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Figure 1. The Community Yarns Working Group
Left to Right: Cherisse Buzzcott, Sue Kildea, Yvette Roe and Donna Hartz. Unfortunately, Melanie Briggs is missing from the photo.

Citation:
Acknowledgement

Yuin Nation and Waminda South Coast Women’s Health and Welfare Aboriginal Corporation
The Team\(^1\) acknowledges the sovereign land of the Yuin Nation, which comprise of Yuin language dialects, including Djiringanj, Thaua, Walbanga, or Wandandian and Dhurga language. All community yarns occurred on the lands of the Yuin Nation. In addition, the Team acknowledges the Waminda South Coast Women’s Health and Welfare Aboriginal Corporation\(^2\) staff, Mel Briggs and Patricia Deaves, who organised the community yarns and supported the Team.

Funding

Funding to undertake this project is derived from several sources and sits within a NHMRC Partnership Grant: Building on Our Strengths (BOOSt): Developing and Evaluating Birthing On Country Primary Maternity Units. Key partners and funders include the Institute of Urban Indigenous Health, the Aboriginal and Torres Strait Islander Community Health Service (ATSICHS) Brisbane, the Waminda South Coast Women’s Health and Welfare Aboriginal Corporation, the Australian College of Midwives, the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, the Rhodanthe Lipsett Indigenous Midwifery Charitable Fund, the University of Queensland and the University of Sydney. The Australia College of Midwives received funding from Merck Serono Pty Ltd (Merck) which is contributing to this partnership project as is funding from a University of Queensland Strategic Grant.

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\(^1\) The Team compromised Prof. Sue Kildea, Dr Yvette Roe, Dr Donna Hartz, Ms Mel Briggs and Ms Cherissa Buzzacott.

\(^2\) Waminda South Coast Women’s health and Welfare Aboriginal Corporation will now be referred to as Waminda.
Community Activation

The South Coast Women’s Health and Welfare Aboriginal Corporation provides culturally safe and holistic health services to the women of the Illawarra Shoalhaven region. They began operations as an Aboriginal Women’s Health Centre in 1984, and Waminda was established in 1990. Their focus is on tailored strength-based care that addresses the social determinants of health. Waminda is a centre of excellence for Aboriginal and Torres Strait Islander women’s health, and a leader in linking culture with education, health and well-being. The service catchment area extends from Kiama to Ulladulla, and includes the discrete Aboriginal communities of Wreck Bay (ACT), Jerrinja (Orient Point) and South Nowra.

Work towards Birthing on Country has been a longstanding part of the Waminda’s strategic direction. In their 2016-2019 Strategic Plan, the Board and community have agreed that their focus for new services will be on the establishment of an Aboriginal Birthing Centre. To this end, Waminda have become a key partner in a National Health and Medical Research Council (NHMRC) Partnership Project aiming to develop and evaluate Birthing on Country Service Models in Australia: Building On Our Strengths (BOOST): Developing and Evaluating Birthing On Country Primary Maternity Units. This partnership project will progress the will of the community to establish and evaluate Birthing on Country in this community and enable staff to not only carry out antenatal and postnatal services but birthing services also. It will strengthen Waminda (and other partner health service organisations’) overall role and capacity to deliver high quality Maternal Infant Health (MIH) care to Indigenous women and infants in a culturally safe and responsive manner.

Report Format

This report provides the recommendations on how Birthing on Country (BoC) could be implemented in the Illawarra Shoalhaven Region under the leadership of Waminda. The recommendations are informed by the community yarning circles conducted in the region in September and November 2017, under the auspices of the Birthing on Country, NHMRC funded project: Building on Our Strengths (BOOST): Developing and Evaluating Birthing On Country Primary Maternity Units. We provide a definition of Birthing on Country, an overview of the national policy context, describe current Birthing on Country activity occurring in South East Queensland and the results of the desktop review and community yarning circles.

Koori is the primary term used for identifying Aboriginal history, people and cultures when relating to both New South Wales (NSW) and Victoria. Koori (Guri) is a word for man/people that comes from the languages of the Mid North Coast and Hunter regions of NSW. The Aboriginal community included in the report referred to themselves as Koori, which will be the name used when referencing the community or community members in this report.
Recommendations

1) Redesign the health system
   a) To improve the pregnancy and birthing outcomes for Australia’s First Nation people, it is essential that key stakeholders actively participate and invest in redesigning the health system. The system redesign should be a transformative and collaborative process with each stakeholder contributing to a pool of resources and providing their unique skills and knowledge. Potential collaborators include: Waminda, NSW Health\(^3\), Aboriginal Medical Services (AMSs) and Public Health Network.

   b) All maternal and infant health and wellbeing service providers in the Illawarra Shoalhaven Region to review, and were necessary re-orientate, services to ensure that services are ‘mother and child centered’ which also accounts for the social and cultural determinants of health and wellness and international best practice.

   c) Waminda take the lead on the redesign by approaching potential collaborators to join a Multiagency Steering Committee (see: Embed community activation-investment-ownership below) to work in partnership to provide an integrated and comprehensive model of care that includes a Midwifery Group Practice (MGP) for Indigenous families in the region.

   d) Waminda to be the lead organisation in the delivery of an integrated 24/7 Indigenous MGP.

   e) Illawarra Shoalhaven Local Health District to negotiate a Collaborative Agreement with Waminda that enables midwives employed in the MGP to provide birthing services at the hospital or home, and will also be extended to include the birth centre when it is operational.

   f) The Australian College of Midwives (ACM) to take the lead in urgently finding a solution to the insurance issues that restrict access and insurance cover for midwives employed in an Aboriginal and Torres Strait Islander Community Controlled Health Organisation (ATSICCHO) to provide care in the hospital, the birthing centre and the home.

2) Wellbeing and Birthing Place
   a) Design and build a multi-purpose Koori Wellbeing Birthing Place (Facility), which will deliver comprehensive holistic maternity care for all women and birthing services for women with no identified risk in pregnancy (refer to Figure 2). The service and facility is mother and child centred as well as allowing for family involvement as determined by the mother herself. Aboriginal cultural integrity provides the governing ethos for the services and facility. The facility design is to incorporate a safe space for women who may be experiencing trauma or distress e.g. interpersonal violence, and require short to medium term recovery and accommodation. This may include crisis accommodation for stays up to about one month when clients will then move on to transitional housing off site.

   b) Family Wellbeing Workers (FWW)\(^4\) and midwives in the MGP to work collaboratively in ensuring a woman focused service. Midwives are a key advocate of the mother’s choice for her birthing experience, which also includes advising women of the birthing process that is, birthing practice and places.

   c) NSW Health to work with Waminda and other stakeholders, through the Steering Committee, to assist in developing the risk management strategy for the development of the Koori Wellbeing Birthing Place. This should be based on previous work conducted prior to opening the Ryde and Belmont Level 2 birthing services in NSW. Key people could include: Prof Michael Nicholl, the Senior Clinical Advisor Obstetrics to NSW Health, Dr Jane Raymond,

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\(^3\) NSW Health is used in its broadest term to include for example the Aboriginal Maternal Infant Health Strategy (AMIHS) Program and the Illawarra Shoalhaven Local Health District etc.

\(^4\) The Family Well Being Worker would be an Aboriginal person from the local community.
3) Invest in the workforce
   a) A **clinically and culturally safe** maternal and child health workforce in the Illawarra Shoalhaven Region is a priority. NSW Health staff employed in the Illawarra Shoalhaven region to undertake mandatory annual cultural safety training which is to be delivered in partnership with an Aboriginal Community Controlled Organisation.

   b) Cultural safety training to be an integral component of the Collaborative Agreement between Waminda and NSW Health.

   c) NSW Health to allow MGP midwives to participate in the maternity specific **mandatory training** and upskilling of which will be part of the Collaborative Agreement with Waminda.

   d) NSW Health **continue to invest** in increasing the size and capability of the Aboriginal maternal and infant health workforce. There should be an emphasis on recruiting, retaining and graduating Aboriginal students and clinicians from the Illawarra Shoalhaven Region.

   e) Universities are encouraged to:
      i) Implement a **systematic ‘pipeline’** that is designed for the increased recruitment and graduation of Aboriginal midwifery and child health students;
      ii) Provide off-base training to enable Aboriginal students to conduct the majority of their studies within the Region; and
      iii) Develop a collaborative education agreement that enables Indigenous students to gain clinical experience in the hospital and primary health care setting.

4) Strength Family Capacity
   a) **Strengthening the capacity of families** is critical to the long-term health and wellness of the mother and baby and should be seamlessly integrated with maternal and infant health services. The Aboriginal community should be involved with the design and delivery of the activities and services. A localised ‘strengthening family capacity’ strategy could be developed to cover the life course of the mother and child e.g. cultural revival, trauma and attachment informed care, resilience, family wellbeing, skills development and employment opportunities etc.

   b) Families are critical in the pregnancy, birthing and parenting journey. Service providers to employ active strategies as informed by the mother, to engage the family in the longer term. Family support and wellness workers to provide seamless integration of comprehensive services that continue to **strengthen the capacity** of the mother and family.

   c) **Integrated and Comprehensive Women and Child Wellbeing and Health Services**
      i) A continued investment in, and collaboration with, Waminda to provide **comprehensive and integrated** mother and children centred services throughout the Illawarra Shoalhaven Region. Women and children would be able to access a **suite of services** including:
         (1) Maternal and Infant Health Services including case load midwifery (to be available for women of any risk status, midwives to work within a MGP)
         (2) Outreach or onsite services may include: obstetrician, ultra-sonographer, diabetic education, dietician, women’s health and pediatric services including reproductive, contraceptive, sexual health services, smoking cessation, dental, immunization, growth assessment and monitoring for well babies and allied health services i.e. psychologist, perinatal mental health workers, social worker, occupational and speech therapist;
Birthing on Country, Best Start to Life

(3) Family Wellbeing Workers (FWW) to support the women throughout their pregnancy, birthing and postnatal journey which may include coordinating wellbeing services, advocacy and engagement with health and human services as agreed to by the client.

(4) Legal and advocacy advice and support;

(5) **One-stop-shop** for accessing capacity building programs, welfare support and shop front for Commonwealth or State agencies e.g. Centrelink, housing etc.

5) **Embed community activation-investment-ownership**

a) **Elders and cultural knowledge holders** are invaluable resources that can contribute positively to the birthing and parenting experience. Waminda to seek input from their Cultural Committee and local Elders Committees (groups) on how Elders and knowledge holders can be included in the Birth on Country program design and delivery, and the birthing facility design.

b) A **model of governance** that is informed by the Aboriginal community which will provide the foundation (ways of knowing, doing, seeing and being) for development and delivery of mothers and children centred services. That is, *services delivery by the community for the community*.

c) Waminda to Chair a **Multi-agency/stakeholder Steering Committee** to work collaboratively to deliver culturally safe, evidenced based and high quality maternity and child health services.
Background: What is Birthing On Country?

Women’s Definition
Aboriginal women across Australia (urban, rural and remote) have led the drive to have Birthing on Country (BoC) for decades. The aspirations and urgency of Birthing on Country becoming a reality is best captured in the following statement.

“Birthing on Country should be understood as a metaphor 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 Birthing on Country... move from being aspirational to actual. The Birthing on Country 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.” Djapirri Mununggirriti

Yolngu Elder, from north-eastern Arnhem Land in the Northern Territory.
National Birthing on Country workshop (July 2012, Alice Springs)[1]

Aboriginal women have not only defined what Birthing on Country is, but more importantly, provided strategic and operational recommendations how it could be delivered in communities. In 2012, over fifty participants came from across Australia to attend the first Birthing on Country workshop in Alice Springs. The objectives of the workshop, under the auspices of the Australian Health Ministers’ Advisory Council through the Maternity Services Inter-jurisdictional Committee, were to:

1. Obtain agreement regarding progressing Australia’s commitment to Birthing on Country programs;
2. Establish jurisdictional steering groups to support the implementation of Birthing on Country programs in Australia;
3. Develop an implementation and evaluation framework for the Birthing on Country program; and
4. Identify potential sites for the Birthing on Country program to be trialled.[2]

Literature Definition
The latest Birthing on Country work grew out of the National Maternity Services Plan (2011)[3] endorsed by all Australian Health Ministers in 2010. The Plan highlighted the challenges faced by Aboriginal and Torres Strait Islander women and families with regards to both access to, and acceptability of, maternity services. It recommended specific actions towards developing and expanding culturally competent maternity care, which included the establishment of Birthing on Country Models. In order to achieve this reform in maternity services a number of steps were carried out under the oversight of the Maternity Services Inter-Jurisdictional Committee. One was a review of the international Birthing on Country literature, conducted in 2012. The Maternity Services Inter-Jurisdictional Committee defined Birthing on Country for this review 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.[4]
The next piece of work undertaken by the Maternity Services Inter-Jurisdictional Committee was the development of a document providing the Guiding Principles for Developing a Birthing on Country Service Model and Evaluation Framework. These reports have been used to assist in the development of recommendations for Waminda and the Illawarra Shoalhaven Local Health District.

RISE

Conceptual Framework

Birthing on Country is a mother and child centered way of providing the best start to life for Aboriginal and Torres Strait Islander babies. Aboriginal ways of knowing, doing and understanding are at the core of Birthing on Country. Birthing on Country is a transformative process that consciously transitions services from standard care to Birthing on Country. The process involves multiple and complex interventions. The conceptual framework is informed by synergy between Aboriginal women’s aspirations and evidence-based practice. The conceptual framework for the Birthing on Country model of care has four interventional components: redesigning the health system, investing in the workforce, strengthening the capacity of families and embed community ownership (Figure 2). We have used this Framework to structure the report and recommendations of the community yarning circles that was undertaken in the Illawarra Shoalhaven Region of the New South Wales South Coast, Figure 6.

Figure 2. RISE: Birthing on Country Conceptual Framework

Essential Features

Each interventional component can be broken down into phases that can be progressed through as a community starts to develop their Birthing on Country Service Model. Although we have suggested four phases for each component it is possible to go from 1 to 4 without transitioning through 2 and 3. Additionally, some smaller communities may not be aiming to get to Phase 4 but instead to stop at Phase 3. See for example the ‘R’ (Redesign) Component of Birthing On Country in the Figure 3. Below are examples of the roll-out of the components. The essential features of Birthing on Country are governance, a suite of mother-child services, a one-stop-shop facility and a birthing facility, Figure 4.
Birthing on Country

Goverance

Comprehensive and integrated Services

One-stop-shop Facility

Birthing Facility

Figure 3. Phases of the RISE

Figure 4. Birthing On Country essential features.
Implementation Example - South East Queensland

The Birthing on Country service was implemented in South East Queensland (SEQ), in an Aboriginal-mainstream Partnership in 2014. The service for South East Queensland has already been developed and evaluated in Brisbane, with funds from a NHMRC Partnership Grant for the Birthing in Our Community (BIOC) program. Below is a schematic chronology of the Birthing on Country in SEQ. Note that a Mater Hospital had been operating the Murri Clinic in 2004 and it took a decade (2014) for BIOC to be operationalised.

![Figure 5 A schematic of the Birthing on Country in SEQ, Aboriginal-mainstream partnership and outcomes.](image)

**Partner Organisations**

The BIOC program has three partners: the Institute of Urban Indigenous Health (IUIH), the Aboriginal and Torres Strait Islander Community Health Service, Brisbane, Ltd (ATSICHS) and the Mater Mothers Hospital (MMH) who developed a high quality, culturally responsive model of maternity care. The Aboriginal-mainstream partnership approach of the BIOC program integrates the resources and expertise of a large tertiary hospital (MMH) with the cultural knowledge, expertise and community engagement of two Aboriginal community controlled health organisations (ACCHO’s), (IUIH and ATSICHS), enabling a unique approach to service delivery.

**Elements of the Program**

The essential components of the program were based on the international Birthing on Country literature review[4] (Appendix 1) and include:

a) Genuine Partnership between ACCHOs and the Health and Hospital Service
b) Indigenous and cultural governance (provided by the ACCHO’s) and clinical governance provided through the hospital
c) Genuine Partnership between ACCHOs and the Health and Hospital Service with program oversight through a Steering Committee
d) Aboriginal-mainstream partnership is grounded in responding to the maternal and infant health needs of Aboriginal and Torres Strait Islander community.
e) Continuity of midwifery carer including a known midwife during pregnancy, birth, postnatal up to 6 weeks as determined by the women
f) Indigenous family support workforce
g) Workforce support through clinical and cultural supervision
h) A Team Coordinator who also manages the day-to-day activities at the Hub with administration support and transport provided through the Hub (services).
i) Wrap around social and allied health services from a Social Worker and Allied Health team also contribute to the service model
j) Investment in the Indigenous Workforce including support for Indigenous student midwives through cadetships
k) Location of services within a Community Based Hub (facility)
l) Integration into a comprehensive model of care provided by ATSICHS and IUIH that includes support for vulnerable families.

**Continuity of Midwifery Carer – MGP**

Care from a known midwife throughout the childbearing experience who works in a Midwifery Group Practice (MGP) requires a minimum of 4 midwives in one group (or 6 midwives=2 groups of 3) due to 24/7 on-call demands and the need for fatigue leave, days off and annual leave. The caseload per FTE midwife in BiOC is 30 women, lower than the mainstream ratio of 36-40 due to the social and medical complexities of the women and care coordination that is required across multiple providers.

**Investment in the Indigenous workforce**

The BiOC service addresses the social determinants of health by providing additional employment and training for an Indigenous workforce to work alongside the midwives. The Indigenous workforce includes Program Managers, administration positions, transport officers, Family Support Workers (FSWs) and sponsored industry-based cadetships specifically for Indigenous midwifery students. The FSWs not only provide ‘cultural support’, but they also provide essential social and emotional wellbeing assessment and support. They gather psycho-social information, they understand the world of the women they are caring for, and they act as powerful role models and advocates as they walk alongside women to become the best mothers they can be.

**Social workers and psychologists**

The FSWs are supported by a social worker who is available to offer professional support that address the social and cultural determinants of health and ensures women are entering motherhood in stable accommodation, with the correct financial support and hopefully free from destructive or violent family relationships. Psychological support is available through the social health team and offers women and their partners’ specialist therapeutic interventions that address the adverse life events that may negatively impact on their ability to parent successfully. Support to strengthen families in contact with child safety services and integrate them into intensive family support services and family wellbeing services are important components of these roles with the staff working closely with the social worker and child safety team at the hospital.

**One-Stop-Shop Facility**

The Maternal and Child Health Care Facility provides rooms for clinical assessments of mothers and children that may be provided by anyone in the multidisciplinary team. Larger rooms are available for culturally tailored antenatal and postnatal care and group education sessions, including Deadly Families Yarning Circle cultural sessions, bellycasting, physical activity and nutrition sessions (‘Work it Out Mums). Steering Committee and other meetings and workshops are held here. Many Aboriginal and Torres Strait Islander women and families experience a range of complex social,
emotional and other health issues with pregnancy and early parenting being optimal times for intervention. The Hub provides a one stop shop for outreach and onsite services and includes for example:

- Sexual and reproductive health clinic
- Paediatric medical services
- Paediatric allied health services – Speech, OT and Audiology
- Visiting ENT services.

**Clinical Outcomes**

In the first four years of operation it has contributed positively to many improved maternal and infant health outcomes including a reduction in preterm birth and caesarean section rates, increased antenatal engagement, normal births and breastfeeding rates.\(^8\)

**Key Learnings**

Some of the key learnings gained from the SEQ site during 2014-2017 are listed below as either operational and research (Figure 6).

**Figure 6: Key learnings from the SEQ site**

**OPERATIONAL**

1. Service delivery should be Mother and Child (family) centred
2. We know what we have to do
3. It isn’t easy
4. It is urgent
5. Critical factors:
   5.1. Leadership
   5.2. Partnerships
   5.3. Organisational Support
   5.4. Measuring and sharing what works
   5.5. Training and education
   5.6. Technical leadership
   5.7. Long-term sustainability
6. Don’t wait to ‘let it happen’ or ‘help it happen’ we need to ‘make it happen’

**RESEARCH**

1. Importance of PAR in research i.e. design, interpretation, analysis & implementation
2. Continue to build on the evidence and respond/implement changes in a timely manner.
3. Provision for early detection and appropriate management of issues that may have an impact on pregnancy, birth and parenting.
4. Inform strategic planning, decision making and resource prioritisation for service providers
5. Understanding where the greatest potential health gain is important for achieving the life expectancy gains
6. Reframing research paradigm, research framework, research questions and potential interventions that will continue to build on the health gains evident
Methods
Desktop Review
A desktop review of key documents that were supplied by different stakeholders and found on the Internet was conducted. Footnotes and references provide information on the data sources used for this report. In particular:

- 2011 & 2016 Census Data
- NSW Centre for Epidemiology and Evidence website (2017)
- NSW Health 2015 Mothers and Babies Report, and
- The Illawarra Shoalhaven Local Health District Health Care Services Plan 2012-2022.

Appendix 1: Reports are documents that should be read in conjunction with the Birthing on Country: Best Start to Life Report.

Community Leadership
As a local Aboriginal community controlled organisation, Waminda exists to ensure Aboriginal and Torres Strait Islander women have a voice, are respected and are treated with dignity by all of community. Waminda Board Members, community members, Chief Executive Officer, Cultural Committee and maternal and infant health staff communicated very clearly that Birthing on Country was a key priority for the women in the community as a means of improving birthing experiences and outcomes in the Region. Birthing on Country would continue to build on the existing Waminda services that provide tailored strength based care that aimed to provide quality health and wellbeing support.

Waminda led community engagement strategies, coordinated logistics and provide guidance to the Working Group on the local cultural protocols when working for the Aboriginal community. This leadership was critical in engaging women, stakeholders and analysis of data. The Working Group was very mindful to accurately record and reflect the concerns and aspirations of the women while also proposing recommendations that could be actioned.

In negotiation with Waminda, it was proposed that the Working Group would undertake two rounds of community yarns from September to November 2017. The yarning circles was conducted in accordance to Aboriginal protocol by firstly acknowledging the sovereign lands of the Yuin Nation and acknowledgement of past and present Elders, and the many Aboriginal people present. The yarning circles were designed to be inclusive, interactive and transparent. Community yarns were convened in Nowra, Albion Park, Balang Healing House (Orient Point), Wreck Bay, Ulladulla and Batemans Bay. The yarning was conducted in a comfortable setting, comprising of open-ended questions with the aim of capturing community insight into what could Birthing on Country be in the region. There were been 6 and 20 participants at the yarning circles. Participants included representatives of the Aboriginal community in all sites, AMICHS, Shoalhaven Drug and Alcohol, South Coast AMS, Waminda, Katungal Health Centre, NSW Health, and FaCS.

The first round of yarning circles focused on privileging the voices of Koori women. Service providers were also present and provided important input. In November, a second round of yarning circles targeted key stakeholders from the region. The following up yarns aimed to provide the initial community yarning circle findings and progress the discussion on Birthing on Country in the region.

Findings
Findings from the Desktop Review
Waminda South Coast Women’s Health and Welfare Aboriginal Corporation
Waminda provides culturally safe and holistic health services to the women of Shoalhaven. They began operations as an Aboriginal Women’s Health Centre in 1984, and Waminda was established in
Their focus is on tailored strength-based care that addresses the social determinants of health. Waminda is a centre of excellence for Aboriginal and Torres Strait Islander women’s health, and a leader in linking culture with education, health and well-being. They offer 21 health service programs, including an established Mums and Bubs program which offers antenatal and postnatal care as well as parenting support, and infant healthcare. Additional services include:

- Women’s Health and Sexual health Clinic
- Early childhood and antenatal services
- Mammography and Cervical screening days
- Pamper days
- Grief and Loss support groups
- Over 40’s physical activity group
- Aboriginal Women’s Health and Well-being project
- Women’s health promotion and information
- Promotion and education awareness raising sessions in schools and the wider community

The Waminda service catchment area extends from Kiama to Ulladulla, and includes the discrete Aboriginal communities of Wreck Bay (ACT), Jerrinja (Orient Point) and South Nowra. Work towards Birthing on Country has been a longstanding part of the Waminda’s strategic direction resulting in the development of their 2016-2019 Strategic Plan, where the Board and community have agreed that their focus for new services will be on the establishment of an Aboriginal and Torres Strait Islander Birthing Centre. Waminda became a key BOOST partner in 2016 with the support of the NHMRC Partnership Application: Building on Our Strengths (BOOST): Developing and Evaluating Birthing On Country Primary Maternity Units.

**Illawarra Shoalhaven Region and District Health Plan**

The map below is copied from the Illawarra Shoalhaven Local Health District Health Care Services Plan and provides a diagram of this region.\[9\]
Figure 7. Map of the Illawarra Shoalhaven Local Health District Communities

The Illawarra Shoalhaven Local Health District provides services to a diverse range of communities with three main population centres: Wollongong in the Northern Illawarra, Shellharbour in the Southern Illawarra, and Nowra in the Shoalhaven. The current population of 368,822 is projected to reach over 425,000 by 2022, with the highest growth rate to be experienced in the Shoalhaven. Many of our communities have distinct health care needs, with a higher than state average level of socioeconomic disadvantage. Cultural diversity, isolated communities, rising levels of chronic and complex needs and potentially avoidable hospitalisations highlight some of the key challenges the local health system faces over the next 10 years.\(^{[10]}\)

In 2011, 10,763 Illawarra Shoalhaven residents were Aboriginal people, representing 2.9% of the total population, of which 60% reside in the Illawarra (6,445) and 40% reside in the Shoalhaven (4,318). Relative to all District residents, Shoalhaven residents are the most socio-economically disadvantaged, especially in the Nowra area, which also has the highest density of Aboriginal people, the highest level of premature mortality, and the lowest level of private health insurance.\(^{[10]}\) Aboriginal people comprise 5% of the Shoalhaven population (twice the percentage of Indigenous Australians for the rest of NSW) and 10% of the children (double the proportion for NSW). Between 2012-2014, 1,165 Aboriginal and Torres Strait Islander babies were born in the region.

The Illawarra Shoalhaven Local Health District Health Care Services Plan 2012-2022\(^{[10]}\) provides an overview of current services, key service issues and service development priorities, outlining strategic service directions for the next ten years under four key reforms which will be taken into account when making recommendations for this report:

- Investing in contemporary patient-centred models of care: which includes the development of District-wide, integrated, continuity of care service models for maternity, neonatal and child and family services in partnership with primary health care providers. Models will have a strong focus on the special needs of vulnerable families, children at risk and children with chronic illnesses, and include early identification and intervention strategies and case management to ensure access to on-going monitoring, multidisciplinary assessment and support at hospital, in the community and at home.
- Developing an Integrated Health System: which includes the development of hub and spoke service delivery models tailored to address the needs of specific communities and groups within those communities.
- Reconfiguring the Capital Footprint to Match Needs: increased capacity for paediatric service delivery at the acute health hubs, particularly in Shellharbour and the Shoalhaven, and for ambulatory paediatric and maternity services at primary health care hubs in each community.
- Building the Workforce of the Future.

An important goal in underpinning NSW Health Strategy is to foster opportunity and partnership with Aboriginal people as a means to strengthening the local environment and communities to:

- Close the life expectancy gap between Aboriginal and non-Aboriginal people
- Increase the number of Aboriginal communities the State Government is partnering with to improve local outcomes
- Support Aboriginal Culture, Country and Identity, and
- Develop local Partnerships between Local Health Districts and local Aboriginal Controlled Health Services (a requirement of the NSW Aboriginal Health Partnership Agreement of which the Aboriginal Health and Medical Research Council of NSW and the NSW Government are equal members). The local Partnership Agreement between the Illawarra
Birthing on Country, Best Start to Life

Shoalhaven Local Health District and Illawarra Aboriginal Medical Service, South Coast Aboriginal Medical Service, Oolong House and Waminda (Aboriginal Health Partners) seeks to improve health outcomes for Aboriginal people in the Illawarra and Shoalhaven region through a range of initiatives that include developing specific positions, allocating appropriate resources, ensuring Aboriginal Health remains a high priority and engaging with Aboriginal stakeholders and communities about the work of the Aboriginal Health Partnership.\textsuperscript{[10]}

**Maternal and Child Health Profile**

Only a few key maternal and infant health statistics were available from the NSW Centre for Epidemiology and Evidence website (2017).\textsuperscript{[11]} The proportion of women receiving antenatal care in the first trimester of pregnancy appears to have declined from 2011 onwards to rates that are less than the average NSW rates for both Aboriginal and non-Aboriginal mothers with Aboriginal mothers being less than non-Aboriginal mothers at almost all time points (Figure 1). Further investigation is required to determine if the sudden drop around 2011 reflects a data capture issue or the actual care women are receiving however the figure for Aboriginal mothers is much lower than the national figure of 54% in 2014.\textsuperscript{[12]}

![First antenatal visit among Aboriginal and non-Aboriginal mothers, Illawarra Shoalhaven LHD, before 14 weeks, NSW 2001 to 2015.](image)

**Figure 8.** First antenatal visit among Aboriginal and non-Aboriginal mothers, Illawarra Shoalhaven LHD, before 14 weeks, NSW 2001 to 2015.

The proportion of low birth weight babies for Aboriginal mothers fluctuates from ~7-16% compared to the non-Aboriginal mothers of 6-7% (Figure 9).
The proportion of Aboriginal women having a normal vaginal birth in the Illawarra Shoalhaven Region was not available however the NSW data shows a slow decline over the years 2001 to 2015 from around 73% to 69% around 8-10% higher than the proportion of non-Aboriginal women (Figure 10).

Figure 10. Type of birth among Aboriginal and non-Aboriginal mothers, Normal vaginal, NSW 2001 to 2015

The proportion of Aboriginal women fully breastfeeding at hospital discharge is ~65% approximately 10-15% lower than the non-Aboriginal rate of ~79% (Figure 11).
Figure 11. Infant feeding at hospital discharge among Aboriginal and non-Aboriginal mothers, Illawarra Shoalhaven LHD, NSW 2015.

A brief service mapping can be seen on the following page (Table 1). Although there are a variety of service providers in the region, mostly offering antenatal and postnatal services Monday to Friday in hours, it did not seem that there were any MGP services for Indigenous women.
Table 1: Maternal Child Health Care Pathway

<table>
<thead>
<tr>
<th>Service Provider</th>
<th>Preconception</th>
<th>Antenatal Care</th>
<th>Birthing</th>
<th>Postnatal, child &amp; Family Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waminda Clinical Services</td>
<td>Workforce: Aboriginal Midwife FT, Midwife P/T, Mental Health Nurse, GP PT x 4, Case Managers x 3, Intensive Family Support Workers x 3. Program workers: Breast and Cervical Cancer Care Coordinator, Chronic Disease Coordinators, Social Workers, Tackling Indigenous Smoking (TIS) Worker. Services: Well Persons Health Check (Medicare Item 715)(WPHC), Fortnightly Child &amp; Family Clinic, Playgroup; patient referral to dental, Obstetrics &amp; Gynaecology Services and Allied health; Reproductive and Family Planning Services; Healthy Lifestyle Program - Dead or Deadly chronic disease prevention exercise program.</td>
<td>WPHC, Referral to Midwife (standing orders for pathology and USS), onsite Blood Collection, Booking in to Hospital referral to Obstetrician. Weekly Antenatal classes QUIT Smoking Campaign Tackling (TIS) during pregnancy. Support and advocacy to Obstetric or other external services; Transport, Home Visits; Outreach Clinics from Wollongong to Burrill Lake.</td>
<td>Fortnightly Child and Family Health Outreach Clinics; Home Visiting up to 6 weeks postpartum or as needed by the family; EMBA (Empowering Mothers and Babies) case conferences, Nabu®, Immunisation©</td>
<td></td>
</tr>
<tr>
<td>Waminda Social Health</td>
<td>Youth: school sessions, pamper sessions, case-worker for women in prison, justice health, and Positive Parenting Programs and Family Therapist</td>
<td>Case conferencing, case workers, housing support, D&amp;A, DV, parenting, mental health plan, EMBA Case Conferencing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waminda Clinical Services &amp; Binji Boori Partnership</td>
<td></td>
<td></td>
<td>Developmental checks GPs or CFHN; Outreach services; joint home visits within the first two weeks of birth</td>
<td></td>
</tr>
<tr>
<td>South Coast AMS, Nowra</td>
<td>General Practitioners x 5 (2 Female, 3 Male) Early Family Support worker to delivery parenting awareness program &amp; post pregnancy care, Child psychologist (out of home care clients), SEWB Counsellor</td>
<td>General Practitioners 2 x female 3 x male, D&amp;A, Nurses, Dentist</td>
<td>Early Family Support Worker delivers parenting awareness program &amp; post pregnancy care General Practitioners, Outreach Clinics (Jerrinja &amp; Wreck Bay), Drug &amp; Alcohol Services</td>
<td></td>
</tr>
<tr>
<td>AMIHS (Binji &amp; Boori)</td>
<td></td>
<td>Midwife 1 F/T, Aboriginal Health Worker and Social Worker</td>
<td>Midwife 1 FTE and AHW 1 FTE up to 2 weeks postpartum, Child and Family Health Nurses from 2 weeks postpartum up to 5 years of age©, Occupational Therapist©, Speech Therapist 0.4 FTE</td>
<td></td>
</tr>
<tr>
<td>GP Shoalhaven</td>
<td>GP Antenatal care referred to hospital for booking at 12 weeks. Pathology and ultrasound referrals</td>
<td>Obstetrician Midwife Clinic (daily)</td>
<td>Public Hospital Staff, No Private Obstetricians, No MGP</td>
<td>Midwifery Support Program from discharge up to one week postpartum (Weekend support when needed)</td>
</tr>
<tr>
<td>Hospital – Nowra Public Hospital Level 3 (ANC Shoalhaven)</td>
<td></td>
<td>Obstetrician Midwife Clinic (daily)</td>
<td>Public Hospital Staff, No Private Obstetricians, No MGP</td>
<td>Midwifery Support Program from discharge up to one week postpartum (Weekend support when needed)</td>
</tr>
<tr>
<td>Hospital – Illawarra</td>
<td>Obstetricians x 7, Gynecology Services, IVF clinic, Early Pregnancy Assessment Units.</td>
<td>Young Women’s Pregnancy Group, Day Assessment Unit, Student MGP GP Antenatal Shared Care Program Early Pregnancy Assessment Service (EPAS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Outreach</td>
<td>Booking in Appointments (daily), Antenatal</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
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### Birthing on Country, Best Start to Life

<table>
<thead>
<tr>
<th>Location</th>
<th>Services/Staffing Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shoalhaven (Osbourne Clinic)</strong></td>
<td>Midwife Clinic, Obstetrician Clinic 2 days per week</td>
</tr>
<tr>
<td><strong>Hospital – Wollongong Public Hospital Level 5</strong></td>
<td>Booking Clinic, Midwife Clinic AMIHS Midwife (non-Aboriginal), Aboriginal Midwife 0.5 FTE, MGP; Hospital 2 x MGP midwifery teams; MGP, Homebirth*</td>
</tr>
<tr>
<td><strong>Hospital – Wollongong Private Hospital</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Private Obstetricians – Shoalhaven</strong></td>
<td>Nil</td>
</tr>
<tr>
<td><strong>Private Obstetricians – Illawarra</strong></td>
<td>Nil</td>
</tr>
<tr>
<td><strong>NSW Health – Allied Health Services</strong></td>
<td>Counselling, Lactation Support, Occupational Therapist, Sleep &amp; Settling; Child &amp; Family Health – Mainstream services, Diabetes Educator, Dietician; Dental, Drug &amp; Alcohol, Perinatal Mental Health Service (PIMS), Community Mental Health.</td>
</tr>
</tbody>
</table>

*Hand held record used by all providers.

Well Persons Health Check Medicare Item 715(WPHC), the aim of this MBS health assessment item is to help ensure that Aboriginal and Torres Strait Islander people receive primary health care matched to their needs, by encouraging early detection, diagnosis and intervention for common and treatable conditions that cause morbidity and early mortality.

Nabu is an early intervention and intensive family support program for women at risk of child being apprehended by child services.

Immunisation provided by Waminda, South Coast AMS, GPs, Community Health.

Blue Book Checks & Refer.

December 2017 position vacant

Home birth is publicly funded for women who wish to have a vaginal birth after one caesarean section and in consultation with doctors.
Findings from Community Yarning Circles

All contributions added richness to the yarn. In light of the different discussions, there were a number of key ingredients needed to support ‘the best start to life’ for mothers and babies (Figure 12). These are discussed in more detail in the following pages. The verbatim quotes are from community members and pseudonyms used.

All participants made a valuable contribution to the discussion and provided important insights to understanding Birthing on Country from Koori women’s community perspective as well as a model for providing mother and child centred care. The participants were of different ages, different communities and had different life experiences. Staff from NSW Health, AIMCH, AMS sector and specialised program providers also attended the meeting. The Working Group also received a written submission from a community member who was not able to attend the yarning circles.

Appendix 2 illustrates the community voices on the barriers experienced by Koori women in antenatal, birthing and postnatal care. In addition, the services and support needed to wrap around mothers, babies and families to improve birthing and health outcomes. Appendix 3 is a list of participants.

Figure 12: Findings of yarning circles collated into themes needed to support “the best start to life’ for mothers and babies.
Voice and Choice Priority

Sovereignty of person and place was expressed by the women in the form of having a choice. A lack of choice and control of their birthing experience was iterated at each of the yarning circle. Women shared how they were not provided any choices in birthing. Participants shared how they wanted their family to be involved the birthing process but informed that it could not happen. For example:

“[we want] whole of family involvement. Hospital currently restricted to 3 support people, dependent on staff.”[Shelly]

“[birthing should be] less bureaucratic, less paternalistic and less judgement. The women birthing on country drive the process it is not clinically driven.”[Vivan]

“control [is] usually the health professional telling you what you have to do”[Jai]

Figure 13: Yarning circles were used to capture to engage people.

Elders shared their traumatic stories of attending hospitals when they were having children which include being provided with no care or poor care, feeling unsafe, experiencing racism and not being respected. An Elder shared:

“Still an outstanding fear of Government and hospitals taking [our] babies.”[Sally]

Birthing on Country was viewed as an opportunity for women to have choice and an important part of the community’s future. One participant said:

“Birthing on Country provides women with choices and uniqueness of their experience to be able to mix and match a suite of programs to ensure a culturally safe and healthy birth.”[Della]

Several participants discussed how Birthing on Country was an important opportunity for healing from previous state-enforced trauma, having support for grief and loss where women are not afraid, but instead feel they are in a safe place:
"[Birthing on Country would be] great healing for the community from past experiences." [Ella]

Midwifery care aims to provide women centred care which involves ensuring that women are informed of her choices (social, emotional, physical and cultural needs). This includes having agency, being supported by the midwife; and feeling culturally and clinically safe. Having a trusting and continuity of care relationship with a midwife is pivotal to ensure women are aware of the choices available to them.

Essentially, community members wanted to birth in a place that the mother [and family] are familiar and comfortable with. One participant suggested:

“A house, home or place that means something to them…. a place where the family [can] sleep over and around them, kids playing, cooking and eating.” [Vivan]

Figure 14: Engaging and insightful discussions.

Recommendation

1) Redesign the health system
   a) To improve the pregnancy and birthing outcomes for Australia’s First Nation people, it is essential that key stakeholders actively participate and invest in redesigning the health system. The system redesign should be a transformative and collaborative process with each stakeholder contributing to a pool of resources and providing their unique skills and knowledge. Potential collaborators include: Waminda, NSW Health, Aboriginal Medical Services (AMSs) and Public Health Network.

   b) All maternal and infant health and wellbeing service providers in the Illawarra Shoalhaven Region to review, and were necessary re-orientate, services to ensure that services are ‘mother and child centered’ which also accounts for the social and cultural determinants of health and wellness and international best practice.

   c) Waminda take the lead on the redesign by approaching potential collaborators to join a Multiagency Steering Committee (see: Embed community activation-investment-ownership

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5 NSW Health is used in its broadest term to include for example the Aboriginal Maternal Infant Health Strategy (AMIHS) Program and the Illawarra Shoalhaven Local Health District etc.
below) to work in partnership to provide an integrated and comprehensive model of care that includes a **Midwifery Group Practice (MGP)** for Indigenous families in the region.

d) Waminda to be the lead organisation in the delivery of an **integrated 24/7 Indigenous MGP**.

e) Illawarra Shoalhaven Local Health District to negotiate a **Collaborative Agreement** with Waminda that enables midwives employed in the MGP to provide birthing services at the hospital or home, and will also be extended to include the birth centre when it is operational.

f) The Australian College of Midwives (ACM) to take the lead in urgently finding a solution to the insurance issues that restrict access and insurance cover for midwives employed in an Aboriginal and Torres Strait Islander Community Controlled Health Organisation (ATSICCHO) to provide care in the hospital, the birthing centre and the home.

**Safe Place**

All participants agreed with the importance of having a safe place to birth. Safety included the cultural, spiritual, clinical and physical. A spiritual and cultural space would embrace cultural birthing practices including ceremony (birth being the first ceremony a person has in their life). Clinical safety would include the receiving quality care by all staff i.e. clinicians, support staff and administrative staff. The safe physically place would provide security and assurance to the mother especially in the situation of inter-personal violence. Elders shared:

“... knowing traditions, nuances, family dynamics. Sometimes it’s the grandmother and other significant women who are supporting and the male partner takes a back seat during the birth and may be supported by other males.”[June]

“... [Knowing] women’s and men’s business and knowing how this plays out during the birth e.g. father of child is not allowed at the foot of bed during birthing, silence may be requested.”[Jen]

“... mixing western medicine with Aboriginal medicines example. mutton fish, geebungs, gum, clay, darmas, oysters (soul food).”[Vivan]

“... [women] being accepted for who they are. Sometimes Aboriginal cultural protocols and ways of greeting and community can be seen by non-Indigenous people as unacceptable or unprofessional e.g. patient and family kiss the nurse on arrival or swear which is seen as unacceptable.”[Amy]

The women also spoke about the significance of birthing on their ‘country’ or as close to community as possible. A participant shared:

“[I felt] isolated and lonely by birthing away from Country and family.”[Dena]

“I want the option of having women Elders doing ceremony with me during my birth, song, dance, plants and bathing in ‘right’ water.”[Tia]

“Protection by family to speak up on women’s behalf as a woman may lose her voice in labour.”[Ali]
“...mothers want to continue play a caring role for other children, especially if the siblings are under five, the mother is a single mother or she is the primary carer. This reduces stress on the mother and allows for the siblings to be part of the birthing experience on country.” [Suz]

**Recommendation**

2) **Wellbeing and Birthing Place**

- a) Design and build a multi-purpose **Koori Wellbeing Birthing Place (Facility)**, which will deliver comprehensive holistic maternity care for all women and birthing services for women with no identified risk in pregnancy (refer to Figure 2). The service and facility is mother and child centred as well as allowing for family involvement as determined by the mother herself. **Aboriginal cultural integrity** provides the governing ethos for the services and facility. The facility design is to incorporate a safe space for women who may be experiencing trauma or distress e.g. interpersonal violence, and require short to medium term recovery and accommodation. This may include crisis accommodation for stays up to about one month when clients will then move on to transitional housing off site.

- b) Family Wellbeing Workers (FWW) and midwives in the MGP to work collaboratively in ensuring a woman focused service. Midwives are a key advocate of the **mother’s choice** for her birthing experience, which also includes advising women of the birthing process that is, birthing practice and places.

- c) NSW Health to work with Waminda and other stakeholders, through the Steering Committee, to assist in developing the risk management strategy for the development of the Koori Wellbeing Birthing Place. This should be based on previous work conducted prior to opening the Ryde and Belmont Level 2 birthing services in NSW. Key people could include: Prof Michael Nicholl, the Senior Clinical Advisor Obstetrics to NSW Health, Dr Jane Raymond, Midwifery Advisory NSW Health, Prof Sally Tracy and Dr Donna Hartz who were key to the development and implementation of the Ryde service.

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*Figure 15: Culture and cultural practices was important to Birthing on Country.*

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6 The Family Well Being Worker would be an Aboriginal person from the local community.
All participants agreed on the importance of a clinically and culturally safe workforce. Women shared experiences where the tension between clinical staff (e.g. a midwife and a specialist arguing about the care to be provided to the mother). The women expressed that they felt judged negatively and did not feel they had a trusting relationship with the hospital staff or their midwife. A number of women described the relationship with the midwife as being ‘under surveillance’.

Participants share the following experiences.

“Racism!! Huge problem in the area when accessing hospital.” [Deann]

“I felt I was a bad mum] I wanted to breastfeeding baby without being told how to hold baby and [the midwife] recording every interaction within the day. This information can be recorded from a simple conversation to an observation or conversation with family members.” [Vivan]

One suggestion was for an in-hospital advocate to be there for the women when they needed them.

Service provides discussed how they were reflective of their clinical practice and worked hard to ensure that they provided women centred care:

“[The Service should be about] strengthening the relationship with midwives.” [Carmel]

Community members and providers agreed that increasing the Koori maternal and child health workforce was a priority. During the yarning circles, a number of women expressed interest in pursuing a career as a midwife but were deterred because they would have to live/travel to Sydney or Wollongong.

“Aboriginal women will open up to Aboriginal staff in hospital.” [Lynn]

Figure 16. Waminda health worker Hayley Longbottom goal is to become a Koori Midwife.

Recommendation

3) Invest in the workforce
   a) A clinically and culturally safe maternal and child health workforce in the Illawarra Shoalhaven Region is a priority. NSW Health staff employed in the Illawarra Shoalhaven region to undertake mandatory annual cultural safety training which is to be delivered in partnership with an Aboriginal Community Controlled Organisation.

   b) Cultural safety training to be an integral component of the Collaborative Agreement between Waminda and NSW Health.
c) NSW Health to allow MGP midwives to participate in the maternity specific mandatory training and upskilling of which will be part of the Collaborative Agreement with Waminda.

d) NSW Health continue to invest in increasing the size and capability of the Aboriginal maternal and infant health workforce. There should be an emphasis on recruiting, retaining and graduating Aboriginal students and clinicians from the Illawarra Shoalhaven Region.

e) Universities are encouraged to:

i) Implement a systematic ‘pipeline’ that is designed for the increased recruitment and graduation of Aboriginal midwifery and child health students;

ii) Provide off-base training to enable Aboriginal students to conduct the majority of their studies within the Region; and

iii) Develop a collaborative education agreement that enables Indigenous students to gain clinical experience in the hospital and primary health care setting.

All participants expressed frustration on how maternal and infant services were often fragmented and hard to access. For example, some services provided antenatal care only, some antenatal care only if women were under 25-years, some postnatal or women’s health care only, some would provide postnatal and infant health services, some provide home visiting but others did not provide transport or care in the home. No services provided birthing care from a midwife who the women had an opportunity to meet in pregnancy. Women felt they had to navigate a health and social support system that was designed to exclude them rather than include them, with some service providers also unsure of what services were available locally.

Service providers shared the examples about the difficulty in providing integrated and timely services for women especially women with complex needs. Comments were made how funding decisions were made in Sydney and it didn’t reflect the needs in the region thereby limiting the services they could provide in the community. Participants unanimously agreed that services need to be comprehensive and integrated into a system of care and services. Pregnancy and birthing was only one part of the journey for Aboriginal children to get the best start in life and women need to able to access a suite of clinical and support services. The discussion was solution focused and a number of options were proposed. One participant suggested that:

“Continuity of care for whole of life and all aspects.” [Marion]

There was a discussion on local leadership to urgently redesign services in order to implement a different model of care. The importance of senior management and organisations working in partnership was considered very important to change the current situation. As one participant said:

“[We need] community leadership [and] advocacy is not enough, there needs to be more control, local governance. Representing the needs of community, responding to demand, and diverse mix of Aboriginal communities, [we] should modify as things take shape.” [Irenie]

Ensuring the Birthing on Country was done appropriately and informed by Aboriginal ways of knowing and doing a participant proposed:

“[leaders and organisations to] form a cultural taskforce to review policies to ensure there is a cultural lens over everything that is done implemented for Koori women.” [Vivan]
Recommendation

4) Strength Family Capacity
   a) Strengthening the capacity of families is critical to the long-term health and wellness of the mother and baby and should be seamlessly integrated with maternal and infant health services. The Aboriginal community should be involved with the design and delivery of the activities and services. A localised ‘strengthening family capacity’ strategy could be developed to cover the life course of the mother and child e.g. cultural revival, trauma and attachment informed care, resilience, family wellbeing, skills development and employment opportunities etc.

   b) Families are critical in the pregnancy, birthing and parenting journey. Service providers to employ active strategies as informed by the mother, to engage the family in the longer term. Family support and wellness workers to provide seamless integration of comprehensive services that continue to strengthen the capacity of the mother and family.

   c) Integrated and Comprehensive Women and Child Wellbeing and Health Services

      i) A continued investment in, and collaboration with, Waminda to provide comprehensive and integrated mother and children centred services throughout the Illawarra Shoalhaven Region. Women and children would be able to access a suite of services including:

         (1) Maternal and Infant Health Services including case load midwifery (to be available for women of any risk status, midwives to work within a MGP)
         (2) Outreach or onsite services may include: obstetrician, ultra-sonographer, diabetic education, dietician, women’s health and pediatric services including reproductive, contraceptive, sexual health services, smoking cessation, dental, immunization, growth assessment and monitoring for well babies and allied health services i.e. psychologist, perinatal mental health workers, social worker, occupational and speech therapist;
         (3) Family Wellbeing Workers (FWW) to support the women throughout their pregnancy, birthing and postnatal journey which may include coordinating wellbeing services, advocacy and engagement with health and human services as agreed to by the client.
         (4) Legal and advocacy advice and support;
         (5) One-stop-shop for accessing capacity building programs, welfare support and shop front for Commonwealth or State agencies e.g. Centrelink, housing etc.

Participants talked about the need for intensive support, especially when things went wrong. They suggested that women have plans in place that include the ability to ‘dial and aunty’ or ‘dial an uncle’ when dads need additional support. Grand mothers against removal were also mentioned as a potential source of support. Community engagement activities that included going out On Country, to special places such as the traditional birthing pools were suggestions for strengthening wellbeing.

Recommendation

5) Embed community activation-investment-ownership
   a) Elders and cultural knowledge holders are invaluable resources that can contribute positively to the birthing and parenting experience. Waminda to seek input from their Cultural Committee and local Elders Committees (groups) on how Elders and knowledge holders can be included in the Birth on Country program design and delivery, and the birthing facility design.
b) A model of governance that is informed by the Aboriginal community which will provide the foundation (ways of knowing, doing, seeing and being) for development and delivery of mothers and children centred services. That is, services delivery by the community for the community.

c) Waminda to Chair a Multi-agency/stakeholder Steering Committee to work collaboratively to deliver culturally safe, evidenced based and high quality maternity and child health services.

Conclusion
The Working Group applied a methodology and methods that aligned with Aboriginal ways of knowing thereby privileging the voices of the Aboriginal women when discussing Birthing on Country and how it could occur in their community. Our approach identified the existing barriers experienced by mothers and families and proposed a number of recommendations that are mother-child centered, community based, involves inter-agency collaboration and more importantly strength based. The recommendations were informed by an examination of available literature, engaging with service providers and capturing the concerns and aspirations of the women in the Illawara Shoalhaven Region.

The success of the implementing all the Birthing on Country recommendations is highly dependent on the local context and the Working Group is optimistic that there are a number of opportunities for this to occur. The leaderships and commitment demonstrated by Waminda Board, Chief Executive Officer and staff to improve the birthing outcomes and community engagement has been exceptional. Discussions with services providers in the region suggest that they are willing to enter arrangements to work collaborative thereby improving services to the women in the Region.

All key stakeholders need to demonstrate leadership ranging from the Executive Level, to policy makers and front line services providers, with the key being mother-child centered care. Each agency can contribute specialist skills and services to Birthing on Country which needs to implement an innovative and efficient model that reflects the needs of Aboriginal mothers and babies.

Figure 17: Recommendations were informed by community participants.
References


2. Kildea, S., F. Magick Dennis, and S. H., Birthing on Country workshop Report, Alice Springs, 4th July. 2013, Australian Catholic University and Mater Medical Research Institute on behalf of the Maternity Services Inter-Jurisdictional Committee for the Australian Health Minister’s Advisory Council: Brisbane.


18. Kruske, S., Characteristics of culturally competent maternity care for Aboriginal and Torres Strait Islander women. 2011 Maternity Services Inter-jurisdictional Committee for the Australian Health Ministers Advisory Council, .

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<tr>
<th>Number</th>
<th>Author/Institution</th>
<th>Title and Details</th>
</tr>
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Appendix 1: Reports

The following documents should be used in conjunction with this report:

- Birthing on Country Workshop Report [1]
- The National Aboriginal Health Plan (2013-2023) [13]
- Primary Maternity Services in Australia Framework for Implementation [14]
- Core Competency Model and Educational Framework for Primary Maternity Services [16]
- Characteristics of culturally competent maternity care for Aboriginal and Torres Strait Islander women [18]
- National Maternity Services Capability Framework [19]
- Nomenclature for models of maternity care: literature review [20]
- National Guidance on Collaborative Maternity Care [21]
- The Australian Rural Birthing Index Toolkit: A resource for planning maternity services in rural and remote Australia [22]
- National Framework for the Health Services for Aboriginal and Torres Strait Islander Children and Families
Appendix 2. Community Yarning Circles

The yarning circles discussion represented diagrammatically in the following pages, with first diagram identifying the barriers and the second diagram illustrating the services needed in the mother-child centred service.

The barriers that mothers, babies and families currently experience in the antenatal, birthing and postnatal care.

The services and support needed to wrap around mothers, babies and families to improve birthing and health outcomes.
Inconsistent MW Care i.e. safety, treated, OBG, EBC, limited choices, no continuity of care

Dont feel safe or respected by staff

No continuity of care & lack of integration

Staff don't listen to what women are saying

Not supportive family

Previous bad experiences with hospital

Dont know what the choices are

Barriers & gaps
<table>
<thead>
<tr>
<th>Collaboration</th>
<th>Community Leadership &amp; ownership</th>
<th>Birthing Place</th>
<th>Community role models &amp; mentors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Partnership with the local hospital, GP's</td>
<td>• By the women</td>
<td>• Outside the current hospital system</td>
<td>• Community obligation</td>
</tr>
<tr>
<td>• Community organisations support</td>
<td>• model of governance</td>
<td>• self contained room</td>
<td>• women have many different roles in the community</td>
</tr>
<tr>
<td>• Early care/intervention in schools</td>
<td>• reflect diversity in community</td>
<td>• Inclusive of family</td>
<td>• cultural midwives, doula</td>
</tr>
<tr>
<td></td>
<td>• Checks &amp; balances</td>
<td>• A safe place e.g. DV,</td>
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<td></td>
<td>• Waminda has a key role</td>
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<tr>
<th>Connection &amp; engagement</th>
<th>Safe Clinical &amp; Culturally workforce</th>
<th>Service model</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Confidence &amp; trust</td>
<td>• working side by side i.e. consultation and collaboration</td>
<td>• Approachable, accessible,</td>
<td>• Family support 24/7</td>
</tr>
<tr>
<td>• knowledge &amp; choices</td>
<td>• Aboriginal workforce pipeline</td>
<td>• outreach services</td>
<td>• women have many different roles in the community</td>
</tr>
<tr>
<td>• having control</td>
<td>• MW training</td>
<td>• Integrated care i.e. MW, specialists (esp female specialist, allied health etc)</td>
<td>• include dads</td>
</tr>
<tr>
<td>• education with community</td>
<td></td>
<td></td>
<td>• Out of home care</td>
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<tr>
<td>• early engagement</td>
<td></td>
<td>• Continuity of care 24/7</td>
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<tr>
<th>Elders &amp; Culture</th>
<th>Parenting Skills</th>
<th>Healing place</th>
<th>External Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Need Elders blessing</td>
<td>• Learning parenting skills, accessible</td>
<td>• Grief and loss i.e. still birth, rape, miscarriage, trauma</td>
<td>• External support services, seeing intergenerational negative behaviours leading to cycle of drugs, alcohol, violence</td>
</tr>
<tr>
<td>• Womens business - cultural protocols</td>
<td>• keeping families together</td>
<td>• spiritual care &amp; healing</td>
<td></td>
</tr>
<tr>
<td>• include traditional knowledge holders</td>
<td>• parents need to teach their kids</td>
<td>• Mental health and social wellbeing, PND</td>
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</table>
Albion Park Community Yarn – Rail Community Centre (29/8)

Barriers & gaps

- Families are included in the birthing
- Things go wrong & there's no support
- Need to support families with disabilities
- Women don't know their choices
- Women don't feel safe
- Don't know midwives in hospital
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<tbody>
<tr>
<td>• Identity</td>
<td>• normalise birth</td>
<td>• community women need to be involved</td>
</tr>
<tr>
<td>• Sense of belonging &amp; together</td>
<td>• needs beautiful environment</td>
<td></td>
</tr>
<tr>
<td>• Community wide support</td>
<td>• A safe place e.g. DV</td>
<td></td>
</tr>
<tr>
<td>• Community driven</td>
<td>• pharmacy, cafe</td>
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<tr>
<td>• Support, ownership &amp; responsibility</td>
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<tbody>
<tr>
<td>• Confidence &amp; trust</td>
<td>• culturally 'safe' and respectful workers, MW's and doctors</td>
<td>• Continuity of care 24/7</td>
</tr>
<tr>
<td>• education on choice, reproductive and sexual health</td>
<td>• component workforce</td>
<td>• whole family involvement</td>
</tr>
<tr>
<td>• need stakeholders forum between services</td>
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<td>• more home visiting</td>
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<tr>
<td>• need parenting programs/support</td>
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<td>• Family support 24/7</td>
<td>• Need Elders</td>
<td>• resilisence</td>
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<tr>
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<td>• cultural knowledge holders</td>
<td>• healing support &amp; personal care</td>
</tr>
<tr>
<td>• Dial a Uncle/Aunty</td>
<td>• protocols of womens business</td>
<td>• grief &amp; loss</td>
</tr>
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<td>• need parenting programs/support</td>
<td>• need to go out to country</td>
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<td>• encourage healthy living</td>
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</table>
Barriers & gaps

- Institutional racism
- Stripping of confidence & feelings of inadequacy
- Women are isolated
- Families not include in birthing process
- Women unaware of choices
- Staff not culturally safe
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<tbody>
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<td>- community driven</td>
<td>- women have many different roles in the community</td>
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<tr>
<td>- women to take control</td>
<td>- cultural midwives</td>
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<tbody>
<tr>
<td>- knowledge &amp; choices</td>
<td>- culturally safe workforce</td>
</tr>
<tr>
<td>- education for women - life coarse changes</td>
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<tr>
<td>- Dial a dad/aunty</td>
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<td>- involve dads</td>
<td>- cultural knowledge holders</td>
</tr>
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<td>- Parenting support skills</td>
<td>- identity &amp; connection to country</td>
</tr>
<tr>
<td></td>
<td>- Traditional birthing places</td>
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<td></td>
<td>- Promote birthing on country</td>
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<td>- 24/7 support</td>
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</tbody>
</table>
Wreck Bay Community Yarn, Community Centre (31/8)

- Barriers & gaps
  - Medically driven model of care
  - Health care resistant to change
  - Barriers to access i.e. transport, engagement
  - Service not culturally sensitive
  - Lack of holistic services
<table>
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<th>Collaboration</th>
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<td>• strategic alliances</td>
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<tr>
<td>• integration/connection</td>
<td>• Driven by the women</td>
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<td>• transport</td>
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<td>• passionate</td>
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<td></td>
<td>• focus on relationships</td>
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<td></td>
<td>• culturally safe</td>
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<td></td>
<td>• Need a FWB worker</td>
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<th>Social health &amp; wellbeing</th>
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<tbody>
<tr>
<td>• Family support 24/7</td>
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<tr>
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<td>• involve Elders especially cultural knowledge</td>
<td></td>
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<td>• culture i.e. traditional birthing practices and places</td>
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<td>• ATODS</td>
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<td></td>
<td>• Advocate</td>
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</tbody>
</table>
Barriers & gaps

- Transport
- Women don't know the pregnancy & birthing journey
- Isolation
- Non-compliant
- Family not included
- Grief & loss

Ulladulla Community Yarn, Community Resources Centre (31/8)
### Collaboration
- Strategic alliances

### Community Leadership & ownership
- Community driven and owned

### Birthing Place
- A safe place
- Strong healing place

### Connection & engagement
- Connection with families including aunties, uncles
- Promote strong women

### Safe Clinical & Culturally workforce
- Aboriginal workforce pipeline
- Culturally component

### Service model
- Continuity of care 24/7
- GMP
- Integration of care

### Family
- Family support needed
- Include dad, uncles, grandfather

### Elders & Culture
- Elders & traditional knowledge holders
- Cultural revival program
- Birthing ceremony & celebration

### Parenting Skills
- Learning parenting skills, accessible
- Keeping families together

---

**Ulladulla Community**
Community Leadership & ownership
• strong womens group, community yarning circles
• model of governance include Elders
• Community capacity building

Birthing Place
• Outside the current hospital system
• Inclusive of family
• women knowledge & choices e.g. water birth, birthing at home

Community role models & mentors
• Community obligation
• belonging, breastfeeding
• understanding your own health
• Create a sense of belonging

Safe Clinical & Culturally workforce
• respect for Aboriginal culture
• respect privacy
• Aboriginal MW
• cultural awareness training

Service model
• Integrated care i.e. MW, specialists, allied health etc
• Continuity of care
• 24/7 promote natural births

Family
• Family support 24/7
• follow up supports e.g. chronic health or birthing issues
• father to be involved

Elders & Culture
• Baby cycle - involving Elders in the growing up of babies to adults

Parenting Skills
• Learn parenting skills
• baby health centre: 0-5yrs

Batemans Bay