Dhuwal-guyaŋanhawuy romdja ga roŋirra rälin, nhaldjarra gan yolŋuy dhawal-guyaŋan ŋäthil baman dhiyal Northern Territory limurruŋgal, North East Arnhem Land.

Birthing on Country for the best start in life: returning childbirth services back to Yolŋu mothers, babies and communities in East Arnhem, Northern Territory.

NHULUNBUY WORKSHOP REPORT

October 2020

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MOLLY WARDAGUGA RESEARCH CENTRE
THE BEST START TO LIFE

CHARLES DARWIN UNIVERSITY AUSTRALIA

YALU ABORIGINAL CORPORATION

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First Nations Terminology

This report respectfully uses the term *First Nations* to refer collectively to the Aboriginal and Torres Strait Islander peoples of Australia.

NDIS	National Disability Insurance Services
Balanda	Non-Indigenous person
Djäkamirr	A skilled companion who can provide support, resources and information during pregnancy and childbirth, also known as a doula
MNCH	Maternal, neonatal and child health indictors
MWRC	Molly Wardaguga Research Centre, Charles Darwin University
NGO's	Non-government organisations
NT	Northern Territory, Australia
PATS	Patient Assistance Travel Scheme
RISE	Acronym used in the Birthing on Country implantation model: R=redesign health service, I=invest in workforce, S=strengthen families, E=embed community governance, engagement and control.
Yolŋu	Australian First Nations people whose ancestral country is north-eastern Arnhem land, Northern Territory, Australia

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EXECUTIVE SUMMARY

Australian First Nations women and babies experience profound maternal and infant health inequities that are not improving in line with national targets. Yolŋu women from the East Arnhem region in the Northern Territory experience some of most profound health and structural inequities in all of Australia. The Nhulunbuy workshop was convened by the Caring for Mum on Country project team to respond to the requests from Yolŋu women in Galiwin'ku to engage with maternity service managers and clinicians about their community's wishes for future maternity services. Yolŋu women from Galiwin'ku, alongside researchers from the Molly Wardaguga Research Centre, met with local and regional maternity service providers to disseminate the findings of the Caring for Mum on Country project and to workshop the possible redesign of maternity services. The Galiwin'ku community aims to be the national 'very remote Birthing on Country exemplar demonstration site'. To achieve this service redesign, a co-ordinated, collaborative, community-driven, participatory action research approach will be necessary, using the RISE implementation framework, to better understand what works for First Nations communities. Yolŋu women need to be supported in leading all aspects of the redesign and to drive community engagement and participation.

KEY RECOMMENDATIONS

There is wide community and maternity service support to redesign the maternity system in North East Arnhem Land, to facilitate the best start in life. The RISE framework was endorsed as a useful tool to guide this process. Service change requires collaboration and communication among and between service providers and with Yolŋu communities. Priorities are:

- Redesigning the system-increasing co-ordination, communication, collaboration, and continuity of carer, investigate the reasons non-Yolŋu health staff leave and incorporating cultural practices and support into childbirth care.
- Investing in the workforce- recruiting and supporting more midwives and doctors to provide culturally and clinical exceptional care, increasing the numbers of First Nations midwives and student midwives, rolling out the djäkamir pilot program through the region and streamlining community liaison and support roles that exist in multiple agencies.
- Strengthening the capacity of Yolŋu families- instigating culturally appropriate reproductive health literacy education, enabling cultural practices to be conducted across the maternity journey in all settings (tertiary and primary care), keeping families strong by physically connecting them with Patient Assistance Travel Scheme (PATS) funds, providing family-friendly spaces in the hospital and addressing overcrowding of houses in remote communities.
- Embedding Community Governance, Control and Engagement- recruiting and supporting Yolŋu women in leadership roles, provide stakeholder access to health outcome statistics, increasing access to interpreters and developing a regional Steering Committee to drive and coordinate systematic change to address the equities.

OVERVIEW

Australian First Nations women have given birth on their country, supported by family and cultural practices until disruption from European colonisation.[1] First Nations women, babies and families experience profound health inequities when comparing health outcomes to non-Indigenous Australians. A disproportionate number of First Nations women experience adverse outcomes in pregnancy and birth and Yolŋu women express concern about these outcomes and other pressures such as a lack of inter-birth interval. For the past ten years, there has been little or no improvement in key maternal and child health (MNCH) indicators. Maternal death for First Nations mothers is 3.7 times higher than for non-Indigenous women in Australian,[2] and perinatal deaths, largely driven by complications of pregnancy, are twice as high, though slightly improved between 2008 and 2018.[3]

Preterm birth is the largest contributor to infant and child mortality and is associated with significant long-life health inequities including developmental and behavioural problems with negative impacts to their schooling and educational attainment,[4] childhood disability, and chronic diseases in adulthood.[5] Preterm birth rates are 1.7 times higher for First Nations babies and highest in the remote regions across the Top End of the Northern Territory (NT), where approximately one in five babies are impacted (18-22% a year) compared to NT Aboriginal (17%) and NT non-Indigenous women (7%).[6]

Prevention of avoidable preterm birth in First Nations families is a major public health priority in Australia. Risk factors for women in remote NT,[7] and East Arnhem in particular, are prevalent and include: only 57% of women attending antenatal care in the first trimester and very high rates of smoking in pregnancy (61%).[6] Inadequate treatment of conditions that are associated with preterm birth are reported (e.g. anaemia, urinary and sexually tract infections) [8] and high rates of maternal anaemia in pregnancy (46%) are contributing to the high rates of post-partum haemorrhage (~38%)[6] and infant anaemia (~65%).[9,10]

Government policy has seen the closure of many regional and remote maternity services across Australia, resulting in centralised maternity management in tertiary hospitals and inequitable distribution across Australia,[11] necessitating the relocation of many women from remote communities to major centres.[12] This disproportionality impacts First Nations families who are a larger proportion of Australia's remote population with research finding that closure

of services adds social risk to women and families, which exacerbates clinical risk.[13] Centralisation of maternity services is also correlated with increasing rates of babies being born before arrival to hospital, often unplanned in transit and with no access to midwifery or medical support.[14]

Birthing on Country is an international social justice movement about redressing colonisation and returning childbirth services back to First Nations communities and their control.[1] Birthing on Country is a metaphor for the best start in life for First Nations families.[15] Birthing on Country Services are complex, evidence-based interventions that include a redesigned maternity service prioritising a First Nations workforce and governance; 24/7 continuity of midwifery carer; holistic support; programs that strengthen cultural identify and connection; and have integrated care pathways across primary and tertiary services.[16] An urban exemplar Birthing on Country service site has been established in Queensland and its evaluated impact includes a 50% reduction in preterm birth and 600% increase in First Nations employment.[17] Few interventions designed to prevent preterm birth in socio-economic disadvantaged and vulnerable women in high-income countries [18] have been as effective highlighting the importance of this research. The intervention was complex and drove structural sustainable changes to the way care is provided. This reduction in preterm birth is unique in Australia considering there has been no change to national rates for First Nations women since the Closing the Gap strategy was announced in 2008.[3]

In October 2020, the Caring for Mum on Country project convened a workshop in Nhulunbuy, NT. This was in response to previous Galiwin'ku community consultations in which senior Yolŋu women called for birthing services to be returned to their island; and that maternity services should better support and incorporate Yolŋu cultural care during pregnancy and birth. Yolŋu women from Galiwin'ku, alongside researchers from the Molly Wardaguga Research Centre at Charles Darwin University gathered in Nhulunbuy to spend time with local service clinicians and managers to explore how a *Birthing on Country* service redesign could improve birthing and health outcomes for Yolŋu mothers, babies, and families. The aims of the workshop were to:

- Facilitate Yolŋu community engagement and feedback to services (local and regional services) who deliver maternity care to Galiwin'ku women during their pregnancy and childbirth journey
- Raise regional awareness of how Birthing on Country Services can address First Nations health inequities
- Test the relevance of the Birthing on Country implementation RISE framework for service managers and clinicians
- Use the RISE framework, to workshop community and regional priorities for maternity service redesign

SETTING

The provision of quality maternity and reproductive healthcare in the NT is challenged by the region's unique characteristics. This includes its large and very remote geography, small but sparsely distributed population, extraordinary linguistic diversity, the high turnover of non-Indigenous professional staff; alongside entrenched health inequities. While First Nations women in the NT compromise 32% of all women giving birth, around 58% of these women live in remote areas with limited reproductive health services and where care during childbirth is not offered.[6,19] This means that many First Nations women are routinely evacuated into regional centres to access the full gamut of reproductive health services; and often for pregnant women, they give birth alone in hospital without the linguistic, cultural and emotional support of their partner, family or community networks.[20] The ancestral country of Yolŋu people is known by the Western name of North East Arnhem Land and includes the island community of Galiwin'ku (See Figure 1). Women in this region travel for planned hospital birth at either Gove District Hospital or Royal Darwin Hospital. Gove Hospital, located in Nhulunbuy is small 30 bed acute care facility providing medical, surgical, paediatric, respite and maternity services. Patients from 15 remote communities are referred to the hospital for inpatient, outpatient and specialist care, including childbirth.[21] In 2017, 142 babies were born in the hospital including 95 First Nations babies.[6]

FIGURE 1: NORTH EAST ARNHEM LAND, NORTHERN TERRITORY

WORKSHOP APPROACH

The one-day workshop was divided into two parts. The first session comprised of presentations about Birthing on Country, alongside the outcomes of *Caring for Mum on Country* project based in Galiwin'ku. The second session was interactive with participants breaking into five smaller groups to discuss and record priorities for maternity service redesign. The RISE framework was used as a tool to guide discussions with the small groups using each RISE component as a topic for discussion. Small group findings were reported back to the larger group and collated (See Appendix 1).

PHOTOGRAPH 1: REPORTING SMALL GROUP DISCUSSIONS. PHOTO CREDIT: PAT JOSSE.

PARTICIPANTS

Over 40 participants attending the workshop comprising of Yolŋu women and leaders, local midwives, doctors, child health nurses, service managers, key leaders from NT Health, Miwatj Health Service, and other service providers. This included many participants who identified as a First Nations people.

Informed written consent was sought from participants who stayed for the interactive afternoon session.

FINDINGS

FIRST SESSION-PRESENTATION SUMMARIES

DIRECTOR'S PRESENTATION- MOLLY WARDAGUGA RESEARCH CENTRE, CHARLES DARWIN UNIVERSITY

Professors Yvette Roe and Sue Kildea introduced the audience to the Molly Wardaguga Research Centre (MWRC), Charles Darwin University. Professor Sue Kildea spoke about her mentor Molly Wardaguga (1938-2009), a traditional midwife and Elder from Maningrida, and her belief that working together, First Nations and other Australian people side-by-side, we can make a difference to birthing outcomes for First Nations people. Professor Kildea presented the Australian and International evidence on redesigning maternity services; and reflected on perinatal outcomes in the region, including one of the highest rates of preterm birth in Australia.

PHOTOGRAPH 2: EXPLORING THE EVIDENCE FOR BIRTHING ON COUNTRY. PHOTO CREDIT: PAT JOSSE.

Professor Roe explained the RISE Birthing on Country implementation framework. The four lettered RISE acronym stands for: 1) **R**edesign the health system, 2) **I**nvest in the workforce; 3) **S**trengthen the capacity of families; and 4) **E**mbed community governance and control. (See Figure 2)

The RISE Framework

Implementation phases

Intervention points	Standard Care	Phase 1	Phase 2	Phase 3	Phase 4
	Redesign maternity care				
R	Routine care in community or hospital	Specific Indigenous antenatal or postnatal programs	Continuity of carer with caseload midwifery & Indigenous workers	Integrated community-based caseload midwifery & wrap around holistic services	Integrated Service/Hub/ Birth Centre & choice of birth place
	Invest in the health workforce				
I	No Indigenous identified positions Workforce with limited cultural understanding	Identified positions Cultural capabilities training	Pathways & support for Indigenous staff Measuring progress of cultural capabilities	Indigenous workforce pipeline and mentoring Minimum standards for culturally capable workforce	Culturally and clinically capable (exceptional) workforce
	Strengthen families				
S	Ad hoc or non Indigenous antenatal or parenting programs	Formal strategies engage families in maternal and infant health programs	Wellbeing framework to strengthen family capacity	Community developed cultural strengthening antenatal & parenting programs	Strong resilient families
	Embed community investment-ownership-activation				
E	No Indigenous engagement strategy	Multi stakeholder engagement e.g. *Community Consultation*	Formal system of governance e.g. *Advisory Group*	Transformative and strategic governance e.g. *Steering Committee*	Indigenous ownership

FIGURE 2: BIRTHING ON COUNTRY SERVICE IMPLEMENTATION RISE FRAMEWORK

CARING FOR MUM ON COUNTRY PROJECT TEAM

Supported by Associate Professor Elaine Ḻäwurrpa Maypilama and Dr Sarah Ireland, Yolŋu from the Galiwin'ku Yalu Aboriginal Corporation- Evelyn Bukulatjpi and Dorothy Bukulatjpi - shared the outcomes and impacts from their 'Caring for Mum on Country' project. The women spoke about the history and aspirations for childbirth services in Galiwin'ku; alongside the importance that cultural caring practices and ancestral knowledge have during childbirth.

PHOTOGRAPH 3: DOROTHY YUŊGIRRŊA (YALU ABORIGINAL CORPORATION), DR SARAH IRELAND (MWRC) AND ASSOCIATE PROFESSOR ḺÄWURRPA MAYPILAMA (MWRC) PRESENT INFORMATION ABOUT THE 'CARING FOR MUM ON COUNTRY' PROJECT BASED IN GALIWINK'KU. PHOTO CREDITE: PAT JOSSE.

They discussed the changes to local childbirth services using the metaphor of a freshwater river flowing to the ocean and the place where the different waters meet as 'Ganma'. This is a cultural metaphor for the turbulence where knowledge systems, meet, exchange and change. (See Figure 3)

Associate Professor Maypilama and Doctor Ireland discussed and explained a reproductive health literacy framework developed during the project- Ŋanakmirriyam Dharuk Ga Mayalimirryaman Miyalkgu Rom -the flesh and skeleton of following women's law.[22] It is embedded on a Pandanus mat a metaphor for the process of working with and integrating Yolŋu and Balanda knowledge systems (See Figure 4). The team discussed the interpretation and translation of the Birthing on Country Implementation RISE framework.[1] (See Figure 4)

FIGURE 3: A YOLŊU RIVER OF CHILDBIRTH CHANGE PRODUCED BY CARING FOR MUM ON COUNTRY PROJECT

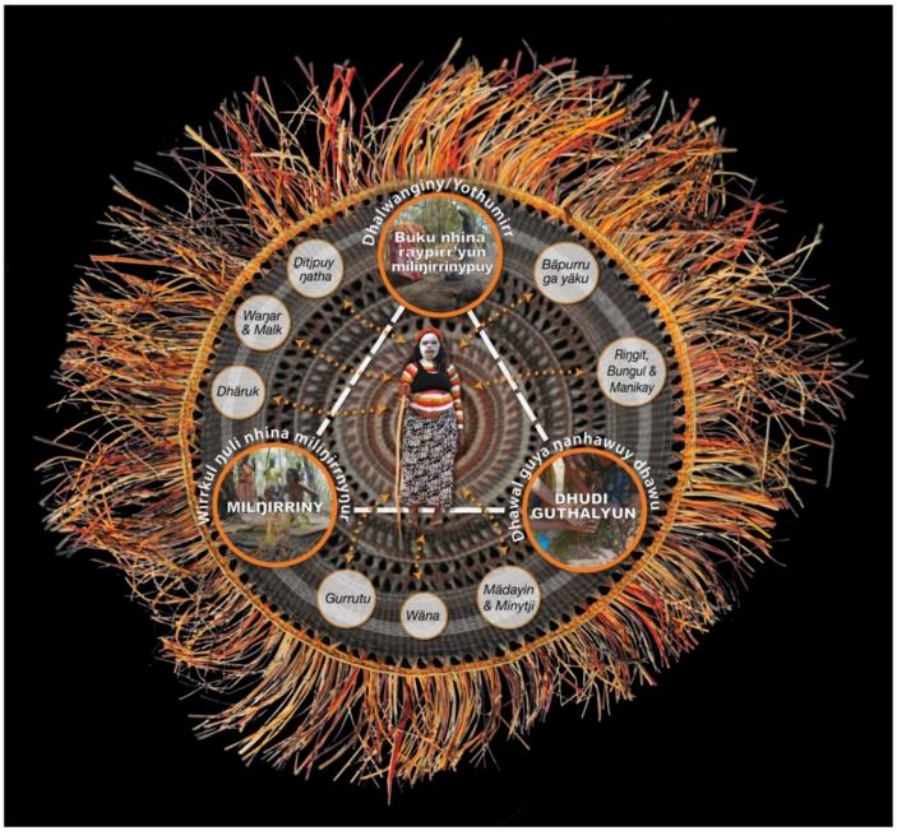

FIGURE 4: ŊANAKMIRRIYAM DHARUK GA MAYALIMIRRYAMAN MIYALKGU ROM – THE FLESH & SKELETON FOR FOLLOWING WOMEN'S LAW©: A REPRODUCTIVE HEALTH LITERACY FRAMEWORK FOR YOLŊU GIRLS AND WOMEN

FIGURE 5: YOLŊU RISE MODEL **(IRELAND, MAYPILAMA ET AL. 2020).**

The Caring for Mum on Country project also piloted accredited doula- childbirth companion-training for Yolŋu women in Galiwin'ku with 11 women graduating from the first course. A short video about Yolŋu doula, known as Djäkamirr- the caretakers of pregnancy and childbirth, was shown https://youtu.be/etfvPLRhjS8

Dorothy Yuŋgirrŋa shared distress over her people's inequitable perinatal health outcomes; and passionately demanded urgent change to improve outcomes for her people, stating that there is urgent need to *'bring the statstics down- the number story for our babies need to get better'*. She stressed that Yolŋu and Balanda can work together. Associate Professor Maypilama noted that Yolŋu do not understand all the decisions that have been made for them and asked that we walk together in the future. The women clearly stated that urgent change is needed, healthy women should be able to birth in Galiwin'ku and that until childbirth is returned to the community, all Yolŋu women need a djäkamirr before, during and after birth.

Audience Contributions

Dr Christine Connors, a public health physician in the Top End of the NT, spoke about the discrimination that still exists and the need to address this, and supported the concept of the Djäkamirr to be rolled out in East Arnhem Land. She reiterated the importance of the work being done, the need for urgent change, and believed it would be supported by the NT government. A/Professor Mish Hill, Acting Chief Nurse and Midwife of the NT, who was involved in the Birthing on Country service redesign in Brisbane, was strongly supportive of working side-by-side, within a safety and quality framework, and noted the importance of not just demonstrating outcomes but applying them.

Djapirri Mununggirri, a representative from Miwatj Health Aboriginal Corporation, spoke about her work in this area over a long time. She was very encouraged by the work that is being done and the common goal to move forward, particularly training of young people. She noted the importance woman's cultural role and praised the Galiwin'ku women for presenting things in a way that can be understood.

PHOTOGRAPH 4: DJAPIRRI MUNUNGIRRI ADDRESSES THE AUDIENCE ABOUT THE WORK INVOLVED IN IMPROVING HEALTH OUTCOMES. PHOTO CREDIT: PAT JOSSE

SECOND SESSION- SERVICE REDESIGN PRIORITIES

The RISE framework proved a useful tool for guiding lively and engaging small group discussion. Several key points emerged from examination of each of the RISE themes, with several encompassed in more than one component.

Improving **collaboration** and **communication** between and among services providers and with community were universally featured in all components and deemed crucial for improving outcomes. It was felt that genuine communication and collaboration between non-government organisations (NGO's), National Disability Insurance Services (NDIS), government housing, hospitals and the increased involvement of community leaders would result in a positive 'collective impact.' Identified ways to increase collaboration included community meetings or roundtables bringing communities, health services, NGO's, and other stakeholders such as schools and child-care together and increased use of telehealth. Participants recognised that health services also need to engage with communities and ask questions about what people want from their health services.

Effective intercultural communication by health services with Yolŋu woman community and more resources in First Nations languages and a co-ordinated health literacy resource approach were recommended, as was more transparency in communication around roles and responsibilities, the use of Yolŋu names and the availability of interpreters. The use of social

media, in particular 'Tik Tok', with messages about health issues was recommended, along with increased use of telehealth to keep families connected, help with case management and to enable low risk women to stay at home longer.

PHOTOGRAPH 5: ASSOCIATE PROFESSOR ĻÄWURRPA MAYPILAMA WORKSHOPS THE RISE FRAMEWORK WITH PARTICIPANTS INLCUDING MISH HILL & GALIWIN'KU ELDER DJANBE MARIKE. PHOTO CREDIT: PAT JOSSE

REDESIGNING THE MATERNITY SYSTEM

When considering Redesigning Health Systems, **continuity of carer** was identified as a major driver of effective maternity service. Redesign should prioritise continuity of carer. It was noted that more remote midwives, flight care services, less staff turn-over, better access to the NT PATS, and improvement of services in the community were needed. A revised model of care should include midwives in every community. Djäkamirr should accompany mothers to hospital, paid for by the PATS system, and some women should also have an escort as a djäkamirr is not a replacement for women who need their partner/ mother/ auntie for support or childcare duties when they are away from community. Several participants thought that **access to health statistics** would be useful for understanding current maternal services and suggested a dashboard with local community data and community reports would be helpful.

Participants thought there should be greater understanding of the **reasons that health staff leave**. It was noted that there are only 10 doctors in the region, 50% male, and that a dedicated female GP for obstetrics was required. A medical outreach Obstetrics and Gynaecology service was also suggested.

Several additions to health services were suggested including the introduction of Yolŋu social workers in community, the recognition of community strengths and identification of strong women. There was a call for **cultural practices to be incorporated into current birthing practices** in hospital including an area nearby for ceremonies (acknowledge the ancestors and pay respect to the land, waters and sea; healing treatments), maternity accommodation; use of a traditional birthing shelter; and incorporation of Yolŋu practices in 3rd stage management including delayed cord clamping, measuring the cord, taking the placenta home for burial; and for women to bring items to connect her to her home country such as earth or a pandanus mat. Midwives needed to understand the significance of the third stage for Yolŋu women. There should be a long term negotiated agreement for women on the care they receive during preganacy and birth. A culturally appropriate place for women and escorts to stay before the birth was recommended, with one local midwife suggesting the re-purposing of empty houses in Nhulunbuy where there were currently 15 houses belonging to a former mining company. The Frangipani room located on the Gove Hospital maternity ward was inadequate being unable to create a homelike non-clinical environment.

Investing in the Workforce

When exploring Investing in the Workforce, participants identified the need for **more midwives and doctors** who could deliver quality antenatal, birth and postnatal care. More general and child health nurses were also needed so that remote midwives can focus on maternal care. More outreach services were also required; currently some communities get monthly visits, others less frequent. More cross-cultural training specific to midwifery for Balanda was also recommended.

Education was needed **to increase First Nations midwife numbers and more Aboriginal health workers**. It was suggested that any Yolŋu Birthing in Country Steering Committee oversee the redesign of maternity services and include Arnhem Land Progress Aboriginal Corporation (ALPA) food stores representatives in their consultations and that there needed to be more Yolŋu across the workforce including receptionists, backed up by a buddy system, work experience, work readiness programs and culturally safe workplaces. In the long term, this would be a pathway to progress career development i.e., 'growing our own'.

Participants universally supported the **roll out of djäkamirr pilot program** to all communities as this was identified as an important initiative in making maternity health services culturally safe. There were calls for Miwatj Health Service and Top End Health Services to invest in the employment of community djäkimirr to care for women during pregnancy, birth and after. It was felt that midwives and djäkamirr would work together; and that djäkamirr should accompany women during emergencies. It was recognised that advocacy is needed through the NT Health Minister and that awareness of midwives and doctors of the program needed to be enhanced.

There also needs to be **integration of community liaison/support roles** such as Maternal Early Childhood Sustained Home-visiting MECH and Strong Women Workers and incorporation of traditional healers, with the use of bush food, medicine, and ceremonies, into workforce. A shortfall in specialised educators such as diabetes educators was identified as an issue as educators currently must come from Darwin. Better cross-cultural induction and supervision was also required so that in the long term, everyone is inducted.

Strengthening the capacity of Yolŋu Families

Participants workshopped Strengthening Families citing the advantage of incorporating programs like **culturally appropriate reproductive health literacy** (preconception education) lead by Yolŋu. Bush camps/retreats and education for young women and a reinvigoration of ceremonial practices such as for girl's period; and then in pregnancy. Antenatal classes for men and antenatal classes that included a range of topics such as Sudden Infant Death Syndrome were recommended. A Strong Men program was suggested, and it was noted that men in some communities are asking to come to antenatal visits and want to be more involved in their partners pregnancy care. The importance of **keeping families connected** through the PATS was discussed and shortfalls in the scheme identified.

Family-friendly spaces in Gove hospital are lacking and there are currently few choices of accommodation in town and a lack of safe spaces. In the long term, a purpose-built facility that can accommodate women in a home like environment and provide cultural activities, food and transport was suggested. Telehealth was also deemed an important method for keeping families connected and assisting in case management, which might allow expectant, mothers to stay at home longer. Overcrowded housing was considered a major issue, as was lack of

food security so that pregnant women could receive adequate nutrition. There is great need for coordinated wrap-around social and cultural support systems.

Embedding Community Governance, Control and Engagement

Participants discussed Embedding Community Governance, Control and Engagement recognising a need for strong **Yolŋu women in leadership roles**. There was discussion about community Boards as some initiatives must go through the Board i.e., health promotion activities and meetings for big decisions. It was felt that more women on Boards would be helpful, though acknowledgement of the cultural sensitivities surrounding discussion about women's business if men are on a board.

The importance of **interpreters** 24 hours across 7 days was reiterated. There was a widely supported recommendation for a Territory wide **Birthing On Country Steering Committee to drive and coordinate systematic change**.

CONCLUSION

The first Birthing on Country workshop in Nhulunbuy successfully facilitated Yolŋu community engagement and feedback to services who deliver maternity care to Galiwin'ku women during their pregnancy and childbirth journey. Attendance by over 40 participants including key local service providers raised regional awareness of how Birthing on Country Services can remove the structural inequities and advance Yolŋu health equities. There was genuine engagement and deep discussion to identify regional redesign priorities. These discussions were guided by the Birthing on Country services implementation RISE framework. The RISE framework was an acceptable and relevant tool for service managers and clinicians. Using the RISE framework, the group was able to successfully workshop community and regional priorities for maternity service redesign.

APPENDIX 1: DETAILED RECOMMENDATIONS FROM BREAK-OUT GROUPS AT WORKSHOP

REDESIGNING HEALTH SYSTEMS	
COLLABORATION	a. Increase collaboration between hospital and women in the community, through meetings, increase use of telehealth, a roundtable to bring communities, NGO's, NDIS, Housing and other stakeholders such as schools, child-care together. b. Increase involvement of community leaders c. A more holistic approach to health d. Health Service needs to ask more questions about what people want. Some practical support such as help to clean and ready the house in community for the new mother e. Balanda could do the CATSINM- 1st people's health course Notes: Why aren't there more community meetings? There is not one representative group but lots of groups
2. Communication	a. Poor communication between organisations - requires streamlining of roles and resources b. More resources in language and a coordinated health literacy resourcing c. More open and transparent communication d. Roles and responsibilities better defined. e. There is an issue with governance as approvals required before education can be done f. Engage more in social media, particularly TikTok, that include messages about healthy babies g. Every conversation in your language so no interpreters but if not possible, interpreters are needed h. Use Yolŋu names first. i. Territory policy and provision of Sex education in all NT schools
3. Continuity of care	a. BOC needs more remote midwives, more flight care, less staff turn-over, better access to the NT Patients Assisted Travel Scheme improving services in the community. The model of care should include midwives and Djäkamirr in every community and continued into hospital and every woman should have an escort b. A dashboard or access to health statistics would be useful c. Why do health staff leave? Wat does the evidence say? d. Medical outreach Obstetrics and Gynaecology to be developed e. 10 doctors in region- 50% male- need a dedicated female GP for obstetrics f. Yolŋu social workers in community, recognise community strengths, identifying strong women g. Area near hospital for smoking ceremonies
4. Djäkamirr	a. A call for Djäkamirr project role out to all communities and for Miwatj/TESS to employ community Djäkamirr to care for women during pregnancy, birth and after b. Midwives and Djäkamirr work together c. Djäkamirr to accompany women during emergencies d. Advocacy is needed through the Health minister e. Telling the story to midwives and doctors f. Access to a birthing champion, who is not the same as the escort g. It is long term, already paired/supported, integrated, workforce certified

5. Culture	a. Use a Yolŋu birth plan b. Women living on homelands also required a Djäkamirr c. Importance of Yolŋu practice in 3rd stage management including delayed cord clamping, measuring the cord and taking the placenta home for burial. Midwives need to understand the significance of third stage. d. Making places more culturally appropriate such as a traditional birthing shelter, (needs aircon). GDH midwives requested a review and advice on Frangipani room, a room where women from remote communities stay while waiting for the birth. A culturally appropriate place for women to stay such as own hotel where escorts can stay was suggested, also the re-purposing of empty houses- currently 15 in N'Buy (Old Sodesco/Rio Tinto hold leases) e. Choice to bring something that connects e.g. - earth, mat. f. Long term negotiated agreement for women on the care they receive
INVESTING IN THE WORKFORCE	
1. Djäkamirr program	a. Cert IV Djäkamirr program into midwifery- different midwifery training model b. Train Djäkamirr in Yolŋu communities
2. Health staff	a. More midwives and doctors at hospitals b. Midwives need to be able to deliver antenatal, delivery and postnatal care c. More general nurses so that midwives can focus on maternal care i.e. child health nurses d. More outreach services- some communities get monthly visits, others less frequent e. Cross cultural training specific to midwifery for Balanda
3. Education	a. Education to increase First Nations midwife numbers, more Aboriginal health workers (AHW). b. More specialised educators such as diabetes educators etc. (currently must come from Darwin) c. Better cross-cultural induction and supervision. In the long term everyone is inducted
4. Aboriginal workforce	a. Yolŋu BOC Committee include ALPA food stores representatives b. Yolŋu across the workforce- receptionists, midwives, AHW etc., backed up by: i. Buddy system ii. Work experience iii. Work readiness program iv. Culturally safe workplace v. Long term- pathway to progress career 'growing our own' c. Stream-line community professionals' roles (MECH, Strong Women workers). d. Traditional healers, bush food, medicine, smoking ceremony
5. Other	a. Need strong governance and leadership Statistics for health outcomes and workforce
STRENGTHENING FAMILIES	
1. Education	a. School i. Reproductive health (preconception education) that is culturally appropriate and lead by Yolŋu b. Antenatal classes for men

	c. Antenatal classes to include a range of things i.e. SIDS d. Bush camps/retreats and education for young women e. Increase ceremony- especially for girls with 1st period then pregnancy
2. Strong Men	a. How to be partners i. Men in some communities are asking to come to antenatal visits and want to be involved
3. PATS Scheme	b. Mum, bub, and escort to travel together if needed to keep families physically connected c. Address PATS shortfalls
4. Family in Hospital	a. Family friendly space in hospitals and town b. Choices of where to stay c. Safe space to stay d. Long term – all-purpose built facilities that accommodate and provide activities, provide food and transport
5. Telehealth	a. Keep families connected b. Case management c. Long term MW in each community with back up and rotation and support d. Mum to stay at home longer if little risk i. Advocate continuity of care ii. Connect/support for community clinics 37-39 wks.
6. Other	a. Food security Priorities pregnant women's nutrition b. Address overcrowding- a major issue
EMBEDDING COMMUNITY GOVERNANCE, CONTROL AND ENGAGEMENT	
1. Leadership	a. Strong women in leadership b. Some initiatives have to go through the Board i.e. health promotion activities and meetings have to be held for big decisions c. More women on Boards d. Difficult to have a discussion about women's business if mainly men on a board
2. Education	a. Better education for Balanda on how to deal with the community
3. Collaboration	a. More collaboration between community and health services. b. Roundtable to facilitate
4. Good stories	a. Good stories told with community people b. Talking circle c. Sharing stories though video and zoom
5. Long term	a. 24hr interpreters b. Continuity of care c. Wrap around women d. Teams connected with community and women e. A birthing journey book

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