CATSINaM 2014 Conference: Outcomes of the ‘Birthing on Country’ Yarning Circles

December 2014
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ACKNOWLEDGEMENTS

CATSINaM would like to thank everyone who participated in the 2014 Conference ‘Birthing on Country’ Yarning Circles for sharing their collective reflections and considerations, and providing guidance on how CATSINaM can prepare a policy position statement that underpins its advocacy agenda for Aboriginal and Torres Strait Islander birthing women and their families.
Introduction

CATSINaM has held an Annual Conference since being formally established in 1998. The conference has multiple purposes, including: networking, peer support, professional development, dissemination of research findings, and sharing nursing and midwifery good practice in Aboriginal and Torres Strait Islander contexts. The 2013-2018 Strategic Plan identified another critical purpose for the conference, depicted in Figure 1, which is ‘Strategy 1.3: Consult with Members on a regular basis about professional support and policy priorities’.

The consultation outcomes from the 2013 Conference have translated into direct action in two ways. First, they have guided the priorities CATSINaM has taken to providing member support, member benefits and professional development options. Second, they have resulted in three policy position statements that are now available on the CATSINaM website: 1) recruitment and retention, 2) clinical placements, and 3) cultural safety. They inform stakeholders of CATSINaM’s position, and are regularly used in CATSINaM’s partnership and advocacy work on building and supporting the Aboriginal and Torres Strait Islander nursing and midwifery workforce.

A priority focus for consultations at the 2014 Annual Conference was on how CATSINaM could work with the Australian College of Midwives (ACM) to develop a joint policy position statement on ‘birthing on country’. This report outlines the process undertaken and outcomes achieved, which will guide ongoing work in creating the ‘Birthing on Country’ Position Statement.

Figure 1: 2013-2018 CATSINaM Strategic Plan and Annual Conference links

- Elevate the profile of CATSINaM as the national peak body for Aboriginal and Torres Strait Islander nurses and midwives
- Increase our Member communication, support and engagement
- Consult with Members on a regular basis about professional support and policy priorities
- Provide support for members to engage in professional development opportunities

Strategic Direction 1
Objective 1.2
Strategies 1.3 and 1.5
Yarning Circles process

The Yarning Circles were a self-led activity where participants broke into groups and worked at a table with six-seven people for about 50 minutes. They chose their table facilitator and documenter, and used the provided recording tools to go through the steps outlined below.

**STEP 1 – Describe birthing ‘on country’ services:** Use the Services A3 worksheet to document your group’s responses to these two questions:

- What would ‘on country’ services look like?
- Where would they be located?

Please use the back of the worksheet if you need more room, especially for the first question.

**STEP 2 – Explore the process needed to establish the services you described:** Use the two A3 worksheets called Process: How do we achieve this? and Process: Enablers and barriers to document your group’s responses to these three questions:

- **How do we achieve this?** This is about the steps that need to be taken to establish birthing on country services. If possible, organise your ideas into ‘immediate steps’ that are required (put on the left side of the page with a link to the first green button), then ‘early steps’ that build on this work (put in the middle of the page with a link to the second green button), and ‘later steps’ that can occur down the track once the foundation is laid (put on the right side of the page with a link to the third green button).
- **What are the enablers?** For example, what things already exist (even if in some rather than all locations) that would help you achieve birthing on country services?
- **What are the barriers?** For example, what do you need to overcome, work around or have someone else address so you can achieve birthing on country services? If you also have ideas about how barriers can be dealt with, then comment on that as well.

Please use the back of the worksheets if you need more room – if you do this, please organise your ideas in the same areas of the page as the front of the sheets.

**STEP 3 – Consider how CATSINaM and ACM can create a position statement about birthing on country:** Use the Position Statement A3 worksheet to document your group’s responses to these two questions:

- How shall we develop it? Please consider that CATSINaM and ACM both have limited resources so we need approaches that are low-cost while being inclusive of who should be involved.
- Which stakeholders should we consult? After naming each group of stakeholders, please describe how you think this should occur.

**STEP 4 - Feedback:** Follow the main facilitators’ lead by sharing your group's responses and suggestions.
Choose which one of your proposals is the most important to emphasise to CATSINaM. Write it on the butcher’s paper. However, know that all your proposals will be analysed and considered.

**STEP 3 - Feedback:** Put your butcher’s paper in the display area so others can see your group’s ratings and top priority proposal.
Outcomes

The outcomes are presented according to the three components and key questions asked for each component.

‘Birthing on country’ services

What would 'birthing on country' services look like?

The features that participants believed would be evident in ideal ‘birthing on country’ services fell into six themes. They are described in this section, along with a seventh theme that described the options that could be made available in already established facilities to support a ‘birthing on country’ approach. All seven themes are depicted in Figure 3.

**Figure 3: What would 'birthing on country' services look like?**

| Culture at the centre: safety and protocols | Family support |
| Community responsive | Staffing |
| Emergency facilities | Antenatal and postnatal care |
| Options in established facilities |

**CULTURE AT THE CENTRE: SAFETY AND PROTOCOLS**

A defining feature of ‘birthing on country’ services is that culture is at the centre of everything that occurs. This strengthens the likelihood that cultural needs are met, cultural safety is experienced by women and their families, and cultural protocols are honoured. The service would need to offer different options for service users, not a one size fits all approach, as protocols can differ between different Aboriginal and Torres Strait Islander nations. It would need to rethink standard approaches to identifying ‘risk factors’ and consider them through a cultural lens, as well as make individual and culturally-informed assessments. It would be a women-centred and children friendly place that provides secure and private services for women and their families.
COMMUNITY RESPONSIVE

A community responsive service would reflect the needs and wants of the community it serves, with the capacity to respond to individual needs. By implication, consultation with women across the community would be required. Where possible, the service would be part of an Aboriginal Community Controlled Health Service that is premised on community governance, consultation and ownership.

FAMILY SUPPORT

‘Birthing on country’ services would place high value on providing family support. A primary form of support is providing accommodation for the birthing mother and family members who are there to support her, e.g. this may include fathers, grandmothers, aunts, Elders, siblings. Some of these people may be present during the birth, a matter that would be the birthing mother’s choice, and have specific roles that are discussed with the staff. These family members may also be involved in antenatal and postnatal care and support provided to the birthing mother (see below).

ANTENATAL AND POSTNATAL CARE

Antenatal and postnatal care should be a standard part of the service. This includes antenatal classes (in which other family members can participate) and regular support programs during the pre-birthing stage (i.e. using art or belly casts). Transitional care would be offered, including a location to stay, whether transiting from ante-natal care to birthing or birthing to post-natal care. Post-natal or ‘extended midwifery care’ would be offered, i.e. support and follow up for up to 4 years, and may involve offering networking opportunities among mothers who use the service. It would be vital for the service to offer continuity of care from antenatal through to the post-natal period, preferably with a similar staff care team.

STAFFING

The service would be staffed by Aboriginal and Torres Strait Islander midwives and doctors; wherever possible, midwives and doctors from the same country/countries as the service location. It would also be valuable to consider including allied health staff on the team. However, it is possible that both Aboriginal and Torres Strait Islander and non-Indigenous staff would be involved. In this case, non-Indigenous staff with knowledge of and skills in the provision of culturally safe services would need to be recruited.

Aboriginal and Torres Strait Islander midwives would have strong leadership roles and be involved in all aspects of the service – antenatal care, birthing and post-natal care – covering education, clinical care and health promotion. They would also work in partnership with traditional midwives within the community. The service would provide opportunities for local community members to be trained in a range of required roles, including continuing on to formal studies in nursing and midwifery, or as Aboriginal Maternal and Infant Care (AMIC) Workers as a starting point.
It would be worthwhile exploring regional, jurisdictional and/or national innovative approaches for increasing the Aboriginal and Torres Strait Islander midwifery workforce to make this more viable for local services to achieve.

**EMERGENCY FACILITIES**

The capacity to deal with emergencies needs to be built into ‘birthing on country’ services that do not have them on-site or within a short distance. This would include clinical systems, communication mechanisms and on call transport options being in place, along with pre-negotiated cooperative relationships with health services that have emergency facilities, including access to obstetricians and gynaecologists.

**OPTIONS IN ESTABLISHED FACILITIES**

It is also possible to create a ‘birthing on country’ service within established birthing facilities. Such facilities could consider one or more of the following options to enable this:

- having an Indigenous-specific birthing centre within the facility
- having more capacity to support home births
- offering small clinics with nurses and midwives that Aboriginal and Torres Strait Islander birthing mothers and their families can access
- engaging independent Aboriginal and Torres Strait Islander midwives and doctors on a contract or casual basis in addition to permanent staffing to help staff their Indigenous specific services.
- providing access to accommodation for birthing mothers and families, and child care services
- establishing collaborative arrangements with smaller ‘birthing on country’ services in urban, regional and remote locations to provide an extension of their service where higher clinical care or emergency responses are needed – these smaller ‘birthing on country’ services may be run through public health or Aboriginal Community Controlled Health Services.

**Where would 'birthing on country' services be located?**

Four themes emerged from participant discussions about the location of ‘birthing on country’ services, which should be considered complementary rather than separate ideas. They are illustrated in Figure 4 and each is expanded upon in this section.

**BIRTHING CENTRES IN LOCAL COMMUNITIES**

Priority was placed on stand-alone and dedicated birthing on country’ services/centres in local communities where the community decides on the site, whether this be in urban, regional or remote locations. Some locations may have larger language and/or nation group communities,
while other locations would involve a number of different language/nation groups. Participants emphasised the importance of the birthing centre being based where Aboriginal and Torres Strait Islander peoples felt safe, and they had access to family links and support. The preference was for locations that were separate from hospitals, although hospital services could be accessible if required (as described above in ‘Emergency facilities’).

**Figure 4: Where would 'birthing on country' services be located?**

![Diagram showing birthing centres in local communities, co-location, mobile services, and other location features.]

**CO-LOCATION**

An option was for the birthing centre to be co-located with Aboriginal Community Controlled Health Services, as they could offer shared administration as well as shared services and more seamless care. Dedicated birthing centres could be built within school or other community grounds that have access to child care facilities and are close to public transport.

**MOBILE SERVICES**

The provision of mobile services should be considered – whether operating from a stand-alone centre or a ‘birthing on country’ service within existing facilities (as described above in ‘Options in established facilities’). This would be particularly useful in regional and remote locations, as this would improve access by taking obstetric services closer to where people live rather than birthing women and families doing all of the travelling.

**OTHER LOCATION FEATURES**

Several other ideas emerged about location. Participants suggested that a ‘birthing on country’ service could be part of a number of small clinics located in a central health service hub, and would assist in providing more Indigenous services in smaller local hospitals. In fact, it should be offered in all hospitals, or at least be evenly distributed among most health services, and be an extension of existing services. It was also suggested that industry partners could contribute towards the creation of these facilities.
The process for establishing ‘birthing on country’ services

What steps do we need to take?

Participants were asked to frame their responses around what they believed were the immediate, early and later steps to take. The common ground that emerged from the different yarning circles is depicted in Figure 5, with more detail provided in this section. A further decision to be made is whether to undertake this on a national scale, or to identify a location, region and jurisdiction where there may be favourable conditions to initiate the process, and then develop a process that can be replicated on a broader scale.

IMMEDIATE STEPS

In order to get started, four immediate steps were identified:

- **STEP 1 - Community Consultation**: The starting point was to consult community members about their needs and wants, and compare this to the existing available services and other sources of information regarding need (e.g. demographic information, and previous requests for improved birthing services or ‘birthing on country’ services for the locations in which consultation is occurring).

- **STEP 2 - Viability assessment**: In this step, the community consultation outcomes would be placed alongside other needs assessment data, such as existing successful ‘birthing on country’ services (dedicated services or extensions of existing facilities), the descriptions of ‘birthing on country’ services provided in this report, and previous reports and recommendations about improving birthing services or developing ‘birthing on country’ services as a basis for planning. For example, consideration should be given to the 2012 national report entitled ‘The characteristics of culturally competent maternity care for Aboriginal and Torres Strait Islander women’ that was researched and written as part of implementing the 2010-2015 National Maternity Services Plan (Australian Health Ministers’ Advisory Council or AHMAC, 2011). A comparative analysis would be produced, along with a detailed description of an effective ‘birthing on country’ service plan and the funding implications (i.e. for establishing stand-alone or extension services).

- **STEP 3 - Promotion**: The proposed ‘birthing on country’ service plan now needs to rally support amongst relevant organisations and allies, including through CATSINaM and the Australian College of Midwives developing a joint position statement, and then be promoted to raise awareness of the request and the rationale for it.

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Figure 5: Process - How do we establish ‘birthing on country’ services?

Immediate steps
- Community consultation
- Viability assessment
- Promotion
- Secure funding and in-kind resources

Early steps
- Design the pilot
- Networking and relationship building
- Recruitment and workforce development
- Evaluation of the pilot
- Secure resources for ongoing implementation

Later steps
- Ongoing implementation
- Expansion into new locations
- Evaluation of ongoing ad expanded services
- Staff retention
- Share the story
**Outcomes of the 2014 Conference ‘Birthing on Country’ Yarning Circles**

**STEP 4 - Secure funding and in-kind resources:** The final step required for moving ahead is to identify options for funding one or more stand-alone or extension ‘birthing on country’ services – this may occur via service or research grants, funding pools associated with current government policy (State/Territory or Australian Government) and existing health services.

**EARLY STEPS**

Once funding is secured, then it is possible to move into the early stage establishment and implementation of one or more ‘birthing on country’ services via these four steps. Steps 1, 2 and 3 would need to commence at the same time, while Steps 2 and 3 would continue throughout the entirety of the early stage:

**STEP 1 - Design the pilot:** Design one or more pilot projects based on the proposed ‘birthing on country’ service plan in different locations, the amount of funds secured, and undertake early trials with a small group of women.

**STEP 2 - Networking and relationship building:** Identify key stakeholders for the pilot, and liaise with them to build and/or strengthen relationships. This would include organisations that could provide mentoring for staff in the pilots (e.g. other ‘birthing on country’ health services), provide training and professional development to staff and/or community members who are recruited into staff roles (e.g. vocational education training providers and universities) and evaluate the pilot (e.g. consulting firms and/or universities). Along with local community members, some of these stakeholders could be included in a Pilot Reference or Steering Group.

**STEP 3 - Recruitment and workforce development:** Recruit midwives, doctors and other Aboriginal and Torres Strait Islander health staff for the pilot sites. Recruit qualified Aboriginal and Torres Strait Islander people into health and administrative staff roles, including local community members. Drawing on the stakeholder relationships in Step 2, provide training to enable community members to take on new roles or progress their career into being an AMIC Worker, midwife and/or nurse.

**STEP 4 - Evaluation of the pilot:** Engage an external evaluator to work with staff, local communities and a Pilot Evaluation Reference Group to design, undertake and report on the pilot evaluation.

**STEP 5 - Secure resources for ongoing implementation:** Utilise the pilot evaluation outcomes to share the outcomes with a range of relevant stakeholders, including funding bodies, and argue for them to become ongoing services. In addition to drawing on the pilot evaluation outcomes, utilise other demographic and comparative data to rally support and lobby for funding and in-kind resources to expand the pilot services into new locations.

**LATER STEPS**

Progressing to the later steps is premised on the pilot evaluation indicating the pilot was successful, even though there may be areas for further improvement, and securing funding and
in-kind resources to continue the pilot and expand into other locations. It involves five steps – Steps 1 and 2 being continuous, while Steps 3 and 4 would be concurrent:

- **STEP 1 - Ongoing implementation:** The funds and in-kind resources secured should enable existing pilots to become established as ongoing services, whether under the auspice of state/territory health or Aboriginal Community Controlled Health Services.

- **STEP 2 – Expansion into new locations:** The funds and in-kind resources should also enable an expansion into new locations to establish ‘birthing on country’ services. This may involve the extension of existing or building of new facilities, the adaptation of existing services and the creation of new services.

- **STEP 3 – Evaluation of ongoing and expanded services:** Develop an agreement amongst all ‘birthing on country’ services to participate in a collaborative evaluation (which will be more cost effective and provide better evidence across different geographical and cultural contexts). Engage an external evaluator to work with staff, local communities and an Evaluation Reference Group to continue, enhance and expand the pilot evaluation design, undertake the expanded evaluation and write a report on the outcomes.

- **STEP 4 - Staff retention and succession planning:** Encourage collaboration amongst all ‘birthing on country’ services to develop strategies that assist in retaining staff, as this will assist with continuity of care for birthing mothers and families. Continue to implement the successful workforce development strategies from the pilot to assist with succession planning. Some staff may undertake training and education that assists them to move from administrative or AMIC positions into midwifery and/or nursing, and other community members may be recruited and upskilled into vacant staff positions.

- **Step 5 – Share the story:** Ensure that progress updates, program events and evaluation outcomes from the ongoing and expanded services are shared with a wide range of stakeholders.

### What are the enablers and barriers in the process?

There will be factors that both work for and against the implementation of the above process to establish ‘birthing on country’ services. So plans can be made to harness the enablers and minimise or work around the barriers, the participants identified what they viewed as enablers and barriers. They are illustrated in Figure 6 and expanded upon in this section.

### Enablers

- **Community and cultural knowledge:** Knowledge of community needs and cultural practices and protocols will be critical to informing the design and delivery of services within involved communities. It will be accessible via the consultation processes with birthing mothers and their families recommended for the ‘immediate steps’, the ‘Reference Group’ identified for the ‘early steps and ‘later steps’, Aboriginal Community Controlled Health Services that are involved in the auspice/delivery of the service or that collaborate with the service, and staff recruited from the local community.
Figure 6: Enablers and barriers in the process

What are the barriers?
- Unsupportive Government policy and funding commitments
- Resistant stakeholders
- Lack of an available and capable workforce
- Risk factors
- Community concerns or challenges
- Lack of resources

What are the enablers?
- Community and cultural knowledge
- Supportive Government policy and funding commitments
- Supportive partners and stakeholders
- An available and capable workforce
- Evidence
- Committed and/or available resources
Supportive Government policy and funding commitments: Current Government policy at the Australian and/or State/Territory levels that is in alignment with the advice provided in this report should enable progress, as there should be political will to support ‘birthing on country’ services that is coupled with funding for a pilot, as well as ongoing and expanded services.

Supportive partners and stakeholders: If CATSINaM and the ACM are supported by a shared vision and the commitment of a range of partners and stakeholders, then this will support the establishment of ‘birthing on country’ services. Important organisations and groups include: nursing and midwifery national organisations, medical national organisations, Aboriginal health national and jurisdictional organisations, consumer advocacy groups, health industry partners (state/territory and Aboriginal Community Controlled Health Services), universities and vocational education training organisations, and communities themselves.

An available and capable workforce: Access to a capable workforce is a strong enabler. This means Aboriginal and Torres Strait Islander midwives, doctors (including obstetricians), AMIC Workers, Aboriginal and Torres Strait Islander Health Workers and administrative workers, as well as non-Indigenous staff who have the skills and knowledge to practice in a culturally safe manner in partnership with their Aboriginal and Torres Strait Islander colleagues. We are aware the Aboriginal and Torres Strait Islander midwifery workforce is smaller than required for our current needs. Therefore, access to effective education and professional development programs, including cultural safety training, in order to upskill the existing and potential workforce will be an enabler.

Evidence: Access to evidence will also be vital, i.e. literature review, evidence from good practice examples in Australia and overseas, and health economic arguments. Some of this material has been assembled in ‘The characteristics of culturally competent maternity care for Aboriginal and Torres Strait Islander women’ 2012 national report (see Footnote 1), but more material specifically about ‘birthing on country’ is needed.

Committed and/or available resources: Any resources that are currently committed to or available to support birthing services for Aboriginal and Torres Strait Islander Australians, including established buildings and other infrastructure, not just funding, will be valuable. Current resources can be redirected and programs reshaped to reflect ‘birthing on country’ services, which will assist in establishing pilot programs, as per the ‘immediate steps’ and ‘early steps’ described above.

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2 CATSINaM recent analysis of the 2013 Australian Institute of Health and Welfare (AIHW) nursing and midwifery workforce data indicates that the representation of Aboriginal and Torres Strait Islander midwives needs to rise from the current level of 0.8% to 3.6% as a minimum, i.e. 4.6 times current figures.
Outcomes of the 2014 Conference ‘Birthing on Country’ Yarning Circles

Barriers

- **Unsupportive Government policy and funding commitments:** If current Government policy at the Australian and/or State/Territory levels is not congruent with the advice provided in this report, this will present a number of barriers to overcome, i.e. a lack of understanding of the concept of and need for ‘birthing on country’ compared to current medical models of birthing, resistance to reshaping programs or redirecting resources, a lack of support for new funding.

- **Resistant stakeholders:** It is possible that some stakeholders may be resistant to a ‘birthing on country’ service delivery model. This is likely to come from individual health professionals or health professional groups with vested interests in the current medical model of birthing.

- **Lack of an available and capable workforce:** The Aboriginal and Torres Strait Islander midwifery workforce is smaller than required for our current needs (see Footnote 3). This is exacerbated by a shortage in midwives overall, particularly in terms of their geographical distribution, as well as insufficient midwives having sufficient knowledge and skills in the delivery of culturally safe services. In addition, Aboriginal and Torres Strait Islander Health Workers and/or AMIC Workers are not routinely involved in or available to support maternity care services.

- **Risk factors:** The viability and safety of ‘birthing on country’ services may be challenged in relation to risk factors such as the existing statistics on higher rates of co-morbidities or complications for Aboriginal and Torres Strait Islander birthing mothers, or the impact of distance from birthing services with emergency facilities. The implications would be the capacity of ‘birthing on country’ services to safely manage complications or ‘high-risk’ births, and rapidly access emergency facilities where required.

- **Community concerns or challenges:** Other possible barriers to be overcome in the process of engaging Aboriginal and Torres Strait Islander communities with the establishment of ‘birthing on country’ services could be limited health literacy, language barriers and fear on the basis of previous inadequate or poor experiences.

- **Lack of resources:** Finally, a lack of resources will be a barrier – whether it is the allocation of new funding, redirected funding or in-kind resources (buildings, equipment and/or staff).
Developing a ‘birthing on country’ position statement

In their introduction to the yarning circles, CATSINaM and the ACM explained that they had made a commitment to develop a joint ‘Birthing on Country’ Position Statement. This is consistent with their core purpose as national health professional organisations, and their intended work as outlined in their respective Strategic Plans. Both organisations have limited resources, so they asked participants to consider this in responding to questions on how the position statement should be developed – both the process and the stakeholders to be involved.

What process should we use to develop the position statement?

A summary of the five elements that were identified for the development process is shown in Figure 7 – each element is described in greater detail below.

**Figure 7: What process should we use to develop the position statement?**

<table>
<thead>
<tr>
<th>Develop an overall plan</th>
<th>Engage with partners and jointly lobby</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engage communities</td>
<td>Identify funding</td>
</tr>
<tr>
<td>Identify research and evaluation evidence</td>
<td></td>
</tr>
</tbody>
</table>

**DEVELOP AN OVERALL PLAN**

CATSINaM and ACM each follow a formal process for developing and endorsing policy papers and position statements. Their first step is to agree on the process they will adopt for creating a joint ‘Birthing on Country’ Position Statement that ensures Aboriginal and Torres Strait Islander Australian voices predominate and endorsement is gained from both organisations. If needed, this could be formalised in a memorandum of understanding or similar document.

**ENGAGE COMMUNITIES**

While the information drawn together from the yarning circles in this report will inform the position statement, further community consultation will be important to develop the content so it will be important to engage a diverse range of Aboriginal and Torres Strait Islander communities. Priority voices would be Aboriginal and Torres Strait Islander women (those who are mothers and those who are yet to be mothers), traditional midwives, and Aboriginal and Torres Strait Islander people working in the midwifery workforce (midwives, AMIC Workers and
Aboriginal and Torres Strait Islander Health Workers). Wherever possible, it would be important to meet with people in their home and/or work location.

**IDENTIFY RESEARCH AND EVALUATION EVIDENCE**

The position statement should be supported by good practice evidence, including research and evaluation on existing ‘birthing on country’ services (in Australia and/or overseas) that describe the benefits of birthing on country.

**ENGAGE WITH PARTNERS AND JOINTLY LOBBY GOVERNMENT**

Once the final document is developed, and the consultation and endorsement process completed as per the agreed overall plan, a strategy will need to be agreed to disseminate and promote the statement to government. This can occur through the leadership of CATSINaM and ACM but in collaboration with other partners who have given their support.

For example, the Board Members in each organisation could pair up on a jurisdictional basis and work with other relevant state-based peak organisations to lobby State/Territory Government. The Chairperson and CEOs of both organisations should approach and discuss the position statement with the Maternity Services Inter-Jurisdictional Committee of the Australian Health Ministers’ Advisory Council, and the Aboriginal and Torres Strait Islander Health Workforce Working Group, as it is relevant to current national strategies over which they have oversight. In addition, the position statement should be included in CATSINaM and ACM’s discussions with current Health Ministers and the Opposition Health spokesperson as part of their regular contact. This is a process they could undertake jointly with other partners and/or seek statements of support from other partners.

**IDENTIFY FUNDING OPTIONS**

The work in lobbying government would then lead on to identifying funding options, as discussed in ‘The process for establishing ‘birthing on country’ services’ section for ‘immediate steps’ and ‘early steps’. This includes funding for service delivery, as well as evaluation and research.

**Which stakeholders should be included and how?**

Participants also identified which stakeholders should be included in the position statement development process and provided advice on how this could occur. The four main groups are shown in Figure 8 with the options for how they could be involved described in this section.

**COMMUNITIES**

Consistent with their responses to the previous question, participants wanted Aboriginal and Torres Strait Islander community members to be directly involved in discussions that inform the position statement; in particular, women and Elders. They suggested that face to face options be used, e.g. yarning circles or community forums, but these could be supplemented by surveys and social media.
Figure 8: Which stakeholders should be consulted and how?

PEAK HEALTH ORGANISATIONS

A variety of peak health organisations were identified, as they would be stakeholders on an advocacy and/or service delivery basis for creating and supporting ‘birthing on country’ services. The groups, reasons for accessing them and recommended methods for gaining input and feedback from each are listed here:

- **CATSINaM** and **ACM** in order to reach midwives, particularly Aboriginal and Torres Strait Islander midwives: Use their existing forums, workshops and feedback mechanisms, along with a dedicated section on their websites through which people can give commentary or make submissions.

- **NATSIHWA** in order to reach Aboriginal and Torres Strait Islander Health Workers who may work in or collaborate with maternity services: Use their existing forums and feedback mechanisms, including links to the dedicated section of the CATSINaM or ACM websites.

- **Nursing and Midwifery Board of Australia, AHPRA**: Make a presentation and hold a discussion at a Board meeting or a formal submission seeking their feedback.

- **NACCHO, State/Territory Affiliates and Aboriginal Community Controlled Health Services** in order to reach Aboriginal primary health care services: Use methods negotiated with the NACCHO and State/Territory Affiliate Boards and Secretariats, e.g. making submissions, responding to an online survey or providing commentary through the dedicated section of the CATSINaM or ACM websites.

- **Local hospital and primary health care networks** in order to reach existing maternity services, including doctors and midwives: Use an online survey and website links for providing commentary through the dedicated section of the CATSINaM or ACM websites.
AUSTRALIAN AND STATE/TERRITORY GOVERNMENTS

Participants also believed that the Departments of Health in Australian and State/Territory Governments should be consulted. Options would include providing a written brief then meeting with the relevant sections of these Departments, and inviting their feedback.

OTHER NETWORKS

Several other suggestions came through that are referred to as ‘other networks’ here as they do not form logical clusters. They were: universities and vocational education training providers, healthy industry partners located on country, Indigenous owned companies, remote-based police and Stolen Generations peak bodies. Recommended methods were not provided, but if some or all are included then suitable options from the methods suggested for the three other stakeholder groups could be selected.
Summary and next steps

It was evident that there is a very high level of support for pursuing the creation of ‘birthing on country’ services amongst CATSINaM Members. The outcomes of the ‘Birthing on Country’ yarning circles provide clear direction to CATSINaM and ACM on what constitutes ‘birthing on country’ services, a process for establishing them, and how to proceed with developing a ‘Birthing on Country’ Position Statement.

Further, the outcomes are both consistent with and expand upon ‘The characteristics of culturally competent maternity care for Aboriginal and Torres Strait Islander women’ 2012 national report (see Footnote 1). They are also instructive for how the ‘middle years’ and ‘later years’ actions in the 2010-2015 National Maternity Services Plan should be implemented (see Footnote 1); in particular, ‘Action 2.2 Develop and expand culturally competent maternity care for Aboriginal and Torres Strait Islander people’ (pp. 39-40) and ‘Action 3.2 Develop and support an Aboriginal and Torres Strait Islander maternity workforce’ (pp. 45-46).

CATSINaM and ACM will consider the advice in this report as they determine a timeframe and associated resources for pursuing this piece of work. The CATSINaM membership will be notified of their decisions, and how they can plan a role in supporting the development of a ‘Birthing on Country’ Position Statement.