14 September 2018

Senator Malarndirri McCarthy
Senator for Northern Territory

Dear Senator,

At the Brisbane Senate Select Committee meeting on Stillbirth Research and Education, you requested Mater Miscericordiae Ltd to respond with some additional information

1. Percentage of birthing women who

identify as Aboriginal and/or Torres Strait islander : 2.5%

have a refugee background : 3.3%

are from a CALD background : 6.9%

2. Information regarding the Birthing in Our Community (BiOC) model of care and community hub.

Birthing in Our Community (BiOC) is a multi-agency partnership program between two local Aboriginal Community Controlled Health Services - The Institute for Urban Indigenous Health (IUIH) and the Aboriginal and Torres Strait Islander Community Health Service, Brisbane Limited (ATSICHS) and the Mater Mothers Hospital. The BiOC programme includes: 24/7 midwifery care during pregnancy and birth to six weeks postnatal by a named midwife, supported by Indigenous health workers and a team coordinator; partnership with the ACCHS; oversight from a steering committee, including Indigenous governance; clinical and cultural supervision; monthly cultural education days; and support for Indigenous student midwives through cadetships and placement within the partnership. Five years on, the partnership program is proving successful with clients, as well as showing improved maternal and infant health outcomes.

Two documents are attached which provide more details.

3. Specific bereavement training for those caring for Aboriginal and Torres Strait Islander women

Within BiOC there is a suite of cultural safety education and training programmes in addition to the cultural and clinical supervision available to the team. Whilst there is not specific training for stillbirth and bereavement care this is currently being discussed with Professor Vicki Flenady and the NHMRC Stillbirth Centre of Research Excellence. The BiOC model of care facilitates the development of trusting and respectful relationships with known members of the multi-disciplinary team (including social workers and psychologists) which supports individualised and responsive care.

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Raymond Terrace, South Brisbane, Queensland 4101 Australia

Thank you again for the opportunity to contribute to this important discussion.

Yours faithfully

Dr Michael Beckmann MBBS FRANZCOG Maree Reynolds

Mothers Babies & Women's Health Services
Mater Health

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Case Study

Birthing on Country (in Our Community): a case study of engaging stakeholders and developing a best-practice Indigenous maternity service in an urban setting

Sue Kildea[1,2,12] RN, RM, BHlthSc(Hons), PhD, Professor of Midwifery and Director

Sophie Hickey[1] BA(Hons), PhD, Research officer

Carmel Nelson[3] MBBS, MPH&TM, FRACGP, FACRRM, Clinical Director

Jody Currie[4] BA, Chief Executive Officer

Adrian Carson[3] GDip(Health Service Management), Chief Executive Officer

Maree Reynolds[5] RN, RM, BN, M Nursing (Management), Director of Nursing and Midwifery, Mothers Babies and Women's Health Services

Kay Wilson[5] RN, RM, BMedSc(Hons), Director of Nursing and Midwifery, Ambulatory and Birthing Services

Sue Kruske[2,3] RN, RM, BHlthSc(Hons), PhD

Megan Passey[6] BMed(Hons), MPH, MSci, PhD, Associate Professor and Deputy-Director of Research

Yvette Roe[3] MPH, PhD, Director of Research and Evaluation

Roianne West[7] BN, MN, PhD, Professor of First People's Health

Anton Clifford[8] Bed, MMedSc, PhD, Postdoctoral Fellow

Machellee Kosiak[9] RN, RM, BHScN, Lecturer in Midwifery

Shannon Watego[5] BEd, (Early Childhood), Aboriginal and Torres Strait Islander Hospital Liaison Officer

Sally Tracy[10,11] RGON, RM, BNurs, AdvDipMid, MA, DMid, Professor of Midwifery and Women's Health, University of Sydney, Midwifery Advisor for the Poche Centre for Indigenous Health, University of Sydney

[1]Mater Medical Research Institute, Midwifery Research Unit, Level 2 Aubigny Place, Raymond Terrace, South Brisbane, Qld 4101, Australia.
[2]University of Queensland, School of Nursing and Midwifery, St Lucia, Qld 4072, Australia.
[3]Institute for Urban Indigenous Health, 23 Edgar Street, Bowen Hills, Qld 4006, Australia.
[4]Aboriginal and Torres Strait Islander Community Health Service Brisbane Limited, 55 Annerley Road, Woolloongabba, Qld 4102, Australia.
[5]Mater Misericordiae Health Services Brisbane Ltd, Raymond Terrace, South Brisbane, Qld 4101, Australia.
[6]The University of Sydney, University Centre for Rural Health North Coast, 61 Uralba Street, Lismore, NSW 2480, Australia.
[7]Griffith University School of Medicine, First Peoples Health Unit, Gold Coast, Qld 4222, Australia.
[8]University of Queensland, Queensland Alcohol and Drug Research Centre, Herston Road, Herston, Qld 4006, Australia.
[9]Australian Catholic University, School of Nursing Midwifery and Paramedicine, 1100 Nudgee Road, Banyo, Qld 4014, Australia.
[10]University of Sydney, 88 Mallett Street, Camperdown, NSW 2050, Australia.
[11]Poche Centre for Indigenous Health, University of Sydney, NSW 2006, Australia.
[12]Corresponding author. Email: sue.kildea@mater.uq.edu.au

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Abstract. Developing high-quality and culturally responsive maternal and infant health services is a critical part of 'closing the gap' in health disparities between Aboriginal and Torres Strait Islander people and other Australians. The National Maternity Services Plan led work that describes and recommends Birthing on Country best-practice maternity care adaptable from urban to very remote settings, yet few examples exist in Australia. This paper demonstrates Birthing on Country principles can be applied in the urban setting, presenting our experience establishing and developing a Birthing on Country partnership service model in Brisbane, Australia. An initial World Café workshop effectively engaged stakeholders, consumers and community members in service planning, resulting in a multiagency partnership program between a large inner city hospital and two local Aboriginal Community-Controlled Health Services (ACCHS). The Birthing in Our Community program includes: 24/7 midwifery care in pregnancy to six weeks postnatal by a named midwife, supported by Indigenous health workers and a team coordinator; partnership with the ACCHS; oversight from a steering committee, including Indigenous governance; clinical and cultural supervision; monthly cultural education days; and support for Indigenous student midwives through cadetships and placement within the partnership. Three years in, the partnership program is proving successful with clients, as well as showing early signs of improved maternal and infant health outcomes.

What is known about the topic? Birthing on Country has been described as a metaphor for the best start in life for Aboriginal and Torres Strait Islander babies, and services that incorporate Birthing on Country principles can improve outcomes for mothers and babies. Currently, few such models exist in Australia.

What does this paper add? This paper demonstrates that Birthing on Country principles can be successfully applied to the urban context. We present a real case example of the experience of setting up one such best-practice, community-engaged and informed partnership model of maternity and child healthcare in south-east Queensland. We share our experience using a World Café to facilitate community engagement, service delivery and workforce planning.

What are the implications for practitioners? Health professionals providing maternity care for Aboriginal and Torres Strait Islander families are encouraged to incorporate Birthing on Country principles into their model of care to address the specific needs and demands of the local Indigenous community and improve maternal and infant health outcomes.

Additional keywords: health services, Indigenous health.

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Introduction

Significant maternal and infant health (MIH) disparities continue between Aboriginal and Torres Strait Islander (herein referred to as Indigenous) and non-Indigenous Australians, including higher rates of maternal mortality,[1] preterm births, low birthweight infants and perinatal deaths.[2] To address these disparities, it is critical we develop high-quality, culturally responsive and sustainable MIH services. Services that incorporate Birthing on Country principles are recommended best practice and although there has been some progress, there are still few such services existing in Australia.[3]

Four years ago in Alice Springs (NT, Australia), an inaugural national workshop commissioned by the Commonwealth government as a key action resulting from the National Maternity Services Plan[4] was held to discuss the provision of maternity care for Aboriginal and Torres Strait Islander families. Here, women gathered and identified the importance of Birth on Country. Several participants emphasised the importance of being born on one's own country and the (positive) effect this has on children growing up, and the:

> . . .ongoing cultural learning for my family, my children. It has become part of our parenting process. It is so empowering and it is the best healing that I could have ever possibly had. No psychological service. No [counselling] service. Nothing else could have achieved what's been achieved by the transformative process of our family healing through connection to country.[5]

Another participant, who had been born on country, described the powerful, and deeply personal, impact:

> . . .that's not really articulated. It's just something that I know and that I accept and it's mine and nobody can take it away. It makes me think a little bit differently about the Others (her siblings who had not been born on country). I guess it'll make me a bit more (pause) forgiving or tolerant. They've missed so much. They've lost so much. And it does make me sad. I can't fix that. . .it makes me cry.[5]

Attendees of the workshop concluded that 'Birthing on Country' should be understood as 'a metaphor for the best start in life for Indigenous babies and their families because it provides an integrated, holistic and culturally appropriate model of care. . . [requiring] system-wide reform'.[5] This is as applicable in the urban setting as in remote communities, as expressed recently by Jody Currie, CEO Aboriginal and Torres Strait Islander Community Health Service (ATSICHS), Brisbane Limited:

> A birthing place is. . .around ceremony, it is about cultural interconnectedness. . .where we revitalise and renew our traditional practices for mother and babies. . .just because we sit in an urban setting doesn't mean we can't bring back those things. . .It is a humanistic thing. . .it is a connection to country. . .it's the start of our first ceremony.[6]

Prior to conducting the workshop, a literature review had been commissioned.[7] Birthing on Country was defined as service

models that had shown positive outcomes from evaluations and other studies and encompassed some or all of the following elements: they were community based and/or governed; they allowed for incorporation of traditional practice; they involved a connection with land and country; they incorporated a holistic definition of health; they value Indigenous and non-Indigenous ways of knowing and learning; risk assessment and service delivery; they are culturally competent; and they are developed by, or with, Indigenous people.[7]

Drawing on a real case example, this paper demonstrates how Birthing on Country principles can be successfully applied in the urban setting. We present our journey and lessons learned developing the Birthing in Our Community program: a best-practice, community-engaged and informed partnership model of maternity and child healthcare in south-east Queensland. The use of a World Café methodology to facilitate community engagement, service delivery and workforce planning resulted in a multiagency partnership between a large tertiary hospital and two local Aboriginal Community-Controlled Health Services (ACCHS). The partnership is driven by a common commitment to improve MIH outcomes for Indigenous families in the region.

The setting: existing Indigenous maternity care at the Mater

The Mater Mothers' Hospital is a tertiary service in Brisbane (Qld, Australia) with approximately 6000 public births per annum; of these, approximately 180–250 are Indigenous babies. The Indigenous Murri Antenatal Clinic ('Murri' being a collective term usually used by Aboriginal people in and from Queensland) was established in 2004 as a service providing antenatal midwifery and obstetric continuity of care for Indigenous women or women having Indigenous babies, with support from Indigenous Liaison Officers. ACCHS, general practitioners and government services also provide antenatal and postnatal care. In 2009, a multimethod evaluation of the Murri Clinic found a consistent gap over the previous decade between Indigenous and non-Indigenous women in teenage pregnancy, small-for-gestational age, low-birthweight babies and perinatal mortality, with a widening of the gap in preterm birth and smoking in pregnancy.[8,9] Women attending the Murri Clinic reported high levels of satisfaction antenatally, yet the lack of continuity during labour and birth, as well as postnatally, left some women feeling abandoned and disappointed, with others not feeling safe when receiving care. Recommendations from the review included improving coordination and communication between community and tertiary services, reducing duplication of services, increasing continuity of carer and culturally responsive care and improving capacity building for Indigenous employment and education.

Using a World Café to engage community stakeholders

Findings of the Murri clinic evaluation were disseminated to community elders, service users, service providers and policy advisors using a World Café workshop,[10] a practical, collaborative and community-oriented strategy for exploring a question or issue of importance to community stakeholders.[11] The workshop was co-hosted by the evaluation leader from the Mater Mothers Hospital and the Director of Community Engagement at the Institute for Urban Indigenous Health to facilitate integration of service providers and researchers' clinical and methodological skills and expertise with Indigenous community members' local knowledge and expertise. The day commenced by presenting the evaluation findings and two overarching questions:

1. How can maternity services for Indigenous families in the hospital catchment area be strengthened and/or redesigned to improve MIH outcomes during pregnancy, birth and the first year of life?
2. What strategies are needed to support the amalgamation and/or integration of MIH services across tertiary and primary care services?

Over two 1.5-h sessions, participants rotated through nine roundtables to discuss six topics: (1) cultural competency in the health workforce; (2) a new model of care; (3) community engagement; (4) family centred care; (5) vulnerable families and social services; and (6) communication, collaboration and information sharing. Each table received a specific question to discuss for approximately 25 min, then all participants were asked to rotate to another table to discuss the next topic, with the new group building on the last group's progress. This meant that every participant had the opportunity to discuss each topic. Scribed notes and recommendations were fed back to the group at the end of the session and then compiled into a report for dissemination.

The World Café identified three key strategies for improving MIH outcomes and integrating MIH services in south-east Queensland: (1) develop a multiagency partnership between the Mater hospital and local Indigenous community-controlled organisations; (2) establish a new model of care and an MIH 'hub', including a stand-alone birth centre; and (3) improve cultural capability of all Mater staff and support career progression for the Indigenous MIH workforce.

Developing a multiagency Aboriginal–mainstream partnership

Successful Aboriginal–mainstream partnerships 'develop genuine, trusting relationships' between strategic organisations to address the 'complex social determinants driving poor Aboriginal health while working towards a more culturally competent model of service delivery'.[12] ACCHSs are well placed to provide accessible and economical, culturally appropriate primary healthcare to Indigenous families,[13] although at this time in Australia they do not provide the full spectrum of maternity services, including labour and birth. Although mainstream tertiary hospitals are the most common place of birth, they often lack the culturally tailored approach that reflects the broad definition of Aboriginal Health that incorporates the social, emotional and cultural well being of the whole community.[14,15]

Thus, after the World Café, three organisations agreed to partner: the Mater Health Service, the Institute for Urban Indigenous Health (IUIH) and ATSICHS. A steering committee was established in 2012 and met monthly, then bimonthly. Partners agreed to share resources and seek further funding to develop and evaluate a new service model. The partners drew from recommendations from the Murri Clinic evaluation,[9] the World Café,[10] the national Birthing on Country workshop[5] and relevant literature to develop a best-practice complex intervention: the multiagency Birthing in Our Community (BiOC) program.

A key component, continuity of care from a known midwife, has been shown to result in many improved outcomes, including a reduction in preterm birth (of 24%),[16] and for at-risk groups, such as teenagers.[17] In Australia, this is usually provided through a midwifery group practice (a small team of three to four midwives who provide care for a caseload of women) and is thought to work through early engagement with women in pregnancy and providing opportunities for early health and social support interventions that has a positive effect on birth outcomes.[17]

Table 1 presents a BiOC program logic model outlining the key components of the partnership that have been incorporated to reflect Birthing on Country principles, in line with community demand.

Achievements and challenges to date

Figure 1 presents early findings of key MIH indicators from women and babies accessing BiOC in its first 3 years compared with national proportions from other Aboriginal and Torres Strait Islander women.[2] Using Chi-squared tests for association ($P < 0.05$), BiOC was found to have significantly higher proportions of women presenting in first trimester and receiving more than five antenatal visits (babies <32 weeks excluded), with significantly lower proportions of women experiencing preterm birth, Caesarean section and admissions to neonatal intensive care. Exclusive breastfeeding at discharge was reported to be at 80% among women in BiOC, with 13% reporting smoking cessation during pregnancy by discharge at 6 weeks postnatal (from 36% at booking-in down to 23% at 6 weeks postnatal). Future analysis with larger numbers and more sophisticated analyses will determine whether these outcomes are due to selection bias or causal effects from the BiOC partnership as outlined in the program logic (Table 1). We hypothesise that the program itself is popular, drives early and continued engagement and results in improved outcomes for mothers and infants and that some of the improved outcomes are due to this.

Starting as a community-based group antenatal care model, clinic days were to be held at the ACCHS, yet there were not enough available consulting rooms to enable privacy and sessions for the midwives, social worker and obstetrician within this busy practice. Transport has been an ongoing challenge for many women attending appointments and events, and inner city parking charges are an additional barrier. Thus, low clinic attendance prompted a switch to a home-visiting model. This proved very popular with women, midwives and health workers, yet the increased travel time over a large geographical area put additional burden on the midwives and affected hours worked. The interagency linking and social and emotional needs of women required more case management than expected, resulting in additional meetings. To manage these challenges, the midwives' caseload has been reduced incrementally from 35 to 25 women per year, corresponding to four full-time BiOC midwives allocated two to three women per month (excluding holidays). An in-house time-in-motion activity confirmed that BiOC midwives spent more time travelling, in meetings and on night shifts (higher rates of normal birth in this group of women) compared with the other midwifery group practice teams at the Mater Mothers Hospital, yet spent similar time on clinical care with women, despite having a reduced caseload.

For the role of the Indigenous health workers, a gap analysis in the beginning identified four priority areas for providing support: (1) social and emotional well being; (2) smoking cessation; (3) breastfeeding; and (4) cultural support and advocacy. Similar to reports from other studies,[18] the integration of this role in the tertiary setting has been challenging, due, in part, to a lack of standardised national competencies and training, although the partnership is making great improvements in this space.

At present, BiOC is running at capacity and caters for approximately half the women having Indigenous babies attending the Mater Mothers Hospital. All women having an Indigenous baby are offered the option of accessing BiOC if there is availability (all-risk). BiOC is popular with women, who are telling family and friends to present early in pregnancy to ensure they can get a place. BiOC is also seeing return clients for subsequent pregnancies.

Lessons learned and future directions

This paper has added to scant literature on applying Birthing on Country principles in an urban setting. We have described the collaborative and innovative process of aligning a new urban maternity care service to the national Birthing on Country framework[19] by developing a multiagency partnership approach between a large tertiary hospital and two local ACCHSs. Although this partnership requires a significant investment of time and resources, it has enabled increased community accessibility to the service and culturally responsive, holistic care that none of the organisations could have provided independently. Maintaining flexibility in service delivery planning has been essential to adapting the service to sustainably meet the needs of the women. Limitations of the World Café methodology may include disruption to the productive flow of conversations due to time constraints; however, careful consideration from the World Café facilitators ensured that the World Café was a very effective medium for both community engagement and service planning, with an ongoing legacy in developing trusting relationships and genuine collaboration between partners. The small sample size may also be limiting; although BiOC is currently running at capacity, the small sample size prevents analysis of subgroups, and there may be restrictions in the ability of BiOC to accept new and returning women for subsequent pregnancies in the future. We are currently expanding the workforce to address this need. The BiOC partners are currently moving the service into a dedicated community location for a primary maternal and child care centre, 'the Mums and Bubs Hub', funded by the Queensland Government and partner organisations, with the possibility of an Indigenous Birth Centre also being explored. The partnership is working towards creating streamlined approaches to support more Indigenous student midwives and improve Indigenous capacity building more broadly, including research experience. We are exploring how best to get ongoing input from the Elders and service users and will be doubling the capacity of the service and increasing other support, such as transport and social work. Partners are adding consultant paediatrician services, paediatric allied health, women's health, perinatal mental health and other specialised services to the Hub. The Indigenous Birthing in an Urban Setting (IBUS) study embedded into this partnership will continue its ongoing evaluation; we have begun recruitment, with more than 170 women currently consented and longitudinal follow-up until 6 months postnatal. The IBUS

Table 1. Birthing in Our Community (BiOC) partnership program logic

This is a live document and was accurate as of October 2016. ToR, Terms of Reference; MoU, memorandum of understanding; AN, antenatal; PN, postnatal; MIH, maternal and infant health; MGP, midwifery group practice; ACCHS, Aboriginal Community-Controlled Heath Service; ASQ, Ages and Stages Questionnaire[20]; Bayley III, The Bayley Scales of Infant and Toddler Development – Third Edition[21]; GP, general practitioner; LOS, length of stay; NHMRC, National Health and Medical Research Council of Australia; IBUS, Indigenous Birthing in an Urban Setting

Inputs (what is invested)	Activities (what is done)	Outputs (what is delivered)	Outcomes (short- and medium-term results)	Indicators (measurement)	Impact (longer-term results)
Governance and resources					
Steering committee of senior management from partners	Signed MoU to improve Indigenous MIH outcomes through improved service delivery and Indigenous workforce development	Decision making and strategic direction	Regular meetings with agreed outputs	Functioning steering committee meeting as per ToR	Partnerships and knowledge exchange
		Indigenous oversight	Funding applications agreed and submitted		
Partnership investment (resources, time and infrastructure)		Reporting against indicators			Joint resources combined to improve model of care
Funding from all partners	Collaborative research agreement Meet in accordance with ToR Leadership, monitoring and reporting Joint funding applications	Guidance for change management			Exemplar site established
Enhanced MGP					
BiOC clinical staff: two Certificate IV MIH workers, two Aboriginal student midwives, four midwives working in the MGP and a program coordinator	Woman-centred AN care and PN care (individual and group) with regular risk assessment	AN scheduled visits and group sessions including bubs pack incentives and belly casting	Early and regular AN care with completed AN screening and treatment (e.g. anaemia, infections etc.)	All primary and secondary outcomes (e.g. % AN visits ≥ 5, % preterm births, mean birthweight); gestation at first AN visit	↑ Support for women
	1 : 1 support from known midwife and MIH worker for pregnancy, birth and PN care (up to 6 weeks)	Continuity of carer from known midwife and MIH worker			↓ Preterm births and neonatal nursery admissions
Part-time administrative support, designated social worker, GP and obstetrician for referral when required	Case review or consultation (with BiOC obstetrician or social worker) referrals and transfer to specialists if needed	Transport to or home-visiting PN care to 6 weeks with hand over to Child Health Nurse for Healthy Under 5 schedule, child health check and immunisation service	Normal birth with known midwife and reduced medical interventions and LOS (mother and infant)	% Breastfeeding (various time points) and fully immunised at 6 months	↓ Caesarean sections ↓ Infant morbidity and mortality
	Clinical governance framework		Exclusive breastfeeding at discharge (6 weeks) and 6 months PN	% Infant hospitalisations <12 months	Presentation in 1st trimester
			Fully immunised at 6 months and reduced failure to thrive	Immunisation coverage rates at 12 months ASQ and Bayley III score	Lower rates of infant developmental delay

(*continued next page*)

Table 1. (*continued*)

Inputs (what is invested)	Activities (what is done)	Outputs (what is delivered)	Outcomes (short- and medium-term results)	Indicators (measurement)	Impact (longer-term results)
Cultural competence and workforce					
Leadership from cultural knowledge holders	Working parties meet regularly and report to steering committee	Strengths-based program of cultural education and mentorship (including racism awareness)	Culturally competent care by a skilled workforce	Completed plans for cultural safety, risk management	Culturally safe and responsive services
Leadership from team members for workforce development	Develop cultural and community engagement strategies and workforce development strategy	Partnership between non-Indigenous staff and cultural mentors supervised by senior	All women complete a well being plan	% Having well being plan	↑ Indigenous maternal and infant health workforce
Holistic understanding of health, including community well being	Refine indicators for measuring culturally competent individuals and organisations	Indigenous cultural supervisors	Community involvement in cultural care planning and cultural sessions	% Having birth plan	↑ Retention of skilled staff
Cadetship and placement for Indigenous student midwives	Develop social emotional cultural and spiritual well being plans (in development)	Belly casting and other family events	Non-Indigenous staff exposed to cultural events	% Culturally competent staff	
	MIH workers provide first welcome visit and monthly family Yarning Day at ACCHS clinic	Well being plan for mum and family, including birth plan		Facility cultural competence score	
	Clinical staff receive regular clinical and cultural supervision	Student midwifery training program		BiOC team member retention, turnover rate and student completion rate	
Harm minimisation					
Harm minimisation strategies for women who smoke, drink alcohol or take other drugs, or for social issues, including housing and domestic violence in pregnancy and postnatally	Smoking cessation program	Smoking cessation incentive program	↓ Smoking and drinking in pregnancy and the postpartum period	All secondary outcome smoking indicators (e.g. % women smoking in pregnancy and at 2 and 6 months PN)	↓ Smoking rates
	Support program for alcohol and other drugs	Alcohol and other drugs support			↓ Preterm births
	Health promotion: individual and groups	Screening and assessment follow-up referral and/or support			↓ Fetal alcohol spectrum disorder
	Fortnightly risk planning			% Safe stable housing	↓ Chronic disease
	Meeting with specialists (e.g. obstetrician, social worker, diabetes educator)			Number of referrals to allied health	↓ Contact with Child Safety services

NHMRC-funded partnership research project	Longitudinal prospective birth cohort study, the IBUS study, using participatory action research approach to evaluate acceptability to women and staff, feasibility, clinical and cost-effectiveness of partnership	Timely evidence-based feedback to improve partnership and service delivery	Acceptability, feasibility, and effectiveness of service by actioning recommendations within the partnership	Number of women consented into IBUS study; % of women who complete follow-up surveys	↑ Evidence base for service planning and delivery, including roll-out to other services
Research staff: research manager and research assistants, as well as chief and associate investigators	Surveys conducted with women at booking-in, 36 weeks AN and 2 and 6 months PN Smoking cessation support and incentives-based invention substudy 'Stop Smoking in its Tracks' In-depth ethnographic substudy exploring women's experiences 'Tell My Story' Cost-effectiveness substudy	Results shared with women and service providers through newsletters, reports, presentations and academic publications		Number of scholarly articles and other reports	

Overarching principles

1. Privileging Indigenous knowledge and releasing and strengthening local capacity (strengths based)
2. Aboriginal and Torres Strait Islander cultural guidance and oversight
3. Woman- and family-centred holistic care engages men and fathers within culturally appropriate framework
4. Partnership approach
5. Birth is a significant life event and a normal physiological process
6. Continuity of carer by a culturally competent workforce integrated into a maternity services network
7. Community development approach
8. Evidence-based approach
9. Right care by the right person at the right time in the right place
10. Care is safe and feels safe

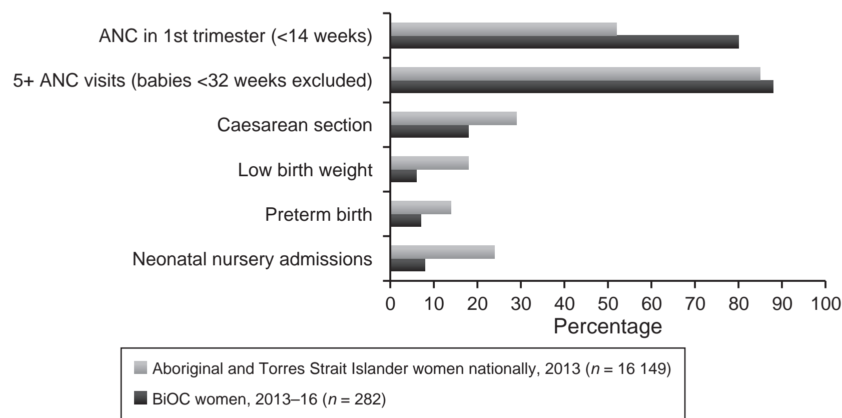

Fig. 1. Maternal and infant health (MIH) outcomes of women in the Birthing in Our Community (BiOC) program compared with Aboriginal and Torres Strait Islander women nationally. ANC, antenatal care (national data from AIHW[2]).

study will document women's experiences and perceptions of the model, and evaluate the partnership's sustainability and cost-effectiveness. We will continue to provide further evidence from ongoing evaluation of this Birthing on Country best-practice model and its effect on MIH outcomes for Indigenous families in an urban setting.

Completing interests

None declared.

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96 Blomfield Street Salisbury Qld 4107
P.O. Box 5638, West End Q 4101
t: +61 7 3274 5700 • ABN: 32 140 019 290

BIRTHING IN OUR COMMUNITY

Birthing in Our Community (BiOC) is a multi-agency partnership program between a large inner city hospital (The Mater Mothers Hospital) and two local Aboriginal Community Controlled Health Services - The Institute for Urban Indigenous Health (IUIH) and the Aboriginal and Torres Strait Islander Community Health Service, Brisbane Limited (ATSICHS). It was launched in 2013 and to date over 300 women have accessed the program.

The program includes:

- 24/7 midwifery care in pregnancy to six weeks postnatal by a named midwife, supported by Indigenous health workers and a team coordinator
- Partnership with the Aboriginal community health services
- Oversight from a Steering Committee, including Indigenous governance
- Clinical/cultural supervision; monthly cultural education days; and
- Support for Indigenous student midwives through cadetships and placement within the partnership.

Our first BiOC mum and bub!

Launch of Birthing in Our Community, October 2013

Deadly Family Yarning Circle Days are held monthly

The new Salisbury Mums and Bubs Hub was officially opened by the Hon Cameron Dick, March 2017

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Our History

The Indigenous Murri Antenatal Clinic ('Murri' being a collective term usually used by Aboriginal people in and from Queensland) was established in 2004 at the Mater Mothers Hospital as a service providing antenatal midwifery and obstetric continuity of care for Indigenous women or women having Indigenous babies, with support from Indigenous Liaison Officers. Aboriginal community health services, general practitioners and government services also provide antenatal and postnatal care.

In 2009, a multimethod evaluation of the Murri Clinic found a consistent gap over the previous decade between Indigenous and non-Indigenous women in teenage pregnancy, small-for-gestational age, low birthweight babies and perinatal mortality, with a widening of the gap in preterm birth and smoking in pregnancy.

Women attending the Murri Clinic reported high levels of satisfaction antenatally, yet the lack of continuity during labour and birth, as well as postnatally, left some women feeling abandoned and disappointed, with others not feeling safe when receiving care.

A world café was held to disseminate the findings back to stakeholders and also to invite the community to provide input into designing the new model. This led to the partnership of three key organisations who committed to provide a new more coordinated and improved maternal and infant health care service for Aboriginal and Torres Strait Islander families. And this became the Birthing in Our Community program.

The Partners

The Mater Mothers' Hospital is a tertiary service in Brisbane (Qld, Australia) with approximately 6,000 public births per annum; of these, approximately 180–250 are Indigenous babies.

The Aboriginal and Torres Strait Islander Community Health Service (ATSICHS), Brisbane Ltd, established 40 years ago, was the first Aboriginal controlled health service in Queensland.

The Institute for Urban Indigenous Health (IUIH) leads the strategic planning, development and delivery of comprehensive primary health care services to the Indigenous population of South East Queensland. It was established in 2009 by the four Community Controlled Health Services in SEQ to provide for the needs of Australia's second largest Indigenous population and now runs over 19 clinics.

We also thank Qld Health for additional funding

Some of the BiOC Team members, March 2017