. Although some suggested that strong effective partnerships can exist without them they do provide a message to all staff and help to cement overarching support and governance

b. In the event of transfer from a primary BoC centre to an acute setting, good co-ordination of, and communication between, all parties will help to ensure a smooth transition for the woman and her partner/supporters

c. Case conferences are recognised as an essential aspect of care, however they need to be sensitively managed and appropriately timed (perhaps around 32 weeks to allow time for planning to achieve the mother’s desired birth)

i. Working in partnership was thought to be challenging with health services delivered through Commonwealth/State/Regional and Local government; all of which may have different visions, service configurations, funding and reporting requirements. Inconsistency is thus likely and unavoidable, at least to some degree

ii. Robust Governance structures, which are community driven and culturally appropriate, were identified as an essential element of effective partnership working

iii. Working within partnerships would need to include Government agencies such as Medicare.

**Terminology**

10. The group acknowledged that terminology was important and different opinions were expressed. Some felt that the term ‘BoC’ may alienate, rather than attract, support; Birthing in Country was also frequently mentioned. Hence, a more appropriate and acceptable term may need to be adopted. Others felt the term was important and should be kept, particularly for use in any government initiative, with individual services having the right to name their own services, taking account of local needs and circumstances. A number of participants emphasised the importance of being born on one’s own country and the (positive) effect this has on children growing up and the “ongoing cultural learning for my family, my children. It has become part of our parenting process ... it is so empowering and it is the best healing that I could have ever possibly had .... No psychological service. No counseling service. Nothing else could have achieved what's been achieved by the transformative process of our family healing through connection to country”. One Indigenous participant, who had been born on country, described the powerful, and deeply personal, impact “that’s not really articulated. It’s just something that I know and that I accept and it’s mine and nobody can take it away ... it makes me think a little bit differently about The Others (her siblings who had not been born on country) ... I guess it’ll make me a bit more (pause) forgiving or tolerant ... they’ve missed so much. They’ve lost so much. And it does make me sad. ... I can’t fix that. I don’t
Know how to fix it. I’ve tried. ... that’s enough now ‘cause I’ll cry”. Some comments from participants regarding the wording and meaning of the words BoC are listed below:

a. If BoC means culturally safe and secure birthing then the environment in most hospitals needs to change

b. Perhaps the term BoC is a component of culturally safe/secure care

c. Some participants thought it might be easier to consider what the term does not include, rather than what it does. An example was given: “it’s not about birthing under the trees; it’s about whatever that person wants and that’s why the medical people are concerned” and “but for some women it is about birthing under a tree or outside” and this cultural choice needs to be respected. “It’s about having family with you, not just the two people they let into the ward”. Birthing centres were mentioned as being more flexible with respect to the number of people permitted into the labour/birth room although there was also disagreement about whether the ‘rules’ were really so different from mainstream facilities. One participant advocated for terminology that distinguished BoC from the Home Birth agenda, especially in urban settings. BoC was also seen as a means of ameliorating some of the more enduring effects of colonisation: “it’ll make it’ll make a huge difference to women to be able to have their babies safely on country ... the connection ... what we don’t understand as white people, is that incredible connection with land and how the process of colonisation and now decolonisation involves coming back to the land and belonging to land ... it’s a way of healing. There’s obviously (pause) huge (pause) political (pause) and perhaps lego-medico [sic], legal barriers to overcome but they’re not insurmountable .... they will be overcome ... I think we will be able to do it.”

d. One group of participants provided the following criteria for inclusion in whatever term was adopted (some items are repeated):
   i. “Country” is not an isolated pocket of earth, it is everywhere
   ii. Spiritual connection to the land
      1. Acknowledging the risk to spiritual and cultural health and wellbeing if BoC is not facilitated
   iii. The necessity for it to be community controlled (this does not necessarily mean that it must sit within an Aboriginal Medical Service although this is certainly one way to address the governance)
   iv. Local community must define what cultural safety is for them (local community is different to local custodians)
   v. Local custodians have important responsibility to local country through law/lore and this must be respected. They have a significant role to play in helping to define, create and maintain cultural safety, but they are not responsible for it alone, rather the service is responsible for providing for the cultural safety needs of all parties
vi. The diversity of Aboriginal and Torres Strait Islander beliefs, protocols, spirituality, identity and practices must be acknowledged
vii. Empowered women, confident and able to care for their own health and their babies health, should be an overarching goal
viii. BoC = cultural safety
e. Some participants were of the opinion that some consideration should be given to whether, and to what degree, terms such as cultural respect/cultural safety are transferable i.e. how might they be interpreted outside an Indigenous context?
f. Overall the majority of participants supported the terminology Birthing on Country (BoC).

Pilot Exemplar Sites

A long-term view of this work is essential. As stated previously, the term ‘pilot sites’ should be avoided as it portrays a short-term view. BoC is about system-wide reform, alongside the establishment of exemplar sites. The initial sites should where possible be funded for long-term success with the view that there will be further rollout after the initial sites have been established. Therefore the sites need to be chosen carefully as they will be leading the reform. A crucial part of the process is building local workforce and capacity, which will take time and will need to align with other work being undertaken by Health Workforce Australia (Action 3.2 of the Plan). Remote areas must be included as sites because a rural/regional context is not sufficient. It was also proposed that at least one of the sites be in a locality where English is not widely spoken.

A strong evaluation framework, including not only clinical indicators but also indicators that measure the social, emotional and cultural wellbeing of women and families is crucial. Participants acknowledged that several sites could probably be identified on the basis of previous consultations, however it was felt that further jurisdictional consultation needed to occur to ensure that there was widespread opportunity for involvement in this program. Building capacity and introducing change will require local ‘champions’ and ‘change agents’.

AFTERNOON SESSION: SIX TOPICS FOR DISCUSSION

During the final afternoon session participants were asked to self-select to join a discussion about one of six topics listed below:

- Key Elements of a BoC Model
- Governance
- Training and Education Requirements for a Skilled Workforce
- Participants Understanding of Two-Way Learning and Working
- Risk
- Community Engagement.

Participants were invited to adopt a ‘matrix’ approach whereby they considered the topic from a i) rural, ii) remote and iii) metropolitan perspective. When responses were collated, however, there was little distinction between these different perspectives. What follows is a broad content summary of each of the six topics.

Results from the morning and afternoon sessions produced considerable content and overlap. Unfortunately, some topics were not progressed as much as they could have been. It is difficult to say if this was because of diverse opinions amongst the groups or for some other reason. Participants were asked to look at the diagram in the literature review, which provided an overview of the components of maternity service delivery models for Indigenous mothers and babies (reproduced on the following page) to identify any gaps or concerns they might have with it.

![Diagram of Components of Maternity Service Delivery Models](image)

Figure 1. Components of maternity service delivery models for Indigenous mothers and babies

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KEY ELEMENTS OF BOC MODEL

Elders and cultural knowledge holders, as defined by the community, need to be included in designing and developing the service. Each individual women will identify her own elders, cultural knowledge holders and cultural practices and will develop and achieve her culturally safe birthing plan. For example, if the community as a whole, via nominated community elders/cultural knowledge holders, regard birth as women’s business, that is taken into account in designing the service. However, the need to respect diversity and women’s choice must also be taken into account, if, for example, a birthing woman wants her partner present to support her birth. Another example is if the community-identified elders and cultural knowledge holders agree that a woman should not dance whilst pregnant, but an individual birthing woman wants to dance as part of her preparation for birth, then she is respected for her right to cultural diversity, and is allowed to choose elders and family members who support her in her own cultural practice of dancing whilst pregnant (even though some community members may disagree).

The Key Elements of a BoC model are:

- BoC needs to be an inclusive process for all of community (including gender inclusiveness) however, it is a women-centred service (women define their needs) and midwives are supported to facilitate this
- That community engagement and a cultural framework for BoC is critical
- That a ‘hub and spoke’ model be considered where midwives have the flexibility to attend women wherever those women choose to birth e.g. at home, at hospital, on a sacred site, outside on country or in a birthing centre
- That BoC is about facilitating and reinvigorating cultural and spiritual practices and that this must be considered a service responsibility
- That there be continuity of care for ALL women including women with identified risk factors
- That BoC is about inclusiveness of all diverse Aboriginal and Torres Strait Islander cultural and spiritual beliefs and practices
- That ‘risk’ needs to be defined by each individual woman within an Indigenous cultural framework
- That BoC is about social, emotional, spiritual and cultural wellbeing
- That BoC models need to work rapidly towards a totally, localised Indigenous workforce; that BoC is about community capacity building
- That BoC must be about trauma informed practice and care
- That BoC is about the importance of normalising birth.
GOVERNANCE

Participants were asked to consider which multiagency/systemic elements might be important and to identify any particular barriers to ensuring high-level accountability and leadership. Some white/non-Aboriginal participants expressed clear preference that Aboriginal leadership was paramount, not least because as “non-Aboriginal people we have a very limited understanding. We can work effectively with Aboriginal leadership ... and we can assist as professionals. We can assist as researchers. We can assist politically and strategically but Aboriginal leadership has to define, manage (and) lead”. Responses suggested that although governance structures were already generally well embedded at a local level, and were operationalised through local services, some degree of reform would be necessary to ensure governance instruments were ‘fit for purpose’ and able to be applied at a local level. That is, whilst the ‘pillars and principles’ have been identified, they may need to be modified for use in different contexts. Strategic guidance may need to be sought for particular aspects of the BoC project and training in governance procedures would almost certainly be required. The need for clarity and transparency throughout all processes was emphasised, with reporting lines and expectations clearly articulated. Annual (possibly more frequent) reports would be required with information provided against key outcome measures identified in advance and which would be expected to evolve over time to reflect variations in health and wellbeing of the local Indigenous population.

The importance of establishing and maintaining trust with communities; and valuing family connections and relationships was emphasised as crucial to underpinning governance structures. A strong sense prevailed amongst participants that cooperation and service utilisation would be less than optimal unless the BoC agenda was community controlled from the outset. Community representatives, including community elders and cultural knowledge holders, were considered best placed to provide the cultural guidance to ensure the governance structures were effective and appropriate for local conditions. Partnerships with organisations such as the NACCHO would be important.

The value of having an agreement such as a Memorandum of Understanding (MOU) between partner organisations was debated with some participants considering these to be of value, whilst others were less convinced, suggesting that regular, and strategic, face to face engagement with key stakeholders was more important. Participants were in general agreement that governance could not be considered in terms of a “one size fits all” approach, but rather that structures would need to be flexible and adaptable, taking account of the history and needs (both current and projected) of the local community. Normal governance procedures would of course be required with clear lines of reporting and communication both within and between the organisations.
The National Aboriginal Health Strategy should underpin this work with its overarching comprehensive primary health care approach and holistic definition of health:

*Aboriginal health means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community... It is a whole of life view and includes the cyclical concept of life-death-life*.\(^{13p.5}\)

Careful consideration should be given to the types of data collected and the various ways in which data are generated, the mode and frequency of reporting, and the manner in which ‘evidence’ is defined and incorporated into clinical practice. Assessment tools that are suitable for individual and corporate use may need to be sourced, whilst acknowledging those that have already been developed. Any BoC model needs to be flexible and adaptable to local circumstances with robust mechanisms in place for consumer feedback as currently very few national indicators include measuring the health system performance from consumer perspective. Future discussions might focus on how feedback is incorporated into a continuous cycle of change and quality improvement. Mechanisms must be in place for effective and timely responses to adverse events (which will need to take account of prevailing socio-cultural norms, in addition to medical descriptions) and criticisms of the service.

**TRAINING AND EDUCATION REQUIREMENTS FOR THE SKILLED WORKFORCE NEEDED TO DELIVER A BOC SERVICE**

Participants considered the importance of services being designed and delivered by Aboriginal people, therefore a capacity building approach that responds to local needs is essential. Opportunities will need to be created for local workers, who must be offered appropriate training and remuneration. This includes elders, cultural knowledge holders and others whose knowledge and expertise in cultural affairs will be integral to the proper establishment of the BoC projects. The cultural safety/security training and education programs for BoC staff (including midwives, health professionals etc.) need to be designed, defined and delivered by Aboriginal people. Local Aboriginal people (i.e. local custodians) who will deliver the local cultural components must be remunerated.

The contribution of Aboriginal health workers must not be overlooked, with opportunities and remuneration in line with the role and responsibilities. Action 3.2 of the Plan states that an Aboriginal and Torres Strait Islander maternity workforce that is supported by culturally aware work environments is integral to providing culturally competent, evidence-based maternity care for Aboriginal and Torres Strait Islander women and babies. Health Workforce Australia is the agency appointed by AHMAC to develop strategies that will lead to an increase in the number of Aboriginal and Torres Strait Islander people in the maternity workforce, and they may have considered a number of these proposals.
However, the development of alternative pathways to learning and skill acquisition will require some thought. There was universal agreement, however, about the need for formal educational programs to be much more flexible and acknowledge the family and community responsibilities, and cultural duties, of Indigenous students. Learning/training schedules must recognise that students may have to leave the workplace/educational environment at short notice and/or for extended periods.

Alternative pathways into midwifery and other health-related educational programs must be provided, including traineeship and/or apprentice models. Entry standards to programs will need to take account of the diverse backgrounds of applicants; who may need to be positively identified and then appropriately supported throughout their courses. Education and training in cultural safety and trauma informed care and practice should be mandatory. Cultural awareness/sensitivity should also be mandatory and on-going; culturally specific; and respect the core values and beliefs of all community members. The content of training programs, however, was not discussed.

Incentives for University providers might also be considered, perhaps along the lines suggested by Dr Christine Kenney and modeled on existing schemes in Aotearoa/New Zealand for Māori and Pacific Island students undertaking health-related degrees.\textsuperscript{14} These include incentives for students in the form of bursaries and scholarships that do not require multiple applications and which provide a ‘living wage’ and completion payments for Universities. Language needs must be considered and incorporated into teaching and learning; bi-lingual employees were an important consideration in this respect. As noted above, at least one of the proposed sites should be in a locality where English is not widely spoken.

Participants shared their concerns about the skill mix that would be required to deliver a BoC model of maternity care and whether sufficient numbers of maternity professionals had the requisite skills. A discussion ensured which focused on the long history of women in Australia birthing in hospitals rather than at home or in an alternative community setting. Participants were concerned about where, and whether, they could recruit and retain staff who were sufficiently skilled and confident to support Indigenous women within a BoC model, in a birthing/primary health care setting. The group was unanimous in agreeing that some up skilling of the workforce would be required in order to prevent unnecessary transfer of care. It was also highlighted that midwifery students were not always provided with in-depth Aboriginal cultural training, nor was it compulsory to undertake the training that was available.

\textbf{PARTICIPANTS’ UNDERSTANDINGS OF TWO-WAY LEARNING AND WORKING}

Participants expressed a strong desire to move away from a didactic style of learning/working which tended to favour a ‘silence’ approach to tasks with few opportunities for interacting and sharing
experiences. ‘Working in partnership’ was frequently mentioned however, apart from vague references to this requiring ‘more than cultural awareness’ and ‘shared ways of working’, details about how it would translate to a local, and individual level were not articulated. A ‘modified’ family partnership training model was also proposed (Appendix 1 – Glossary: Family Partnership Training Program).

Concerns were expressed that all too often models of care were ‘dropped’ in from above rather than being grounded in, and informed by, the specific needs of local communities. A ‘bottom-up’ approach to learning and working was favored; not least, because this was understood as more in keeping with the cultural values and beliefs of Indigenous communities. Participants indicated that this model of development was more likely to produce accountability structures and measures that were relevant and appropriate. Purpose-specific self-assessment tools were suggested as a possible mechanism for evaluating, and improving, individual performance.

There also needs to be recognition that it’s not the non-Aboriginal staff who do the ‘real’ jobs and the Aboriginal staff are just the ‘assistants,’ both need to be treated as equal professionals. Two way learning/working would mean that Aboriginal/non-Aboriginal staff could advocate for each other in different environments e.g. in hospital the non-Aboriginal worker can advocate for the Aboriginal worker and in the community the Aboriginal worker can advocate for the non-Aboriginal worker.

**RISK**

Most participants were of the opinion that women of ‘all risk’ categories should be permitted to access the BoC model because understandings of risk are also socially and culturally located, and not simply medically defined. However, the model would support women with risk factors who need higher level care, liaising with tertiary services and ensuring a culturally safe service is provided to women when they do need to access other services, for example for birthing. Some participants who were of the opinion that the opportunity to roll out a BoC program would be a ‘one off’ and for that reason it should be “a staged approach focusing on the mothers that are low risk.” Decision making processes must involve community representatives; be underpinned by ethical principles such as justice, dignity, equality, beneficence etc.; be open and transparent, and employ culturally acceptable communication channels. Participants reiterated the importance of explaining the significance of Clinical Governance structures, and the possible restrictions they impose on clinical practice. Similarly, (Statewide) Guidelines and local hospital/community policies would need to be examined and adapted to BoC environments.

A partnership approach, together with extensive consultation, will be needed to identify and agree on perceived ‘risk’ factors, with equal weight given to risks associated with spiritual, emotional, and cultural disenfranchisement. As previously mentioned, any classification of risk must take proper account of
Indigenous understandings of risk being contextual; as being culturally embedded and embodied and inseparable from social relations. The importance of preserving and reviving cultural practices was highlighted as an important factor when discussing risk. It was suggested that at times, Aboriginal women may not be treated with the same care or ethics around risk and consent throughout pregnancy, birth and the postnatal period.

COMMUNITY ENGAGEMENT

Community engagement was viewed as an essential element to the BoC project. The significance of identifying and incorporating the voices of Indigenous elders (recognising that elders are not just old people but also cultural knowledge holders) as key sources of cultural knowledge was repeatedly emphasised; the diversity and complexity of cultural and spiritual beliefs was also reiterated, not least as a means of challenging notions of Indigenous cultures as homogenous. With regards to diversity, it must be recognised that within any community there are diverse definitions of what an elder is (Appendix 1 - glossary). Each community has the right to define the term elder for themselves and for their community and to nominate which people will be regarded as the elders or cultural knowledge holders for the BoC project. This will ensure that the details of maternity service provision are defined by women and remain women-focused.

Participants agreed that choice was important at all levels of service provision; a ‘one size fits all’ approach was unlikely to meet local needs. Although some elements of service provision might be common and hence amenable to replication across the sector, diversity in consumer preferences should also be anticipated and welcomed. Thus, BoC will be determined and informed by local community. The importance, and challenge, of ensuring Indigenous families and other stakeholders have been consulted was highlighted several times throughout the day. Important points included:

- It is not enough to recommend that ‘the community’ be consulted but rather to carefully consider the basis for representation
- Consultation should be undertaken in a timely manner
- All processes, conclusions and recommendations should be accurately and fully documented
- Consultation processes must be seen to be transparent and fair
- A complaints procedure (or equivalent) might usefully take account of, and provide possible solutions to, grievances arising from community members who disagree with decisions
- Consultation should be understood as a flexible and ongoing process, which takes account of changing needs

All present agreed that establishing proper and considered engagement, essential for long-term partnership working, would take time and effort. Rushing this task was futile and likely to result in superficial relationships that would not be sustained. Of greater concern was the potential that haste
and a lack of appropriate consultation could alienate key stakeholders and community members. Some participants voiced concerns that the (rather rapid) timescale to name and ‘pilot’ the BoC ‘exemplar trial sites’ pre-empted proper consultation. Others talked of the ‘consulted to death’ syndrome where consultation rather than action is a risk to the BoC agenda; participants recognised the pressing need to “actually see it happen. A reality and not just a talk. I think talk has been dragged on too long and I think we need to put things in action”.

A suggestion was made to engage the NACCHO in discussions, suggesting they should lead the ‘sideways’ conversations that need to occur throughout the Indigenous communities. However, participants felt that this alone would not be sufficient as not all communities, some of which are potential sites, have community controlled health organisations or are members of NACCHO.

Community engagement should involve communities at a ‘grassroots’ level; i.e. all members must be valued and encouraged to contribute. Partnerships with key individuals (grandmothers/elders/cultural knowledge holders) should be sought at an early stage in proceedings with consideration as to how these relationships might be nurtured over time, or as one participant stated, “over many lifetimes!” It was also noted that elders, aunties, and cultural knowledge holders, need to be remunerated for their time with regard to consultation processes.

Engagement was perceived as an on-going and dynamic process, which would require the energies and commitment of all parties involved in the BoC project. Engagement processes need to facilitate the articulation of conflicts, and discussion should occur in a ‘no blame’ environment. Access to appropriately trained facilitators/mediators, skilled in conflict resolution techniques, would be beneficial and help to ensure speedy and effective results. Sustaining high-quality engagement is costly and hence adequate, and on-going, funding needs to be made available, at least for the duration of the initial BoC sites. A final comment was made in relation to the term ‘initial sites’ for the BoC project when it was felt that what was needed was total reform of pregnancy and birthing services for all Indigenous women, regardless of whether they live in remote, rural or urban settings.

**LIMITATIONS**

The World Café methodology used in the workshop influenced discussions undertaken and supported optimal adherence to the majority of the workshop program. With only a one day workshop, the lack of time limited the opportunity to discuss issues both within and outside the workshop program.
The allocated funding for the workshop presented some limitation on the number of attendees with many attending expressing the desire to have additional representatives from their respective organisations or jurisdictions. Aside from this, some key invitees were unable to attend.

The BoC potential sites had not been identified prior to the workshop, and therefore representatives from relevant communities were not necessarily invited to participate in the workshop. This will be considered in the future planning of the BoC initial exemplar sites.
REFERENCES


LIST OF ABBREVIATIONS AND GLOSSARY OF KEY TERMS

LIST OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACCHS</td>
<td>Aboriginal Community Controlled Health Service</td>
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<tr>
<td>ACCHO</td>
<td>Aboriginal Community Controlled Health Organisation</td>
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<tr>
<td>AMS</td>
<td>Aboriginal Medical Service</td>
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<tr>
<td>BoC</td>
<td>Birthing on Country</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>MGP</td>
<td>Midwifery Group Practice</td>
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<tr>
<td>MSIJC</td>
<td>Maternity Services Inter-jurisdictional Committee</td>
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<tr>
<td>NACCHO</td>
<td>National Aboriginal Community Controlled Health Organisation</td>
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GLOSSARY OF KEY TERMS

Aboriginal Spirituality: “derives from a philosophy that establishes the holistic notion of interconnectedness of the elements of the earth and the universe, animate and inanimate, whereby people, the plants and animals, landforms and celestial bodies are interrelated. These relations and the knowledge of how they are interconnected are expressed, and why it is important to keep all things in healthy interdependence is encoded, in sacred stories or myths. These creation stories describe the shaping and developing of the world as people know and experience it through the activities of powerful creator ancestors. These ancestors created order out of chaos… (and)... thus laid down not only the foundations of all life, but also what people had to do to maintain their part of this interdependence – the Law. The Law ensures that each person knows his or her connectedness and responsibilities for their kin, for country (including watercourses, landforms, the species and the universe), and for their ongoing relationship with the ancestor spirits themselves.”

An Aboriginal Medical Service (AMS): is a health service funded principally to provide services to Aboriginal and Torres Strait Islander individuals. An AMS is not necessarily community controlled. Therefore not all AMSs are eligible to be members of NACCHO and its affiliates. If an AMS is not community controlled it will be a government health service run by a State or Territory government. These non-community controlled AMSs mainly exist in the Northern Territory and the northern part of Queensland.
Appendix 1: Glossary of Terms

An Aboriginal Community Controlled Health Service (ACCHS): is a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it through a locally elected Board of Management. All ACCHSs are AMSs but the reverse is not the case. An Aboriginal Community Controlled Health Service is:

- An incorporated Aboriginal organisation
- Initiated by a local Aboriginal community
- Based in a local Aboriginal community
- Governed by an Aboriginal body which is elected by the local Aboriginal community.16

Delivering a holistic and culturally appropriate health service to the Community which controls it. By definition, organisations controlled by Government to any extent are excluded. By definition, organisations which adopt a vertical approach to health, inconsistent with the Aboriginal holistic definition of health as defined by the National Aboriginal Health Strategy are excluded.16

BoC: maternity services designed and delivered for Indigenous women that encompass some or all of the following elements: are community based and governed; allow for incorporation of traditional practice; involve a connection with land and country; incorporate a holistic definition of health; value Indigenous and non-Indigenous ways of knowing and learning; risk assessment and service delivery; be culturally competent; and be developed by, or with, Indigenous people.

Birthplace Study: the birthplace cohort study compared the risks and benefits of 64,000 ‘low risk’ births in England in four settings: nearly 17,000 home births, 28,000 midwifery unit births (stand alone and alongside obstetric units) and nearly 20,000 obstetric unit births and found that midwifery units appear to be safe for the baby and offer benefits for the mother.12

Community: Every Aboriginal person living in that place regardless of their age, sex or ancestral country

Community Control: Community Control is a process which allows the local Aboriginal community to be involved in its affairs in accordance with whatever protocols or procedures are determined by the Community. The term Aboriginal Community Control has its genesis in Aboriginal peoples' right to self-determination.16

Cultural Competence: The term Cultural Competence will be used in line with the term used within the National Maternity Services Plan (2011)1 and other key national documents.17 The term is widely used across international health care literature and refers to both migrant and Indigenous populations. The concept evolved from the work of Cross and colleagues18 and is supported by Aboriginal academics in Australia: Cultural competence is a set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations. Cultural competence is much more than awareness of cultural differences, as it focuses on the capacity of the health system to improve health
Appendix 1: Glossary of Terms

and wellbeing by integrating culture into the delivery of health services. To become more culturally competent, a system needs to:

- value diversity
- have the capacity for cultural self-assessment
- be conscious of the dynamics that occur when cultures interact
- institutionalise cultural knowledge
- adapt service delivery so that it reflects an understanding of the diversity between and within cultures.  

**Cultural Connections:** “In Australia Aboriginal people continually have to defend their culture and authenticity. McDonald has argued that the refusal to ‘allow’ Aboriginal people to change, locking them into a past-oriented traditionality results in an underestimation of their ongoing understandings of selves and country, of sharing and caring, and of the consciousness of cultural difference captured by the term ‘the Koori way’. In refuting the idea that culture is ‘lost’ when it changes, she has been able to acknowledge the centrality of spiritual awareness in many Wiradjuri people’s lives, notwithstanding changes in their social and material lives. She is conducting analyses of how the impacts of government policy actually prevent Aboriginal people from living according to their own spirituality, socially oriented values and understandings. She is documenting how much cultural stress this puts people through.”

**Cultural Safety:** Cultural safety is about creating environments that promote the strengthening, revitalisation and renewing of culture. A culturally safe environment is one where there is no assault, challenge or denial of an individuals’ identity of what they need. Cultural safety requires that an organisation adapt service delivery so that the service reflects an understanding of the diversity between and within cultures. Organisations need to create environments where our cultural differences are respected and nurtured.

**Cultural security:** Cultural security is subtly different from cultural safety and imposes a stronger obligation on those that work with Aboriginal and Torres Strait Islander peoples to move beyond ‘cultural awareness’ to actively ensuring that cultural needs are met for individuals. Cultural security recognizes that this is not an optional strategy, nor solely the responsibility of individuals, but rather involves society and system levels of involvement.

**Elders and Cultural Knowledge Holders:** Elders may also be known as cultural knowledge holders. Each community has the right to define the term elder and to nominate which people will be regarded as the elders or cultural knowledge holders for the BoC project. Elders may be any age and are not necessarily old people. Likewise not all old people are elders. Generally, elders are people with cultural knowledge who are willing to share it, however cultural knowledge holders can actually be young people who may have learnt from elders who have already passed away or who may have passed through stages of Aboriginal cultural learning at an early age.
Appendix 1: Glossary of Terms

**Family Partnership Training Program (FPTP)** aims to assist health workers develop the core skills of ‘helping’ needed to establish a facilitative relationship with parents; and that will help parents to deal with the problems facing them and identify their strengths. In order to work within a model of family-centred practice, workers need to be effective helpers. The FPTP has been designed to enable health care providers to develop supportive and effective partnerships with parents who have a variety of needs that may interfere with their ability to adapt to the parenting role. The course emphasises the use of skilled communication to help parents: explore difficulties from the parents’ perspective; clarify their understanding of situations; set goals appropriate to the parents themselves; and design long term strategies to enable them to adapt effectively and thereby optimise the psychosocial development of their children.\(^{20}\)

**Identity:** “identity was viewed as a component of spirituality and the result of spiritual development... relationships within community and the sense of belonging to the community were described as the basis of Aboriginal identity.... All participants considered cultural practices, sacred sites and spiritual connections with ancestors as important components of their wellbeing.”\(^{21}\)\(^{p.16}\)

**Local Custodians:** Custodians of country are sometimes called ‘traditional owners’ and are the caretakers and knowledge holders and those ancestrally connected by blood and/or law/lore to the land with responsibility to that exact land.

**National Aboriginal Community Controlled Health Organisation (NACCHO):** is the national peak body representing over 150 ACCHSs across the country on Aboriginal health and wellbeing issues. To be a member of NACCHO and its affiliates an ACCHS must be:

- Initiated by a local Aboriginal community
- Based in a local Aboriginal community
- Governed by an Aboriginal body which is elected by the local Aboriginal community, and
- Delivering a holistic and culturally appropriate health service to the Community which controls it.\(^{16}\)

**Primary Maternity Service:** Primary maternity services may be provided in public maternity units, birth centres, in the community or in a combination of these settings. Care includes antenatal, birthing, and postnatal care for women with low-risk pregnancies.\(^{22}\) Some antenatal and postnatal services may be provided for women with risk factors, in collaboration with higher level services, however this does not extend to planned onsite birthing service for women with risk factors.

**Strong Women Workers:** Work collaboratively to promote the Strong Women, Strong Babies, Strong Culture Program and combine traditional Aboriginal culture with contemporary mainstream pregnancy care knowledge to promote healthy pregnancies and support early parenting.
Appendix 1: Glossary of Terms

**Traditional Midwife:** refers to midwives recognised by the local community, who may or may not be formally educated and regulated. In some Canadian jurisdictions traditional Aboriginal midwives and other healers are recognised under Health Professions Legislation as able to serve Aboriginal communities. Australia does not have similar legislation however individuals with this expertise certainly exist in Australia and are usually well known by local communities.

**Trauma Informed Care and Practice:** Trauma informed programs and services internationally represent the new generation of transformed mental health and allied human services organisations and programs which serve people with histories of violence and trauma. Trauma survivors engaged in these services are likely to have histories of physical and/or sexual abuse as well as other types of trauma including chronic neglect and/or protracted emotional abuse, witnessing domestic violence, civilian involvement in wars and civil unrest, refugee and combatant trauma. Such trauma frequently leads to a diversity of mental health as well as other types of co-occurring problems such as poor physical health, substance abuse problems, eating disorders, relationship and self-esteem issues and contact with the criminal justice system. When a human service program seeks to become trauma-informed, every part of its organisation, management and service delivery system is assessed and modified to ensure a basic understanding of how trauma impacts the life of an individual who is seeking services. Trauma informed organisations, programs, and services are based on an understanding of the particular vulnerabilities and/or triggers that trauma survivors experience (that traditional service delivery approaches may exacerbate), so that these services and programs can be more supportive, effective and avoid re-traumatisation. The multiple violations of the historical experiences of American Indian nations and Aboriginal Australians, interlinked with the institutional destruction of American Indian and Aboriginal families, have resulted in violent behaviours across generations. These create chronic endemic crisis. Government interventions may increase the trauma.

**Two way learning:** refers to a practice of drawing on two necessarily separate domains of knowledge. More recently, the terms ‘two way learning’ and ‘both way learning’ have come to indicate the acceptance of a mixing of western and Indigenous knowledge. The Ganma metaphor, for example, likens the meeting of these knowledge systems to the meeting of two bodies of water in a lagoon where salt and fresh water come together.
## APPENDIX 2. ACTION 2.2.3. NATIONAL MATERNITY PLAN 2011

<table>
<thead>
<tr>
<th>The initial year</th>
<th>The middle years</th>
<th>The later years</th>
<th>Signs of success</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2.3 AHMAC undertakes research on international evidence-based examples of birthing on country programs.</td>
<td>Australian governments develop a framework, including an evaluation framework, for birthing on country programs. Australian governments develop a pilot for a birthing on country program that includes a consultative selection process with Aboriginal and Torres Strait Islander communities and local maternity care professionals to identify initial birthing on country sites.</td>
<td>Australian governments establish birthing on country programs.</td>
<td>Birthing on country programs for Aboriginal and Torres Strait Islander mothers are established.</td>
</tr>
<tr>
<td></td>
<td>Based on the outcome of investigations, jurisdictions consider the development of a birthing on country pilot program that includes consultation with Aboriginal and Torres Strait Islander people.</td>
<td></td>
<td>A birthing on country framework is developed.</td>
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</tbody>
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AHMAC: Australian Health Ministers’ Advisory Council
## APPENDIX 3. WORKSHOP PARTICIPANTS

<table>
<thead>
<tr>
<th>Name</th>
<th>Position Title</th>
<th>Organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ann Kinnear</td>
<td>Executive Officer</td>
<td>Australian College of Midwives</td>
</tr>
<tr>
<td>Ann-Marie Hayes</td>
<td>Director, HIPPO Unit</td>
<td>Women’s and Children’s Health Network</td>
</tr>
<tr>
<td>Arimaya Yates</td>
<td>Research Officer Health Information</td>
<td>Victoria Aboriginal Community Controlled Organisation</td>
</tr>
<tr>
<td>Bonnie Fisher</td>
<td>MSIJC Chair</td>
<td>SA Maternal &amp; Neonatal Clinical Network</td>
</tr>
<tr>
<td>Carole Taylor</td>
<td>Chief Executive Officer</td>
<td>Council for Remote Area Nursing Association</td>
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<tr>
<td>Chris Caudle</td>
<td>MSIJC Secretariat</td>
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<tr>
<td>Christine Kenney</td>
<td>Research Fellow</td>
<td>Edith Cowan University</td>
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<td>Christine Tippett</td>
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<td>Deanna Stuart-Butler</td>
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<td>Deborah Schaler</td>
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<td>Denella Hampton</td>
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<td>Desley Williams</td>
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<td>Clinical Lead Obstetrics &amp; Gynaecology</td>
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<tr>
<td>Djapirri Mununggirritj</td>
<td>Manager of the Yirrkala Women’s Resource Centre, Aboriginal Elder</td>
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<td>Donna Ah Chee</td>
<td>A/Chief Officer</td>
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<td>Fleur Magick</td>
<td>Aboriginal Cultural Healing Educator</td>
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<td>Francine Douce</td>
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<td>Helen Stapleton</td>
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<td>Australian Catholic University &amp; Mater Mothers’ Hospital</td>
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<td>Hope Peisley</td>
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<td>Primary and Ambulatory Care Division Dept. of Health and Ageing</td>
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<td>Jackie Ah Kit</td>
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<td>Jeremy Oats</td>
<td>Medical Co-Director Integrated Maternity Services</td>
<td>NT Health</td>
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<td>Julie Tongs</td>
<td>Chief Executive Officer</td>
<td>Winnunga Nimmityjah Aboriginal Health Services</td>
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<td>Karen Atkinson</td>
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<td>Aboriginal Health Council of SA</td>
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<td>Katie Sullivan</td>
<td>Maternity Emergency Care Course Coordinator</td>
<td>Council for Remote Area Nursing Association</td>
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<td>Leshay Maidment</td>
<td>Deputy Chief Officer</td>
<td>Central Australian Aboriginal Congress</td>
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<td>Lesley Barclay</td>
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<td>University Centre for Rural Health</td>
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<td>Linda Turner</td>
<td>Chair</td>
<td>Anyinginjyi Health Aboriginal Corporation</td>
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<td>Machellee Kosiak</td>
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<tr>
<td>Maggi Richardson</td>
<td>Senior Midwife</td>
<td>Royal Darwin Hospital</td>
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Appendix 3: Workshop Participants

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<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Margaret O'Brien</td>
<td>Recall Support Officer</td>
<td>Danila Dilba Health Service</td>
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<tr>
<td>Nicole McCartney</td>
<td>Policy Officer</td>
<td>Aboriginal Health Division</td>
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<tr>
<td>Rachael Lockey</td>
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<tr>
<td>Rhonda Marriott</td>
<td>PhD Murd, RN, Midwife</td>
<td>Centre for Child Health Research</td>
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<td>University of Western Australia</td>
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<tr>
<td>Roianne West</td>
<td>PhD Candidate Adjunct Lecturer</td>
<td>James Cook University</td>
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<td>School of Nursing &amp; Midwifery</td>
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<tr>
<td>Ros Johnson</td>
<td>Associate Director, Maternity Services</td>
<td>Maternity, Children &amp; Young People’s Health</td>
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<td>NSW Ministry of Health</td>
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<td>Rosalie Schultz</td>
<td>Director, Clinical Services</td>
<td>Anyinginyi Health Aboriginal Corporation</td>
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<tr>
<td>Rose McEldowney</td>
<td>Professor Health</td>
<td>Charles Darwin University</td>
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<tr>
<td>Rosemary Bryant</td>
<td>Chief Nurse &amp; Midwifery Officer Australia</td>
<td>Department of Health and Ageing</td>
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<tr>
<td>Ruth Langford</td>
<td>Indigenous Medicine Therapist</td>
<td>Nayri Niara Centre for the Arts of Healing</td>
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<tr>
<td>Shearlee Fitz</td>
<td>Alukura Branch Manager</td>
<td>Alukura Women’s Health</td>
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<tr>
<td>Sue Kruiske</td>
<td>Professor and Director</td>
<td>Queensland Centre for Mothers and Babies</td>
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<td>Sue Kildea</td>
<td>Professor and Director Midwifery Research Unit</td>
<td>Australian Catholic University and Mater Medical Research Unit</td>
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<tr>
<td>Terri Barrett</td>
<td>Midwifery Director</td>
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<td>Timothy Metcalf</td>
<td>General Practitioner</td>
<td>Australian College of Rural &amp; Remote Medicine</td>
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<td>Tracey Coles</td>
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<td>Tracy Martin</td>
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<td>Wendy Ah Chin</td>
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Appendix 4: Workshop Program

APPENDIX 4. WORKSHOP PROGRAM

BIRTHING ON COUNTRY WORKSHOP
Alice Springs 4th July 2012

8.45am
ARRIVALS & COFFEE
Workshop Welcome - Facilitator Ann Marie Hayes
Welcome to Country - Lhere Artepe
Ways of working together today

9.00am
Formal welcome & purpose - Chair MSIJC - Bonnie Fisher
Presentation of Birthing on Country Painting - explained by Margaret O'Brien from Danila Dilba health service, Darwin
Cultural oversight & community control - Donna Ah Chee
Birthing yarn - Djapirra Mununggurrji
Literature review - an overview - Sue Kildea—Researcher

10.30am
MORNING TEA

11.00am
Small group discussion World Café style
Feedback to large group - key elements & principles
Small group discussion World Café style

1.00pm
LUNCH
Presentation by Midwives from Orange Medical Service
Small group discussion World Café style

1.45pm
What underpins good practice, Risk and barriers, Cultural considerations and competency, How would we make these elements/ideas transferable?

3.15pm
AFTERNOON TEA
Tools/ to support work & outcomes
Identify areas for pilot - remote/rural / metro 4.40pm
Where to from here - Way forward - Actions?

4.55pm
FORMAL THANKS AND CLOSE OF WORKSHOP

Explanation: Women have the responsibility of gathering bush foods. These include bush wheat, bush plums, bush jams, bush emors, honey ants and various bush medicines. The activities are, accompanied by ceremonies, rituals, song and dance cycles and body painting in celebration of the Dreamtime and the anticipated abundance of the harvest. They also propagate the forces that control the health of the land and keep it happy.

Background: Title: “Bush Wheat” by Gabriella Possum #KB04
APPENDIX 5. CONGRESS ALUKURA PRESENTATION

CONGRESS ALUKURA
Birthing Service
25 Years On

Dona, Ah Chee and Leahay Maidment
Acting CEO and Deputy CEO
Central Australian Aboriginal Congress
Alice Springs

Birth on Country Conference
2012

Our Dreaming for the Future

To become the leading Aboriginal community controlled provider of comprehensive primary health care services in Australia.

Our Aspirations
1. To be the leading Primary Health Care provider for Aboriginal people in Australia.
2. To improve the health of our community.
3. To provide the highest quality services to our communities.
4. To assist communities who wish to establish their own community controlled health services.
5. To remain a community controlled organisation.
6. To promote opportunities for Aboriginal people to work in all areas of health to Congress.
7. To maintain self determination.
8. To secure the right that controls to determine people's dreaming.
9. To expand the services offered by Congress in alliance with community.

ALUKURA

- Aboriginal women's health and birthing centre
- A branch of Central Australian Aboriginal Congress (CAAC)
- A community controlled Aboriginal Primary Health Care Service (AMTS) in Alice Springs.
- CAAC established in 1973 to provide comprehensive primary health care to Aboriginal people in central Australia.

ALUKURA'S HISTORY

- Early 1980’s - Research & consultation with central Australian Aboriginal women was commissioned to address the need for appropriate health and birthing options.

Consulted:
- Several hundred women
- 80 different Aboriginal communities
- 11 language groups

Congress Service Overview

- 7000 current patients for clients from Health Service Area of 100km radius of Alice Springs
- 3000 unique visitors each year
- 100 000 episodes of care each year
- 150 births per year
- Average birth weight around 3100 grams
- Low Birth Weight Average 14%
- More than 50% First Trimester presentations
ALUKURA’S HISTORY

- Aboriginal Women discussed the:
  - Need for traditional law & birthing practices.
  - Experience of birthing & health care under ‘white’, predominantly male medical supervision.
  - Mainstream health services were failing Aboriginal women.

ALUKURA’S HISTORY

- Research & consultation culminated in an Aboriginal Women’s “Birthrights” Conference at Basso’s Farm, 1984:
  - Generated the philosophy, aims and objectives of the “Alukura Model.”
  - Premised on “Women’s health & birthing being Women’s Business.”

ALUKURA’S HISTORY

- Congress responded by establishing the Alukura, an Arrernte word meaning “women’s camp” to:
  - Provide antenatal & postnatal care.
  - Promote women’s health checks.
  - Seek funding for birthing service.

- 1st operated out of Congress clinic then from an old Aboriginal Hostels house in 1986.

ALUKURA’S HISTORY

- The service was reviewed in 1989 and it was recommended that:
  - Alukura expand it’s organisation and functions to fully implement Aboriginal women’s preference for their own alternate health and birthing service that fostered cultural support by providing a service run by women:
    - “Women’s health is strictly women’s business.”

ALUKURA’S HISTORY

- 1991 – funding was received to establish purpose built facilities from DAA
- The service moved into its current location in Percy Court in 1993:
  - Clinic & admin
  - 2 birthing suites
  - Accommodation unit
  - Located on 5 hectares of bush land

ALUKURA MODEL

Underlying philosophy:

- Aboriginal people distinct & viable cultural group with own cultural beliefs & practices, Law & social needs.
- Every woman has the right to participate fully in her pregnancy & childbirth care, & determine the environment & nature of such care.
- Every Aboriginal woman has the right in pregnancy & childbirth to maintain and use her own heritage, customs, language and institutions.
Appendix 5: Congress Alukura Presentation

ALUKURA BIRTHING FUNDING
- Originally funded with special purpose grants from Commonwealth health from the Alternative Birthing Program
- Now absorbed into Congress’s single funding agreement where the Alukura allocation is an internal decision from the core primary health care (PHC) budget apart from sexual health funding for the YWCHEP and the NFP
- The recent potential for Medicare to fund midwifery led care has not been realised
- No funds have ever been provided from the NTG on the basis that birthing in the community would reduce the need for birthing in hospital

ALUKURA SERVICES
- Maternity Service
- Women’s Health Clinic including weekly O&G clinic and colposcopy on site
- Nurse Family Partnership Program
- Young Women’s Community Health Education
- Cultural Liaison
- Transport
- Pharmacy
- Midwifery Training
- Annual Breast Screening
- 1200 unique clients, more than 12,000 episodes of care with about 150 antenates per year
- Free service, no cost to clients

MATERNITY SERVICE
- Midwifery Led Model of Care
- Caseloading
- Providing Continuity of care
- GP, specialist and allied health support
- Dedicated maternity service along with women’s health clinic:
  - Maternity Service > Midwives, GP, Obstetrician, Diabetic Educator, Aboriginal Liaison Officer
  - Women’s health clinic > GP, Women’s health nurse, Aboriginal Health Worker, Aboriginal Liaison Officer

MATERNITY SERVICE 1993-1997
- 17 births at Alukura
- Births attended by:
  - Midwives
  - Traditional Grandmother
  - Support person
  - GP
- No’s small but Alukura was – and still is – providing bulk of antenatal care

MATERNITY SERVICE 1997-2002
- Birthing ceased in 1997 due to an inability to recruit doctors and midwives with sufficient skills and experience for birthing in such a setting
- 1997-2002 continued to provide antenatal & postnatal care

ALUKURA REVIEW
- Alukura review 1998
  - To determine the extent to which Alukura met the needs of central Australian Aboriginal women
  - To consider what was needed to re-establish birthing
  - To examine Alukura’s impact
Appendix 5: Congress Alukura Presentation

ALUKURA REVIEW
- The review found:
  - Alukura was recognised as playing a key role for Aboriginal women.
  - Quality of care considered to be high:
    - Technically
    - Culturally appropriate & sensitive
  - Many young Aboriginal women’s preferred place for birthing was Alice Springs Hospital

MATURENITY SERVICE 2002 ON
- May 2002 birthing service recommences with an agreement with ASH that would enable Alukura midwives to maintain accreditation for the small number of Alukura births
- Alukura midwives obtain visiting privileges to Alice Springs Hospital as Independent Midwives to birth low risk women only either in ASH or at Alukura
- Manage births of eligible Alukura clients at the hospital – improves continuity of care
- Addressed young Aboriginal women’s preferences

MATURENITY SERVICE 2002 ON
- Unique arrangement/service:
  - Admitted as public patients with private care provided by Alukura midwife
  - Benefits of hospital services
  - Providing choice
  - Maintain midwives accreditation with the ACM by ensuring adequate numbers of births for Alukura employed midwives

BIRTHING
- 88 births from May 2002 until 2008
- A critical incident in 2008 led to the temporary cessation of the birthing service and a review of the ASH birthing Agreement
- The key issue identified was the need to ensure adequate clinical governance

The Revised Alukura / ASH Birthing Agreement and the Alukura Group Midwifery Practice 2010
- Alukura midwives under the direct clinical supervision of the ASH Obstetricians
- Alukura midwives part of the ASH orientation, induction and professional development
- Birthing for high and low risk women which ensured skills maintenance for all births
- Provides a higher level of continuity of care as many more women were eligible for the service

Group practice or caseloading
- Caseloading midwifery is a one-to-one service, requires 24 hours on call for 8 months of the year
- Group practice is a team approach, women has a named, primary midwife responsible for her care but also meets other members of the team who may attend her in labour
- Shared on-call between team
- Group practice has been demonstrated to be a more sustainable model
Appendix 5: Congress Alukura Presentation

Group Midwifery Practice at Alukura: barriers which led to the temporary cessation of the program in Dec 2011

- Shortage of midwives who are eligible for Medicare Billing and capable of birthing at Alukura
- The 1 week in 4 on call roster meant that there was not the capacity to provide ongoing antenatal care to their primary case load in the week they were on call
- Releasing midwives for blocks of time to orientate at ASH
- Need increased levels of cultural brokerage
- Inadequate funding levels for sufficient staff to make it sustainable

Group Midwifery Practice at Alukura: facilitative factors

- Alukura already established with good community support
- Landmark MOU with ASH which enabled birthing of low and high risk women and met the Medicare requirements for Obstetrician supervised midwifery midwifery care
- Based in primary health care setting
- Long history of Grandmothers and other Indigenous women’s involvement
- Good relations with local maternity unit, both midwives and obstetricians

Alukura Birthing Program the Future

- Re-establish the GMP
- Recruit appropriately skilled staff who are eligible for Medicare to make funding sustainable
- Consider altering the on call roster to 1 day in 4
- Fund at least 1 additional midwife
- Ensure postnatal care is provided daily
- Consider the option of home birthing for low risk women
APPENDIX 6. DJAPIRRI MUNUNGGIRRITJ OPENING SPEECH

(Transcribed by Rachael Lockey from a recording of the speech, difficult to hear at times therefore muffled speech replaced by …)

When I was invited to this workshop I thought, well…this BoC is the most powerful thing. I came to a place where I could understand the stories I heard from my mum and my grandmother and I’m sure each of you have experienced that, each of you are now bringing your child into this world from the two special people, mother and grandmother. I know I am not a midwife but I have worked with many midwives and…. midwives through my career have been a real role model. Because of two way learning.

BoC…. is about all things. BoC brings spiritual meaning to the modern world that we live in now. BoC lies deep and wide… deep…and wide….because it stretches from the ancient to the future, and it is for our generation to continue singing … the identity of the Indigenous people of this world. It has been a pretty amazing journey for me and sometimes I...I just do not have the words to describe it anymore … when you are grateful with pride, happy, dignity and courage.

In the fifties when I was born … I was born birthing in the country… mission wasn’t established then … I look back and cherish those moments. BoC connects Indigenous Australians. Either way you look at it from the moment you see the sun for the first time … the time you breathe for the first time and see the universe around you … that’s important. I think for this particular workshop that’s very important, that’s why each of you have come here … and the same applies for all of us. This is important, that’s why all of you have come here and set a place for us all to be in the Centre of Australia. Because at the Centre of Australia when you look at from your own world view … Of where your clan group is … you come from the centre … you see the woman weave the mats...where does it come from, from the centre. That is where the foundation of BoC begins, the most powerful of tool begins right there.

BoC, you have the atmosphere, the environment, around you, you are created and born in this world … because even in your culture there is a balance. Like what you saw in the painting, a balance between the philosophy of Yolngu and the land…a perfect balance. It is like the yin and yang in the Chinese philosophy and that’s when you are categorised into, from the moment you are born, because you know yourself… a child brings the feeling, from the moment you are born, a feeling of being connected, to every environment, the trees, the birds.

My philosophy as a Yolngu came from the east … Western Kimberley, that’s were my totem came from… the crocodile … BoC again is a metaphor… a metaphor… what we hear, as you all heard in the Welcome to Country speech this morning, we are here to share our knowledge, we are here to not fight with one another… whose politics is the best, we are here about the sovereignty and rights of all people, no matter what you are, what colour you, no matter what language you are. So I thought this is what I believe…and with this I travel the world… it’s not about someone who gets credit about something … its not about for Aboriginal people let’s forget about the white people…let’s bring it together. And I think… to my understanding… in how I see… it’s the perfect, a perfect journey in life to instruct something positive…. without this or that…but working together…because it is for our
young, non-Aboriginal and... Indigenous young people that we gather at these sort of conferences to talk about... to set up something... for twenty years time and we on this table can look back and learn... and participate... in what I have to offer to make this people or this generation something they can be proud of.

So I thought... again it’s an amazement and again words cannot describe what you feel in your very being, your very being that will inspire you to talk to governments....

What is it that we need to put together, a strong voice, and one of us can report this in Canberra, outside parliament house and put recommendations of what we think is the best, and the best of the very best. If Indigenous people and non-indigenous people come together there is power ... We need to create that connection... connection that comes from the grass roots.... and I know you around the tables are very smart people

But going back to... where I was born, like I said there was no hospital, hardly any non-Indigenous midwives around... Aboriginal people were the midwives, mums, other mums and other aunties and grandmas, how successful did they do that, and how, throughout the generations they were never recognised.... How they were not recognised and how can we as Indigenous people bring our young ones ... And take up what they have left behind...the mothers and the grandmas.

When I was about ten I was old enough to be around my grandmother and my mother and how they fought ... I see the differences now.....I see the difference now...

Taking yourself to the foundation of your roots you obtain the key.... The key to open up doors....opening up doors into the modern world so you can understand what to do.

My mum brought me, she had to carry me by paperbark ... huts and shelters ... paperbark ... with her grandmother being the midwife ... so I thought this morning I would share that because there are ways in culture, our culture...

There are many of places around out territories and states of BoC that has meaning ... meaning to not just you as a midwife to the child that is being born into the world ... and to opening the eyes of the politicians.
APPENDIX 7. LITERATURE REVIEW PRESENTATION

**Midwifery Research Unit**

*Birthing on Country*

Sue Kildea
Professor of Midwifery, Midwifery Research Unit, Brisbane

**Acknowledgement to Country**

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**Where we are coming from**

... **Multiple reviews . . . no action**

- Women have not been feeling safe as they progress though our maternity services
  - National Review, 2009
  - NT, Review, 2008
  - Qld, Hirst, 2005
  - NT, Kildea, 1999
  - Senate Committee, 1999
  - NT, Danila Dilba, 1998
  - Qld, King, 1998
  - NT, Review, 1992
  - Etc.......

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**Maternity Services Review, 2009**

- It is vital that approaches to change are evidence-based and take full account of consumer preferences
- Priority areas include
  - R & R
  - Aboriginal and Torres Strait Islander women

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**National Maternity Services Plan**

- Endorsed by AHMAC 2010
- Priority areas
  - Increased access
    - Local maternity care
    - Expand models
  - Quality care in rural and remote
  - Service delivery
    - High quality, evidenced based, culturally competent
  - Workforce
    - Develop and support Aboriginal and Torres Strait Islander and rural and remote
  - Infrastructure
    - Safe, high quality, woman centred.

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**National Maternity Services Plan**

- Action 1.4
  - Increase access for women and their family members in remote Australia to high-quality maternity care
- Action 2.2
  - Develop and expand culturally competent maternity care for Aboriginal and Torres Strait Islander people
Appendix 7: Literature Review Presentation

National Maternity Services Plan

- **Action 2.2.3**
  - Development and implement a national evidenced based Birthing on Country service delivery model

- **Action 3.2**
  - Develop and support an Aboriginal and Torres Strait Islander maternity workforce
    - Health workers / Cert IV Maternal Infant Health / AMIC workers
    - Midwives
    - Doctors

**Birthing on Country**

The Literature Review (L/R) criteria included: Maternity services designed and delivered for Indigenous women with some or all of these characteristics:

- Community based and governed
- Incorporation of traditional practices
- Involve a connection with land and country
- Incorporate a holistic definition of health
- Value Indigenous and non-Indigenous ways of knowing and learning, risk assessment and service delivery
- Culturally competent
- Developed by, or with, Indigenous people

**Literature Review Questions**

1. What are the components of maternity service delivery models that have been implemented for Indigenous mothers and babies?

2. Which of these models have been most effective? And why?
   - Only include models that have been evaluated

3. What have been the barriers and facilitators of the successful implementation and sustainability of these models? And why? Were the barriers resolved?

**Results**

- Desirft of high quality research in this area
- Very little high quality evidence, small numbers, short term evaluations, lack of comparison data
- Little evidence to link interventions to maternal infant health (M/IH) outcomes
- Replication in other sites has not always produced the same results
- Difficult to combine results & draw conclusions: Wide variation in design, outcome data & quality

Evaluation of Birthing on Country Models - Australia
Appendix 7: Literature Review Presentation

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**A successful model**

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**Bringing birth back**

- Builds capacity in the community
- Restores skills and pride
- Builds family and community relationship
- Inter-generational support and learning
- Models respect for traditional knowledge
- Promotes healthy behaviours
- Supports self determination
- Integration of traditional and western medicine

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**Bringing Birth Back to the Community: Midwifery in the Inuit villages of Nunavik**

- Culturally appropriate health care requires respect for the choice of community based child birth and may also challenge the world view of medically trained health professionals who are concerned with access to medical technologies and medico-legal liabilities'
  
  — Janet Smylie MD,

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**Success factors**

- Inuit leadership & governance
- Care within culture and language
- Locally educated midwives
- Competency based model
- Culture of normal birth
- Young multiparous population
- Midwifery led inter-professional model of care
- Broad role and scope of practice for midwives
Appendix 7: Literature Review Presentation

**The Evidence**

BMJ

Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study

**Birthplace cohort study**

- Compared the safety of births planned in four settings:
  - Home
  - Freestanding midwifery units (FMUs)
  - Alongside midwifery units (AMUs)
  - Obstetric units (OUs)
- Midwifery units appear to be safe for the baby and offer benefits for the mother

**64,000 ‘low risk’ births in England, April 2008 - April 2011**

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<th>Place of birth</th>
<th>Primip Women</th>
<th>Multip Women</th>
<th>Primip Baby</th>
<th>Multip Baby</th>
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<tr>
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<td>53%</td>
<td>55%</td>
<td>56%</td>
</tr>
<tr>
<td>Natural birth</td>
<td>44%</td>
<td>44%</td>
<td>48%</td>
<td>50%</td>
</tr>
<tr>
<td>Transfer 12%</td>
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<tr>
<td>Natural birth</td>
<td>44%</td>
<td>44%</td>
<td>48%</td>
<td>50%</td>
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<tr>
<td>Transfer 12%</td>
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<td></td>
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<tr>
<td>Alongside midwifery units</td>
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</tr>
<tr>
<td>Natural birth</td>
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<tr>
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<tr>
<td>Obstetric units</td>
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</tr>
<tr>
<td>Natural birth</td>
<td>44%</td>
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<td>50%</td>
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<tr>
<td>Transfer 10%</td>
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</table>

**Inulitsivik midwifery service**

- Retrospective cohort 2000-07
  - n=1,377 labours; 1,388 babies
  - 10.4% preterm
  - 92% vaginal birth
  - 1.6% CS
  - 2.9/1,000 stillbirths
  - 3.6/1,000 NND
  - 6% Urgent transfer
  - Accepted for birth 2011

**Some of the fears**

- Mothers and babies will die
- We will be blamed
- No-one really wants to birth in communities anymore – it is only the old ladies
- All the women with risk factors will stay
- There are too many women with risk factors anyway
- You’ll only get ‘cowboys’ to work in them

**Challenges**

- Maternity workforce
  - Small numbers
  - Retention a real issue
  - Remote – added challenges
- Multi-agency collaborations
  - Health and Education
  - Multiple providers
  - Governance
  - Sharing resources
  - Clinical privileging

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Appendix 7: Literature Review Presentation

**Inulitsivik Midwifery Service**
- Most effective birthing on country model in literature
- Community based, Inuit-led initiative on Hudson Coast of Nunavik region of northern Quebec
- Context, geography & challenges: similarities with remote Australian setting
- Support on-site birthing centres & onsite training of midwives in 3 remote communities
- Excellent MIH outcomes
- Links to greater social functioning, community healing, regaining of dignity and self esteem & decrease in domestic violence

"I can understand that some of you may think that birth in remote areas is dangerous. And we have made it clear what it means for our women to birth in our communities. And you must know that a life without meaning is much more dangerous."
- Josapie Paddayat
  Elder, Chair of Inulitsivik Health Board

"to bring birth back to the communities is to bring back life"
- Puvungnuk Elder
  1988

**Birth on Country**
- Maternity services designed by and delivered for Indigenous women

**Governance**
- Indigenous control, community development approach, shared vision, cultural guidance & oversight

**Philosophy**
- Respect for Indigenous knowledge & incorporation of traditional practice
- Respect for family involvement
- Partnership approach
- Women’s Business
- Community of care
- Capacity building approach
- Particularly with training and education
- Holistic definition of health

**Training & Education**
- Partnership
- Education 2-way
- Learning: appropriate, timely and sustained
- Competency-based, delivered
- Career pathway from students to midwifery

**Service Characteristics**
- Community-based, Quality-oriented, Designated ongoing training, Involvement of local health centers, focusing on antenatal care and trust
- Outreach transport, infant feeding & group sessions
- Social, cultural, and emotional support
- Ongoing education and training committed
- Effective, integrated into primary care services

**Results**
- Community healing as evidenced by reduced family separation at critical times
- Redefinition of skills & values, capacity building in the community
- Supporting community & family relationships
- Increased community & family involvement
- Improved Maternal and Infant Health Outcomes

Thank you