East Arnhem Region Mothers and Babies World Café

NHULUNBUY,
NORTHERN TERRITORY,
AUSTRALIA

1 & 2 MARCH 2023

CHARLES DARWIN UNIVERSITY AUSTRALIA | MOLLY WARDAGUGA RESEARCH CENTRE THE BEST START TO LIFE

MIWATJ HEALTH ABORIGINAL CORPORATION | phn NORTHERN TERRITORY An Australian Government Initiative | RURAL Workforce AGENCY NT | NORTHERN TERRITORY GOVERNMENT | NT HEALTH

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- The Birthing on Country Centre for Research Excellence at the Molly Wardaguga Research Centre (MWRC), Charles Darwin University (CDU)
- Miwatj Aboriginal Health Corporation (Miwatj Health)
- Northern Territory (NT) Health including the Office of the Chief Nursing and Midwifery Officer (OCNMO)
- Northern Territory Primary Health Network (NT PHN)

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Report authors

S. Moore[1], J. Allen[1], S. Ireland[1], L. Hinds[2], R. McCalman[1], F. French[3], S. Luckie[3], T. Clasquin[1], E. O'Connor[3], C. Newfield[4], M. Hill[3], S. Kildea[1], Y. Roe[1]

Author affiliations

1. Molly Wardaguga Research Centre
2. Miwatj Health Aboriginal Corporation
3. Northern Territory Government NT Health
4. Northern Territory Primary Health Network

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Executive summary

The East Arnhem Region Mothers and Babies World Café 2023 was a collaboration between the Molly Wardaguga Research Centre (MWRC), Miwatj Aboriginal Health Corporation (Miwatj Health), Northern Territory Health (NT Health), and the Northern Territory Primary Health Network (NT PHN).

This meeting built on recommendations published in the first *Nhulunbuy Workshop Report 2020* that had been convened by the Caring for Mum on Country project (Ethics clearance #HI8031); and was a funded activity of the Birthing on Country Centre for Research Excellence at the MWRC, Charles Darwin University (CDU), a Lowitja Grant and the Yalu Aboriginal Corporation. This led to a multiagency grant application between Miwatj Health, Yalu Aboriginal Corporation, the NT Department of Health, Australian Doula College, Care Flight and Australian Red Cross; later joined by Marthakal Homelands Health Service. Partners were awarded a Medical Research Future Fund to work together to redesign services to promote the best start to life for First Nations children and families by transforming maternity care systems. Partners agreed that together they would establish Australia's first very remote Birthing on Country exemplar demonstration service.

Both workshops were in Nhulunbuy in response to the Yolŋu community and health care providers requests to address inadequacies in maternity services in the region. Over 50 stakeholders gathered to decide how to redesign maternity services for the region. Participants included Yolŋu women from Galiwin'ku, Yirrkala, Gapuwiyak, and Nhulunbuy, alongside non-First Nations community members from these regions. The RISE framework [1] was used to guide group discussion, including:

- Service redesign to include midwifery continuity of carer and a community hub
- Increasing First Nations workforce, and workforce clinical/cultural capability
- Integrating cultural and holistic wellbeing programs and services
- Embedding First Nations engagement, governance, and control

Key issues in the region include the high rate of preterm birth and other poor maternal and infant health outcomes; rapid turnover of midwifery staff and staff shortages, particularly in remote communities that can be without 24/7 onsite midwifery services for days or weeks at a time; women from remote areas waiting for birth in Nhulunbuy without the support of known carers and kin; discontinuity of information / lack of integration between Gove District Hospital (GDH) and primary care.

In 2022, 244 women received antenatal care in GDH; 156 birthed in GDH, 88 were transferred to Darwin for birth or birthed interstate. Of the birthing women, approximately 24% live in the town of Nhulunbuy, and ~76% live in the surrounding communities. Only ~9% (n=21) of Aboriginal women and ~69% (n=37) of non-Aboriginal women live in the town. The community of Galiwin'ku is the largest remote community in the GDH catchment, with 32 women birthing in GDH in 2022, and a smaller proportion birthing in Darwin. The hospital is staffed to establishment (midwifery full time equivalent [FTE] = 12.94) and provides outreach obstetric services to Mamarika (Anindilyakwa-Groote Eylandt). There is a current on-site midwifery vacancy on Groote Island that is being recruited into.

Miwatj Health have 5.8 FTE midwifery staff living in remote communities and an additional 1 FTE regional position providing support. However, these midwives are required to conduct nursing duties and be available for the emergency on-call roster. Non-clinical support is provided to pregnant women by the Maternal Early Childhood Sustained Home-visiting (MECSH) team, strong women workers and additional clinical support is provided through local general practitioners (GP) and outreach GP (Obstetrics). In 2022, Miwatj Health provided antenatal care to 147 women across East Arnhem. In Galiwin'ku, March 2023, the antenatal caseload was 29 women (approximately 50 pregnant women each year will be resident in Galiwin'ku with a small number (~<10) in the outstations). The community midwives are on-call for maternity emergencies.

Together GDH and Miwatj Health have midwifery resourcing for the area that equates to 18.74 FTE midwives across a very large geographic area providing care for ~244 birthing women (~13 women per midwife per year) with 64% (~156 women) birthing in GDH per year. However, there are ongoing recruitment and retention issues reflective of current and ongoing national and international midwifery workforce shortages.

Participants discussed the major barriers and opportunities to implementing "gold standard" maternity care in the region *(summarised in the table, see Page 20)*. These discussions are reflected in the coming pages of this report, and the resulting Agreed Actions *(see Page 29)*.

Major barriers	1) Lack of continuity of carer within services 2) Lack of continuity of information across services and systems 3) Under-representation of First Nations people in the health workforce 4) Limited accommodation options for families and escorts during sit-down 5) Limited cultural safety training for health workforce
Major opportunities	1) Provide continuity of carer through an MGP 2) Increase integration of care by developing a shared governance model with information sharing 3) Employ more Yolŋu staff, including djäkamirr 4) Build accommodation that feels safe and comfortable during sit-down 5) Invest in cultural safety training for the organisation

Conclusion

A key component for maternity service redesign is changing how midwives work so they can develop relationships with a caseload of pregnant women, provide their labour and birth care, and continue to visit women and their new babies until six weeks after birth. The major outcome of the World Café was an agreement by GDH and NT Health to establish a GDH MGP within 6-months.

The major issue yet to be agreed is how to best adapt the 'gold standard service' to benefit all women across the region. The question for the research team and partners is how services can be redesigned for Galiwin'ku women, the site of our prospective non-randomised clinical trial.

Glossary and abbreviations

ACCHO
Aboriginal Community Controlled Health Organisation

AMS
Aboriginal Medical Service

Balanda
Non-Indigenous person

Birthing on Country
Birthing on Country is a metaphor for the best start in life for Aboriginal and Torres Strait Islander babies and their families, an appropriate transition to motherhood and parenting for women and an integrated, holistic, and culturally appropriate model of care for all.

Continuity of carer
Midwives provide care to a caseload of women per year and deliver their care antenatally, during pregnancy, labour, and birth, and the first six weeks afterwards. Women receive labour and birth care from a known midwife (or back-up midwife) who they have developed a trusting relationship with during pregnancy.

Core of Life
An evidence-based, health promoting relationships and reproductive health education program that aims to empower young people and the wider community.

Djäkamirr
A skilled Yolŋu companion who can provide support, resources and information during pregnancy, childbirth, and the postnatal period, also known as a doula.

FIFO
Fly-in fly-out is a method of employing people in remote areas by flying them temporarily to the work site instead of relocating employees and their families permanently.

FTE
Full-time equivalent adds the workload of full-time and part-time employees together to determine overall workforce resource.

GDH
Gove District Hospital

GPO
General Practitioner (Obstetrics)

MNCH
Maternal, neonatal and child health

MGP
Midwifery Group Practice *see Continuity of Carer*

MW
A midwife is educated, competent and authorised to provide safe, effective delivery of quality services that promote health and wellbeing for pregnancy, birth, the postnatal period, and transition to parenting. The midwife is responsible and accountable for maintaining their capability for midwifery practice that may include:

- providing women's health support, care, and advice before conception, during pregnancy, labour, birth, and the postnatal period
- promoting normal physiological childbirth and identifying complications for the woman and her baby
- consultation with and referral to medical care or other appropriate assistance,
- implementing emergency measures.

MWRC
Molly Wardaguga Research Centre, Charles Darwin University

NGOs
Non-government organisations

NT
Northern Territory, Australia

NT OCNMO
Northern Territory Office of the Chief Nursing and Midwifery Officer

PATS
Patient Assistance Travel Scheme

Project ECHO
Project ECHO® (Extension for Community Healthcare Outcomes) is an innovative model of inter-professional education and case-based learning, which aims to democratise clinical knowledge and deliver best-practice care to people in communities that lack ready access to specialists.

RAN
Remote Area Nurse

RISE
Acronym used in Birthing on Country Service implementation:
R = redesign health service,
I = invest in workforce,
S = strengthen families,
E = embed community governance, engagement, and control.

Service levels
Service levels (Level 1 – Level 6) describe the level of maternity service offered, service and workforce requirements by level, and specific risk considerations.

SONT
Specialist outreach services in the Northern Territory (SONT) provide the logistics and co-ordination to support remote health visits.

SWW
Strong Woman Worker- First Nations women who provide support to pregnant women and new mothers.

Yolŋu
Australian First Nations people whose ancestral country is north-eastern Arnhem land, Northern Territory, Australia

Birthing on Country recognises that when women give birth in Australia, in hospitals, birth centres, communities or at home, they are doing so on the sovereign lands of the First Peoples of Australia, who have never ceded ownership of their land, seas and sky. Women are frequently not able to, or do not choose to, birth on their traditional lands. The Birthing on Country movement is driving system-wide reform, aimed at transferring funding and control of maternity services for First Nations families from mainstream services into First Nations hands through community-controlled health services. Birthing on Country recognises the importance of a First Nations workforce to drive a strengths-based service that is clinically and culturally safe [1].

Introduction

Over the millennia, First Nations women across Australia have given birth on their Country, supported by family and cultural caring practices, until recent disruption from European colonisation.

Today, First Nations women, babies and families experience profound health inequities, disproportionately experiencing adverse outcomes in pregnancy and birth compared to non-First Nations Australians. For the past ten years, there has been little or no improvement in perinatal indicators. Maternal death for First Nations mothers remains 3.7 times higher than for other Australian women [2], and perinatal deaths, largely driven by complications of pregnancy, are twice as high [3].

Preterm birth is the largest contributor to infant and child mortality and is associated with life course health inequities, with negative impacts on schooling and educational attainment, childhood disability, and chronic diseases in adulthood [4]. The proportion of preterm liveborn babies born to Aboriginal mothers in the NT in 2019 was twice that in non-Aboriginal mothers (16% and 8% respectively); whereas low birthweight was more than twice that of non-Aboriginal mothers (14% and 6% respectively). East Arnhem (Figure 1) is the health district with the highest proportion of low birthweight babies born to Aboriginal mothers (21%) [5].

Preterm birth and low birth weight are largely preventable by addressing the social determinants of health [6], through service integration and solutions that place First Nations mothers, babies and communities at the centre. A growing number of maternity services are establishing Birthing on Country to best meet the needs of First Nations mothers, babies, and families.

Figure 1. East Arnhem Land (shaded orange), Northern Territory, Australia.

World Café program and structure

The two-day World Café was facilitated by the Gove District Hospital Director of Nursing and Midwifery, Shernell Luckie (pictured below), *and the Co-Director of the Molly Wardaguga Research Centre, Professor Yvette Roe.*

Day One commenced with a Welcome to Country and opening address by Sally Maymuru (Miwatj Health Service), and Mandaka Marika. Representatives from each convening organisation provided an overview of the services they provide and reported key data for the region.

The World Café sessions comprised of presentations, with breakout discussion groups to explore areas of concern and generate possible actions to address them. Day Two finished with summary of the World Café and a list of actions, agreed to by the participants.

The RISE framework [1] was used to guide discussion (Figure 2). The RISE Framework is an innovative tool that maps current maternity service provision and guides service redesign to ensure that more First Nations babies are born healthy and strong. Components of RISE include service redesign to include midwifery continuity of care and a community hub, increasing First Nations workforce, strengthening clinical and cultural capability of workforce, integrating cultural and holistic wellbeing programs and services to strengthen families, and embedding First Nations engagement, governance, and control.

Figure 2. RISE Framework [1]

Participants

Over 50 stakeholders (10 First Nations, 40 non-First Nations) gathered to decide how to redesign maternity services.

There were approximately 20 midwives and/or nurses (including 2 from Anindilyakwa - Groote Eylandt), 8 researchers, 4 senior government representatives, 3 allied health or family support professionals, 2 midwifery students, 2 program leads, and 2 medical officers. Participants included Yolŋu women from Galiwin'ku, Yirrkala, Gapuwiyak, Nhulunbuy and non-First Nations community members from these regions.

Update from Partner Organisations

Gove District Hospital

Maternity Unit Manager, Fiona French

Fiona French *(pictured above)* provided an overview of the current GDH model of maternity care noting that GDH is the only facility in the region that provides care during childbirth.

> *As a Level 3 service, GDH has capacity to provide safe care for the woman with a singleton pregnancy identified as 'low-risk' from 36 weeks gestation and a singleton neonate that weighs ≥2000g at birth.*

Women with higher complexity are cared for during pregnancy in GDH or Royal Darwin Hospital; and plan to birth in the Royal Darwin Hospital. From 37-38 weeks of pregnancy, women from remote communities across the jurisdiction come for **sit down** *"this is where women wait at a hostel and sit there until they go into labour…and often they do so without an escort or any family support"* [7].

Currently the unit is staffed to establishment (midwifery full time equivalent = 12.94), with a multidisciplinary team comprising of full time and part-time midwives, general practice obstetricians (GPOs) who provide care across specialties at GDH, and a part-time Aboriginal Liaison Officer (ALO). The remaining allied health support is provided as required by GDH core services; dietician, social worker, interpreter, physiotherapist, and activities provided by the Core of Life program.

Women return home anywhere from 2–7 days after the birth; women residing in the township of Nhulunbuy are offered at home midwifery visits by hospital midwives. The midwives in the maternity unit often provide nursing (medical/ surgical) care, in addition to maternity care.

In 2022, 244 women received antenatal care in GDH, 156 birthed in GDH, 88 were transferred to Darwin for birth or birthed interstate. The community of Galiwin'ku is the biggest remote community in the GDH catchment, with 32 women birthing in GDH in 2022. It is acknowledged that improving continuity of care can reduce unwarranted variations in care and improve perinatal outcomes.

Miwatj Health

Maternal and Women's Health Program Lead, Laura Hinds

Laura Hinds (*pictured above*) provided a regional profile of the communities serviced by Miwatj Health, including Bulunu which takes in Nhulunbuy, Gunyangara, Yirrkala, Gapuwiyak and Barra which covers Ramingining, Yurrwi (Milingimbi) and Galiwin'ku. Miwatj Health does not provide maternity services to Mamarika (Anindilyakwa -Groote Eylandt) however provides other health care.

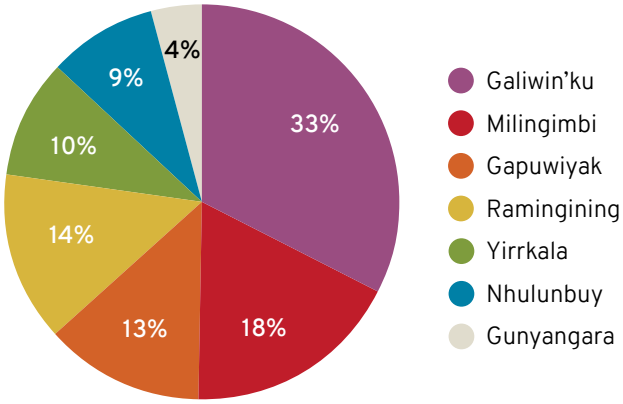


Figure 3. Miwatj Health region population per community (2021 census and Communicare data)

The breakdown of current midwifery and maternity staffing levels for each are at the time of the World Café (March 2023) was:

- Yirrkala 0.8 FTE
- Nhulunbuy/Gunyangara 1.0 FTE
- Gapuwiyak 1.0 FTE
- Galiwinku 1.0 FTE (agency)
- Ramingining 1.0 FTE and Milingimbi 1.0 FTE – both use flexible work structure (6 weeks on, 4 weeks off) - backfill is provided either by another Miwatj Health midwife or a Miwatj Health remote area nurse in consultation with Maternal/Women's Health Program Lead or GPO where appropriate.

The current primary health care roles for clinical maternal and newborn care within Miwatj Health communities includes community midwives; Aboriginal Health Practitioners; a Maternal/Women's Health Program lead (outreach, Nhulunbuy); a GPO in Nhulunbuy; Child Health teams in community; and Child Health Program Lead (outreach, Darwin).

Most midwives working in community also contribute to the emergency on-call roster and provide nursing care to the whole family (e.g., child health checks and immunisations). Non-clinical support is provided by the MECSH team made up of nurses and Aboriginal community workers, and a MECSH Co-Ordinator who is based full time in Galiwin'ku. In 2022, Miwatj Health provided antenatal care to 147 women in East Arnhem. In Galiwin'ku, March 2023, the antenatal caseload was 29 women (approximately 50 pregnant women each year). The community midwife is on-call for maternity emergencies. When women leave their remote communities for sit down and birth care there is no continuity of carer across service jurisdictions. The one exception to this is a GPO who is jointly funded by Miwatj Health and NT Health with a full-time position split between the different services operational footprint including the remote communities and GDH. This means some women receiving medical care in GDH may already know the obstetrician from care provided in the community. This is an exception to how all other components of maternity care are delivered.

NT Primary Health Network

Health Workforce Education Team Lead, Chelsea Newfield

Chelsea Newfield *(pictured above)* provided an overview of the Rural Workforce Agency Northern Territory (RWA NT), a dual agency within the NT PHN. She shared workforce development projects provided in partnership with other agencies to address workforce challenges and inspire potential workforce models. The RWA NT contribute to addressing health workforce shortages and maldistribution in regional, rural, and remote NT through a range of Commonwealth-funded programs, grants, and subsidies for three priority areas:

1) access – improving access and continuity in essential primary health care.
2) quality of access – building health workforce capability; and future planning – growing the sustainability of the health workforce.
3) workforce development and capacity building projects.

Early Career Remote Nurse Program

- A pilot program to develop a supported graduate nurse placement and training program in partnership with Central Australian Aboriginal Congress (Congress) intended to provide supported placements opportunities to early career nurses including training and mentorship to develop the necessary skills to practice nursing in a remote setting.
- A 2-year program:
  - Year 1 – a 6-month rotation in a town clinic within a Congress clinic, followed by a 6-month Alice Springs Hospital rotation, which includes completion of several education courses.
  - Year 2 – consists of gaining exposure and experience in rotational Congress remote clinics, with further courses and training provided.
- 8 of 13 nurses remain in the program; the full evaluation report will provide recommendations regarding the scalability of the program across the NT.

Mala'la Aboriginal Workforce Development Project

- A workforce development program in partnership with Mala'la Health Service Aboriginal Corporation (Mala'la) aimed at attracting and retaining a skilled local Aboriginal health workforce.
- An on-country training program was developed and provided to 15 Aboriginal Mala'la employees to undertake a Certificate II in Aboriginal and Torres Strait Islander Primary Health Care as pathway qualification towards becoming a registered Aboriginal Health Practitioner -> 6 graduates.

Northern Territory Project ECHO Disability Network: Inter-professional education, tele-mentoring, and case-based learning, which aims to democratise clinical knowledge and deliver best-practice care to people in remote communities that lack ready access to specialists.

Single GP Employer Model: Scoping activities currently underway for the Big Rivers region.

The 2020 Nhulunbuy Birthing on Country Workshop

Molly Wardaguga Research Centre

Senior Research Fellow, Dr Sarah Ireland

Dr Ireland (*pictured above*) gave apologies from Associate Professor Läwurrpa Maypilama who was unable to attend and introduced Rosemary Gundjarranbuy from Galiwin'ku to provide context to their work. For many years, Läwurrpa has been leading work in Galiwin'ku, which culminated in the 2020 Nhulunbuy Birthing on Country Workshop. Dr Ireland provided a recap of the 2020 Nhulunbuy Birthing on Country workshop, which was convened by the *Caring for Mum on Country* project team [8]. Over 40 participants gathered to answer the call for the return of birthing services to First Nation communities and control. Galiwin'ku aims to be the national exemplar for the very remote setting for returning primary birthing services. It was reiterated that Yolŋu women need to be supported to lead this work in a Yolŋu way, so we have to look at the Balanda barriers and systems that often make Yolŋu leadership difficult.

The key findings of the 2020 workshop were that there was *'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 *(detailed below)* [9] was endorsed as a useful tool to guide this process and the attendees agreed that service change would require collaboration and communication among and between service providers and with Yolŋu communities.

Dr Ireland spoke of the legacy of Molly Wardaguga, Burarra Elder, whose vision was to support women's cultural and birthing aspirations, especially in remote locations, and use research to dismantle the barriers imposed by westernised approaches to birthing and maternal healthcare.

Priorities identified in 2020 under the RISE components were:

Redesign the system by increasing co-ordination, communication, collaboration, and continuity of carer.

Invest in the workforce by 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 djäkamirr pilot program through the region and streamlining community liaison and support roles.

Strengthen the capacity of Yolŋu families by 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.

Embed Community Governance, Control and Engagement through 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 co-ordinate systematic change to address the inequities.

"It's just amazing today...of how important this project is, it's rapidly moving, rapidly in the ears of politicians and... in the lives of community people. And those community people are all of us right now."

Djapirri Mununggirritj *(pictured on the right, with Tez Clasquin on the left)*

The RISE Framework and health service redesign

Molly Wardaguga Research Centre

Co-Director, Professor of Midwifery, Sue Kildea

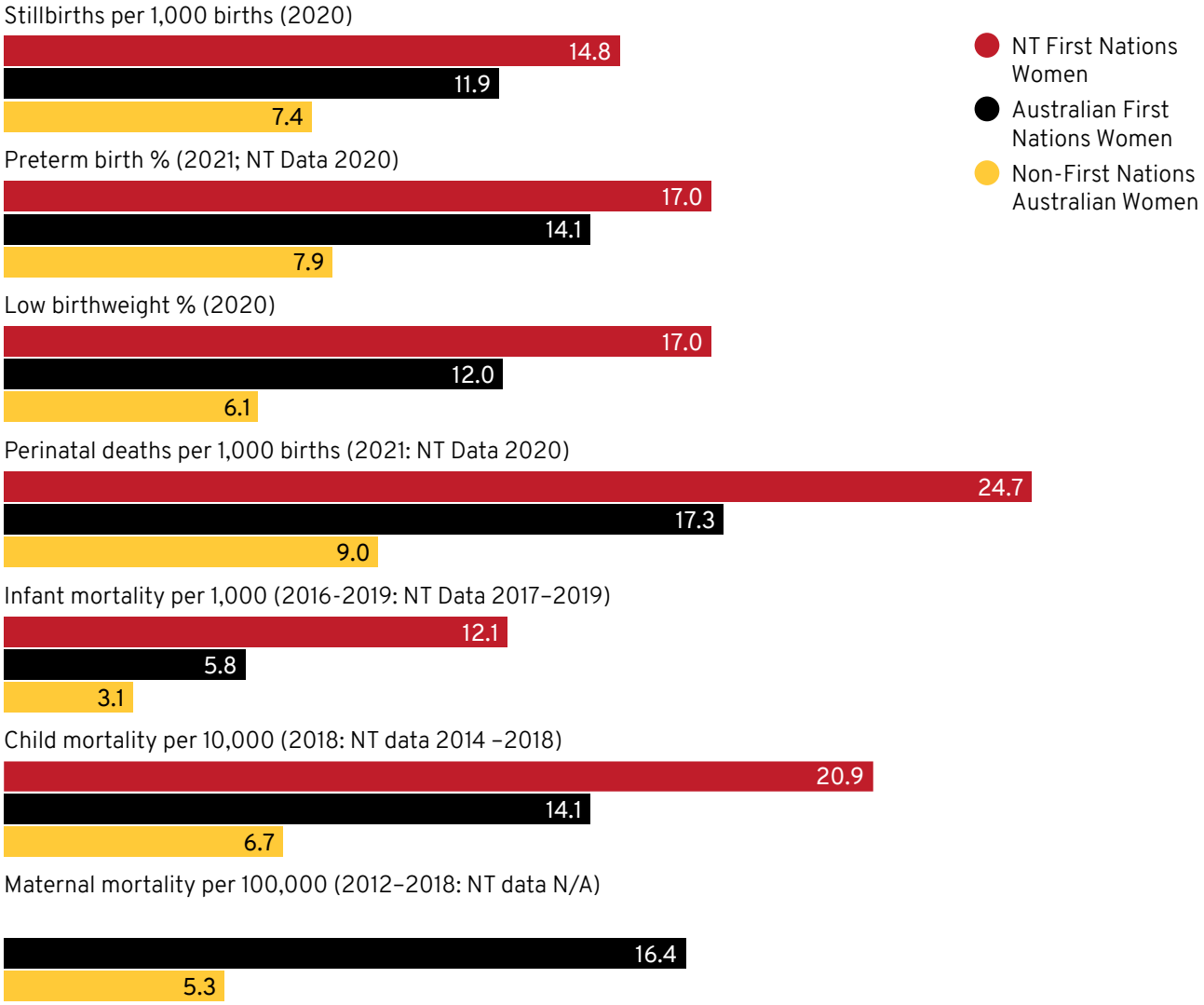
Professor Kildea (*pictured left*) provided an overview of the RISE framework and described how RISE can be used to assist health service redesign. She suggested RISE would be a useful tool to guide and provide structure to the discussions over the two days of the World Café. She acknowledged Molly Wardaguga, Burrara Elder and traditional midwife, and founding member of Mala'la health board. She noted that birth is our first ceremony in life. If we get this right, we can change the pathway of life. That story has not changed since the 1999 *"And the women said"* report. She reiterated that what women said then, is the same as what was said at the first Nhulunbuy workshop in 2020 and again today and asked, *'how can we make this happen?'* We know 'what women want.' She then pushed for a call for action and spoke of when Molly was invited to be a keynote speaker at the Perinatal Society of Australia and New Zealand (PSANZ) conference. She asked, *'What is the point? You mob don't listen!'* Molly did travel to PSANZ, and this very question was the title of her presentation.

Timeline of key documents

Reports and research	Findings and discussion
1990s *And the Women Said report*	We don't have a problem understanding what women want, we have a problem with making it happen
2004 *PSANZ: What's the Point? You mob just don't listen!*	
2007 *1+1 = A Healthy Start to Life*	**New model:** MGP at Darwin Hospital **Outcomes:** embedded First Nations student midwives, sought Elder cultural advice and support, reduced racism because midwives knew the women, cost less and improved outcomes **Challenges / learnings:** lack of backfill for MGP midwives and poor governance and backfill in remote areas, no access to birth centre, First Nations student midwives initiative not ongoing, need to focus on building the First Nations workforce, get the governance structure right from the start. Be careful with the caseload for MGP in town - ~32 was best
2012 *Indigenous Birthing in an Urban Setting (IBUS) study*	**Process:** Community consultation led to a multi-agency partnership between the Mater Mother's Hospital (South Brisbane) and two ACCHOS (Institute of Urban Indigenous Health and Aboriginal and Torres Strait Islander Community Controlled Health Service, Brisbane) to redesign services. Action Research guided the implementation process, which helped each organisation become braver in accepting the roles and responsibilities to collectively deliver the solution. Establishment of the Birthing in Our Community (BiOC) service. **Outcomes:** earlier and more frequent attendance by mothers carrying a First Nations baby and better outcomes [9]. **Findings:** the BiOC service delivered fewer preterm births (5 percentage point reduction) and neonatal admissions, more spontaneous vaginal births and breastfeeding and cost savings (-AU$4810) per mother-baby pair [10].

The numbers story

Professor Kildea demonstrated that the maternal statistics are worst in NT for First Nations women *(see *References)*.



Participatory Action Research in North-East Arnhem land

Professor Kildea explained that we need to learn to deeply listen and trust each other to be able to collectively change the story of women in this region. Participatory action research (PAR) offers a way of learning continuously so we can understand the impact of the work we do and change as needed to ensure that we are getting the outcomes that are of value.

The PAR method includes cycles of Planning, Acting, and Reflecting:

- Stories from women, families, and workers
- Numbers story – clinical and costing (data linkage Miwatj Health, NT Health)
- Meetings, workshops, working groups
- Essential components include
  - effective communication
  - trusting relationships
  - committed leadership
  - shared vision
  - flexibility within clear expectations
  - acknowledging challenges
  - strong governance for sustainability
- Unique considerations in North-East Arnhem context:
  - Multi-lingual, multiple communities, remote
  - More women birth from Nhulunbuy and Galiwin'ku
  - Community desire for Mums and Bubs Hub that feels safe in Nhulunbuy
  - A Yolŋu workforce that is embedded in model of care
  - There will be an accredited unit on cultural knowlege as a part of the Djäkamirr training course (Certificate II Doula Practice).

Aboriginal Community Controlled Health Organisations and Health Services: What do they need?

Miwatj Health
Maternal and Women's Health Lead
Laura Hinds

Laura Hinds showcased the Miwatj Health Maternity Redesign Project which will include 4 months of community consultation (March – June 2023) regarding Miwatj Health programs:

- Maternal Early Childhood Sustained Home-visiting program – Yolŋu families parenting program and wellness model.
- Maternal / Women's Health Program Lead
  - midwife and GPO visiting remote communities with ultrasound
  - orientation in remote communities / clinical supervision
  - risk management / clinical governance
- Laura reported on other work being conducted by Miwatj Health including:
  - Culturally appropriate resource development, specific for communities
  - Women's journey – confirming pregnancy, remote care in community, birthing, postnatal, child and family health

- **Internal needs:**
  - community consultation
  - increasing FTE across all communities
  - standardisation of maternity practice
  - nurses/MWs into clinical roles
- **External needs:**
  - shared care antenatal policy
  - integrated service agreement
  - grant opportunities
  - NT Health PATS policy currently under review to address ongoing inconsistent application of escort eligibility criteria across the jurisdiction; including low acuity versus high acuity – reliance on aeromedical retrieval to hospital
  - take care to the women – MWs and doctors working across both services
  - increase access to GPOs/MWs/pregnancy ultrasounds in all remote areas
  - communication challenges between organisations
  - struggle retaining midwives in communities
  - need culturally appropriate safe place – mums and bubs hub for pre/postnatal stay
  - problems with backfill / permanent staff / FIFO roster.

Continuity of Care Breakout Session

This session, facilitated by Professor Yvette Roe from MWRC, was interactive with participants breaking into smaller groups to discuss and record priorities for continuity of care, in the East Arnhem region. The RISE framework was used to guide discussion of barriers and opportunities for each component of RISE. Group findings were reported back to the larger group and collated here (see Table).

Comments from World Café participants

Djapirri Mununggirritj:

Never walk in front in me because I may not follow. Never walk behind me because I may not lead. Walk hand in hand and side by side together to make a better community.

Participant:

We have policies and guidelines that create harm and prevent us from caring for the women. Example of the PATS policy, and how it prevents women from having their family with them during their pregnancy and birthing journey.

Community member:

We need people to come to our homelands, to come to our homes to care for us, and teach us about how we can care for ourselves. Teaching us to care for our mob so that if women birth in our community we can keep them safe. We also need birth environments like we see on TV. With big baths, warm lighting. Spoke about Purple House — how they integrated Aboriginal ceremony and practices into renal care. Having gardens with healing medicine. Having space for families and children to be healed.

Community member:

We need mums and bubs facility in Nhulunbuy. I am a grandmother and had a grand baby. There is not enough education in the schools to teach children and young people about pregnancy and becoming a parent. Shared an experience of her granddaughter being scared to talk to the midwives. Shared her experience of having a baby with MGP in Darwin. All women should have this care. Spoke about weaving. Weaving is big thing in the East Arnhem region. It is an important ritual in pregnancy. The spiral of the weaving needs to be taught to our children. Bridge the gap, build trust and relationships with First Nations people.

Miwatj Health midwife:

Big action — we need to address the fragmented ways of working that currently exist across the East Arnhem region. We need to get more staff to travel to remote communities to understand the context, to connect with the people etc. Laura Hinds encourages people to seek the opportunity to do this. SONT travels every month to remote communities. We need to use this as a platform for creating relational connection. From a family strengthening perspective, this is about connecting care with the family and community. Discussed Navigator models — talked about MGP blue. This could help connect the communities, GDH with the MGP blue team and ensure continuity of practice. We need service agreements to enable establishment of an MGP between providers that is underpinned by the evidence (you can't do half of it and expect the same outcomes).

Rosemary Gundjarranbuy (pictured right):

shared the story of visiting the new aged care centre (Nhulunbuy). She told of her connection with that place, the building, and the people. The vision is visible straight away. That vision recognised many people are from the East Arnhem region. This vision, the building, the people made me feel very connected to this place. This is what we are talking about. This is the relationships, the connection and what we are talking about to help each other. We come here to share our knowledge, to build relationship to make the best service for milyalk and their babies in the East Arnhem region.

Dr Sarah Ireland:

spoke to one opportunity — all women should have telephone access to a known midwife. With the number of the FTE midwives in Gove Hospital. Can we combine hours of work across agencies to create an MGP. Reflective supervision. Create education programs — masters of midwifery to help remote and regional staff get the clinical and cultural staff to care for mothers and babies. Let remote staff from Miwatj Health and NT Health do a week -month or so at Nhulunbuy so they feel connected with the service and have a clinical support system for when the go to community.

Rosalind Beadle:

spoke about the retention issues in remote communities - we need to create midwifery-specific roles, value the role of midwifery, and be guided by the community in how midwives can partner relationally with yothumirr (pregnant) women in community.

Breakout session findings	What are the barriers to Gold Standard maternity care…	What could be done to provide Gold Standard maternity care…
Redesign services	• disjointed client journey without continuity of carer (midwife or obstetrician) • community-based midwife not part of acute service model • no local midwives in some communities • no multi-institutional cultural and clinical governance • 'Darwin effect'- urban models not necessarily best for region • maternity care system is patriarchal/paternalistic	• develop collaborative partnerships between services (i.e., connect GDH with primary health care) • implement an MGP in Gove • send midwives/students to remote communities to develop relationships with women and their families during pregnancy (SONT Travel) • build place for sit down and birth centre (like Nhulunbuy aged care facility) • use interpreters more frequently • develop buddy system for remote midwives • start the new model in one community, then expand
Invest in clinically exceptional workforce	• transitional workforce with high midwife burnout/turnover in remote areas • significant midwifery deficits in Galiwin'ku • GDH midwives doing non-maternity work • midwives to do a stint in GDH before going remote • midwives currently providing fragmented care / shift work may not choose to work in MGP model	• develop wrap-around supports for midwives working remotely • embed more midwifery students in the maternity service • develop new positions › e.g., Maternity Navigator, Maternal and Child Health Co-ordinator • ensure every woman has 24/7 phone access to a midwife • develop a Masters in Remote Midwifery • continuity of carer models may attract experienced MGP midwives to work remotely

Breakout session findings	What are the barriers to Gold Standard maternity care…	What could be done to provide Gold Standard maternity care…
Invest in culturally exceptional workforce	• power differentials between women and staff • power differentials within the workforce • inadequate cultural safety training • not enough Yolŋu workers	• walk together – develop trusting relationships • embed strong cultural leadership • embed Djäkamirr role to provide cultural support to women • require education in cultural safety, trauma-informed care
Strengthen Families	• multi-lingual communities • poorer health prior to pregnancy • lack of support safe/adequate accommodation for women and families including other children • unable to have anyone (i.e., father of the baby) escort from community to GDH	• provide higher standard, safe accommodation that caters to families during sit down • enable escorts to travel with women using PATS • increase access to sexual and reproductive health (including how to assist with unexpected birth in remote community) • promote school engagement • bring back women's camps to exchange stories
Community engagement, governance, and control	• unclear on the governance of new models	• develop governance model between Miwatj Health and NT Health • Yolŋu and Balanda can walk together, similar to aged care facility • embed strong cultural leadership with local Yolŋu staff • build a Mums and Bubs Hub/Birth Centre › e.g., Purple House for dialysis patients where Yolŋu healers can come in for birthing services

Setting up MGP in Far North Queensland

Queensland Health

Midwifery Unit Manager, Tish Funnell

Tish Funnell gave an online presentation on setting up the MGP across three sites in Far North Queensland.

The service provides evidence-based, woman-centred care.

The service is based on 4 principles:

1) empowering women
2) multidisciplinary care
3) culturally appropriate care
4) caring for midwives – midwives caring for women

happy midwives = happy women

Service components

- Named or known midwife (90% known midwife at birth)
- Collaboration with Aboriginal Health Services
- Midwifery Navigator (Cairns) for tertiary care – who attends birth if possible
- Identified positions and pathway from early career midwives into MGP -> clinical midwife -> Midwifery Unit Manager
- Maternity Care Assistant (Cadetship) pathway to Bachelor of Midwifery
- Culturally capable adapted resources with yarning tool for women who decline recommended care
- Caring for midwives
  - Full scope of practice including endorsement
  - Annualised salary with industrial agreement
  - Professional development opportunities
  - Flexible working arrangements
- Facility at Weipa hospital – welcoming outside spaces, birth space with pool
- Bringing birth closer to home, not on country

Setting up MGP in a Rural Hospital

Queensland Health

Clinical Midwifery Consultant, Anne Bousfield

Anne Bousfield from South-West Queensland (*pictured left*), presented on setting up an MGP in rural and remote Queensland. The service started small in 2012 then expanded to deliver Maternity Continuity of Care for all women in South West Queensland. The service now has three Level 3 services as below. Women with complexity beyond the scope of Level 3 capability, are transferred to Toowoomba (Level 4) or Brisbane (Level 6).

> *"It is continuity of CARER - not CARE - that women want"*
>
> Anne Bousfield

Roma Hospital: **150 – 165 births /** **+ 40 birthed away**	• 2 birthing rooms, water immersion / not waterbirth • Inside-outside co-designed rooms • 8 Full Time Equivalent (FTE) • Training positions for local midwives • Workforce midwifery attrition, half new graduates • 3 Senior Medical Officers (SMO) • Flying obstetric service staffed by Mater
St George Hospital: **40 – 50 births**	• 24 birthed away • 3 FTE – usually 1 FTE down • 6 SMOs medicalises birth
Charleville Hospital: **50 – 60 births**	• 40 birthed away • 4 FTE • Training for local midwives • 2 SMOs

Key to success of the services

- Convincing evidence (i.e., Goondiwindi had a successful MGP)
- Enthusiastic Director of Nursing who was a midwife
- Couldn't recruit to RN/RM shift work - ***needed*** continuity to attract midwives!!
- Mob advocating for model
- Workshop with everyone – all disciplines, exec team, flying obstetricians etc.

Issues

- 2013 staged approach 4 FTE (transitioned two roles to MGP roles), ultimately couldn't sustain a core. There was a developing recognition that you did not need to be a RN to do rural and remote midwifery. After a few years, 100% MGP and no core staff (needs nursing staff support)
- Recognition that you did not need to be a nurse to do rural and remote midwifery
- Nurse training for how to care for stable inpatient maternity patients:
  - under a midwifery plan as there was resistance from older nurses
  - a local procedure clearly defines roles of nurse and midwife and clarifies expectations and boundaries
- Hub and spoke model
  - Hub is hospital – midwives travel to outreach spokes
  - increased FTE to account for travel time
- Cunnamulla example
  - Aboriginal Medical Service (AMS) weekly midwife clinic (known midwife)
  - 15 birthing women per year – birthing service now closed – women turning up to birth regardless
- Rural Maternity Taskforce has found continued deep desires from the community for local birth services
- Patient Travel – two units, with two bedrooms in Charleville and St George for women who relocate for birth – need better collaboration with AMS for sit down
- Virtual Midwife – Senior Midwifery Advisor – Retrieval Services Queensland – ideally available 24/7
- Needs students and graduates for MGP succession planning:
  - not alone in birth suites for first six months, escalation, communication, relationships
  - then offsite supervision out of hours – as determined by the graduate and the senior midwifery team
- 2-year commitment is requested of graduates due to the significant investment in supervision in the first 12 months
- 2019 Rural Maternity Taskforce Report: go to Level 2 not Level 1 if issues with GPO/access to caesarean section
- Barriers with nurses/midwives that oppose working in continuity of carer models
- Preterm Birth Alliance launch in 2023
- Work out early who the white-anters are
- Early adopters - get them onside and assisting

Recommendations

Start small, one community, get feedback, expand; speak positively of the model to attract more midwives. Barriers with Level 3 services $$$ and retention of GPOs.

How do we embed a continuity of care model across organisations in the East Arnhem Region?

This session was facilitated by Professor Yvette Roe (pictured above). *Participants again broke into groups and addressed the questions: 'What are the barriers working against us getting to continuity of care?' and 'What are the opportunities?'*

Redesign the maternity service – continuity of carer

Develop an all-risk continuity of carer model for women planning to birth at GDH.

Considerations during the next 6 months:	• Number of midwifery FTE and annual caseload per midwife (MGP) • Clinical governance framework • Rostering of GDH core staff midwives per shift • Single employer model being explored nationally and in the Big Rivers Region of the NT for some medical staff • Ward phone 24/7 for clinical midwifery support to midwives in remote communities • Community-based space or facility for MGP • Midwifery students in new model • Video conferencing Miwatj Health clinics for students • Telehealth for allied health • Professional development (culturally safe, trauma-informed care) • Aboriginal Liaison Officers and Interpreters • Milestones election cycle • Men aware • Tutoring support for First Nations women at GDH who want to become midwives.
Considerations during the next 18 months	• Roll out to MGP to women living in Galiwin'ku • 2 FTE GDH, 2 FTE Miwatj Health
Considerations during the next 3 years	• Roll out MGP to all of North-East Arnhem • Birth Centre in Nhulunbuy or on Galiwin'ku • Embed new graduates in the model

Redesign the maternity service – continuity of information

- Read only access for organisations to other systems
- New Acacia system opportunity to share information
- Increase knowledge of available services and referral pathways in guidelines
- My Health Record (not well used now) need to ensure better use of information
- SharePoint system database for review of all patient in service
- Consider information sharing with local private GP
- Handheld record / digital style – innovation opportunity
- Single employer model

Invest in workforce

- Address significant midwifery staffing deficits in Miwatj Health remote communities, for example Galiwin'ku
- Ensure ongoing planning for remote staff safety
- Mums and Bubs hub space in community, Nhulunbuy, and Darwin
- Djäkamirr employment
- Integration similar to the standard set by the Aged Care Facility in Nhulunbuy
- Education and two-way learning – connecting with stories
- Clinical and cultural skills lifelong learning
- Graduate pathways for midwives and nurses new to remote
- Midwives:
  - How many per community
  - In schools helping with Core of Life programs
  - Midwives role in early pregnancy counselling
  - Midwives antenatal and intrapartum skills – how to increase confidence and competence of midwives working in remote settings – need consistent Maternal & Child Health education
  - Midwives appropriately remunerated for skills
  - Place-based training to develop confidence in new skills while being paid
  - Develop an exchange program of midwives between GDH and Miwatj Health

Strengthen families

- Programs that are First Nations led
- Strong bloodlines- Gurruṯu (strong community, strong identity)
- Djäkamirr in Nhulunbuy
- Increase First Nations staff working with women on the ground
- Training for Balanda – language and cultural – so that Yolŋu and Balanda, and Anindilyakwa and Balanda can work together
- Creating a safe place for all women - First Nations and Balanda
  - Issues with cultural and physical safety for women in hostel for sit down
  - Away and safe from male view
  - Address housing and food crisis
- Wellness activities like yoga
- Strong fathers' program – women need support from the fathers – bring program back, and have more education for fathers
- The new aged care facility has the ideal setting for mums and bubs hub/birth centre

Midwifery expert advisory panel

An expert advisory panel (pictured below from left to right): *Mish Hill (Chief Nurse and Midwife, NT Health), Professor Sue Kildea (Co-Director, MWRC), Laura Hinds (Maternal and Women's Health Program Lead, Miwatj Health), Fiona French (Clinical Midwifery Manager, GDH), Tez Clasquin (Facilitator, MWRC), and Anne Bousfield (Clinical Midwifery Consultant, Queensland Health); addressed a number of themes and drew on participation from the audience.*

The discussion, captured in bullet points below, ranged around how to prioritise the work, improving capability of midwifery workforce, additional support requirements, capacity and capability, and ways the model might work.

How to prioritise this work?

- Focus on population outcomes - look at the numbers story
- Staged approach- start with small team then attract and develop the workforce
- Leader has to understand continuity of care and working with medical colleagues
- Nhulunbuy has clinical governance from NT Health so could start here first
- Clarify the role of the caseload midwife/MGP
- Mitigate risk of negative outcomes during implementation and into the future
- Manage understanding between NT Health and Miwatj Health (roles and responsibilities)
- Could NT Health support midwifery deficits in remote communities?
- Working out the politics

Question from the audience:

How do midwives get support for helping young mums with their mental health - suicide?

Answers from the panel:

- NT has Commonwealth funding to address this
- A young woman's program was implemented in Brisbane, group-based care. Now have strong perinatal mental health leadership.
- Documenting this need in MGP establishment phase

- Learnings from the Best Start To Life gathering in Mpartwe (Alice Springs) in 2022 – need strong, multidisciplinary, wrap-around services
- Programs that used to work well have disappeared including Strong Women, Strong Baby, and strong culture programs
- First nations employees needed in these programs

Question from the audience:

Does the governing body from Miwatj Health understand this work deeply?

Answer from the panel:

Regionalisation of Miwatj Health means inconsistencies in availability/strength. Presence of Miwatj Health services/support is extremely important. For example, end of life care needs to be community-based, not in a hospital. Expand. Programs for pregnant women must be prioritised. The importance of everyone collaborating, nobody leads or follows- we walk together on the journey.

Cultural framework- Blend the two cultures together and you will get the results - expertise of Yolŋu and Balanda

Improving capability of midwifery workforce

- Protecting midwives in MGP from lots of administration and being deployed away
- Core staff have an important place, education for nursing staff needed
- MGP is new for many midwives working in Gove
- Autonomy readiness
- Decision making
- Reflective practice
- Trauma-informed care
- Midwives committed to cultural safety - clinical supervision

How can we get additional support?

- Using research frameworks and partnerships (e.g., Australian Nurse-Family Partnership Program, trauma-informed care, toolkit for BoCS)
- Visiting 'technical support'
- Appropriate training, supervision, remuneration to attract and retain midwives and also allied health (social work, child health nurses)
- Growing a local workforce (i.e., Djäkamirr program, Certificate 2 being developed)
- First Nations student midwives incorporated into program – currently need to move away from base to study
- What is attractive for midwives?
- Single-employer model for midwives - could be similar to (not yet in the NT) single-employer GP employment model being explored nationally
- One way is to establish MGP
  - Can Miwatj Health purchase midwifery services supplied by NT Health?
  - Need strong relationships between organisations

Capacity and capability

- Small components in the system can be fixed as a short-term goal (in Nhulunbuy and other communities)
- Remaining strengths-based in our approach to change
- Midwives asked how they want to work and where
- Upskill the First Nations workforce
- Think from a needs-based lens- multiple remote communities have no midwives
- Could place midwives in community while establishing MGP in Nhulunbuy
- Pre-conception care and education to improve women's pregnancy and birth
- Increase Core of Life programs

Working through this

- Practical, pragmatic short-term solutions AND 5-year long-term outcomes
- Discussion that this could start in Galiwin'ku first if it is needs based, however Nhulunbuy can be established sooner and be beneficial in next 6 months
- Build on the expertise of Darwin MGP midwives - more regular meetings
- High level discussions between NT Health and Miwatj Health- fix division of care here
- Keep Galiwin'ku in our plans- pressing need for change now
- There is possibility of GDH midwives outreach program to remote communities
- Waiting two years to start in Galiwin'ku puts the numbers story at risk
- Could prioritise the reform of the midwifery role working in remote community health centres - a more effective use of midwifery hours (i.e., not on-call for acute nursing)
- MGP model one possible solution to protecting role of the midwife

Agreed actions

Co-ordination of integrated care across these jurisdictional boundaries is complex, requiring high level organisational leadership, funding realignment, and a cross-jurisdiction commitment to doing things differently. To begin addressing these complexities, the following actions were agreed by partner organisations.

What	When	Who
Participate in working groups	Now	MWRC have invited NT PHN
Commitment to work in partnership to improve outcomes, integration, service review, which will assist lobbying, recruitment and retention, education, research, community consultation	Now	Miwatj Health / ALL
Commitment to develop Yolŋu workforce	Now	Miwatj Health
Full organisation and board commitment	Now	Miwatj Health
Clinical supervision and education support	ASAP	NT Health/OCNMO
Registered Undergraduate Students of Midwifery (RUSOMS) employed	Now	GDH
Student midwives program to support First Nations Students	Now	CDU
Research framework	Now → 5 years	MWRC
Steering Committee and governance	Now → 5 years	MWRC
Reflective practice training	In development to be ongoing	MWRC
Ethics and data	Ongoing	MWRC
Lobby for resources	Ongoing	MWRC
Assist with business proposal for Mothers and Babies hub	Ongoing	ALL
Develop GDH Business Planning Framework	2 months	NT Health/GDH
ICT and EMR- investigate continuity of information	3 months	DONM GDH
Implementation of a NT Remote Midwifery Project ECHO Network	3 months	NT PHN, NT Health and Miwatj Health
Employment model for Djäkamirr	3 months	MWRC
Co-write report from World Café	3 months	MWRC to draft then hand to Miwatj Health, NT Health, NTPHN
Establish an MGP Project management support	6 months	NT Health/GDH/OCNMO
24/7 clinical midwifery phone support	6 months	GDH/NT Health
Masters of Midwifery Practice	12-18 months	CDU

Gathering close

Shandi Mununguրr, Rosemary Gundjarranbuy, and Djapirri Mununggirritj *(photographed left to right)* took the stage to close the World Café.

Sheena from Galiwin'ku (not in attendance) had made an audio recording about her birth experience that she wanted to share with the participants. Rosemary Gundjarranbuy introduced Sheena's talk and spoke in language so all Yolŋu women could hear what the presentation was about.

Shandi Mununguրr told the audience that traditionally grandmothers used to talk to the miyälk (women) about normal childbirth with grandmothers cutting the cord. They did not talk about intervention. Yolŋu need more education about caesarean section and induction of labour, and better understanding of what was going to happen.

Shandi Mununguրr also spoke of the tragic loss of her baby and how difficult it is getting a baby home for burial. She noted that the World Café had been good – hopes that moving forward, Yolŋu will have more support and not have to go through what she has had to do. She wants to do djäkamirr training in the future.

Professor Yvette Roe talked about research translation being the goal of the Molly Wardaguga Research Centre. 'We aim for gold standard'. Professor Roe and Shernell Luckie wrapped up the World Café.

Sheena (who has other children) spoke about choosing a caesarean section this time, so she did not have to be away from home for as long, compared to if she had to sit down in Nhulunbuy and wait for labour to start. She did not have an escort and would have liked a djäkamirr. She wanted a normal birth but opted for caesarean section as she did not have the support she needed.

Conclusion

There two key outcomes of the World Café:

1. Gove District Hospital and NT Health to establish a MGP within 6-months (by September 2023), with a list of agreed actions to occur over the short to medium term.
2. It is yet to be agreed how best to adapt the 'gold standard service' to improve services and maternity care to benefit all women across the region. In the first instance, how should services be redesigned for Galiwin'ku women, the site of our prospective non-randomised clinical trial.

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Appendix 1: Speech by Djapirri Mununggirrit, an Elder from Yirrkala

"Government tried to stop birthing and services in Gove Hospital — community and midwives came together to carry the voice of the women was amazing — we don't want our women going to Darwin or Katherine it is so far away from the Yolŋu people — that was a moment of strength — the history was generated by women, midwives, community members — the fear of going elsewhere and a child being born on other peoples' country — all of Nhulunbuy was there, we painted up and led the march — we were on a battle or war within ourselves as women — that guy was a politician, forget what his title was, minister for health, but what he got was something that he didn't expect, it was powerful, like a double edged sword — a voice of a women penetrating the heart of this politician, deep inside his heart making change — he went back and it wasn't very long at all to see the maternity ward close down — something bitter coming to this township — the midwives, the doctors, and the Yolŋu women — it was a miracle to see things happen so rapidly — news came, the maternity ward would open up again — more broader now as we see the vision of the women especially birthing on country is such a powerful thing — what is this gonna look like — and we are now looking forward with excitement, it's burning across Australia — I see the smiling faces of midwives here, and the beautiful work that the women of Galiwin'ku have done — it's a collaboration — when women come together with brilliant ideas from both side of the culture — from little things big things grow — the trees are happy, the soil is happy, the leaves are happy, the midwives have smiles on their faces, the women are so happy cuddling their baby in their arms — this work is so precious in the lives or you and I and I believe we can be more and more and more until we see a turnaround of healthy kids born across Australia — it's the work of you people, of individuals, or everyone of us — bring the cultures together, inter marrying, Balanda and Yolŋu culture — it's eternal but it can go external and be that fire in all of us!!!"

The conveners of the World Café extend our gratitude to workshop participants who contributed their time, knowledge, and expertise. We acknowledge the Yolŋu women from East Arnhem who shared their wisdom and spoke of their birthing experiences.

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