



By Mob, For Mob

Waijungbah Jarjums Evaluation Report

September 2020



Evaluation Framework – Waijungbah Jarjums

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Acknowledgement

The Queensland Government proudly acknowledges Aboriginal and Torres Strait Islander people as the First Peoples and Traditional Owners and Custodians of the land and waters on which we meet, live, learn and work. We acknowledge and celebrate that the country is rich and vibrant, with diverse thriving Aboriginal and Torres Strait Islander cultures, based on their values of reciprocity, recognition and respect for Elders and Country. We also acknowledge the ongoing leadership and commitment of Aboriginal and Torres Strait Islander people working in collaboration together and with others to create services and supports, striving to ensure that children are raised safely and have the same opportunities as other Australians. That is to be in strong, healthy and culturally rich families, given every prospect to succeed, live long, prosperous lives and become leaders of the future.

We pay our respects to the Ancestors of this country, Elders, knowledge holders and leaders – past, present and emerging. We give our gratitude to the many people who generously contributed to the development of this Strategy. We are particularly grateful to the Aboriginal and Torres Strait Islander people who contributed their experience and cultural authority.

Growing Deadly Families Aboriginal and Torres Strait Islander Maternity Services Strategy 2019 — 2025 Published by the State of Queensland (Queensland Health), December 2019

Artwork

Britney and Stefanie Noffke

Bundjalung, Yuggera and Yuggerbul women who live on Yugambeh Country.

The focus of this piece is the powerful way a baby brings people together. All generations; kids, teenagers, adults, grandparents and kinship network. It represents the beauty in the community honouring the arrival of the baby into the physical world. This is depicted in the centre of the painting around the birthing tree. The symbols in the sky are our elders looking down on us protecting us and guiding us.



The eagle is “Mibbin” and is the protector and totem for the Yugambeh Speaking People.

The tree is a Boab tree is the tree of life as it’s holds lots of water. Its big belly represents the pregnancy. It is also a medicine tree that’s seeds are a good source of Vitamin C and Calcium. The bark is used to treat fevers. It not only symbolises the growth of a baby it also symbolises the kinship, the DNA, the lineage, the womb and the love felt by all.

The Lily represents that not every family has an easy journey and that some journeys may start off like the lily in muddy or murky water but through the journey a beautiful creation is made. The flowers represent the stages of the 9 month pregnancy with the increase of size for gestation.

Other symbols in the painting represent family, the three trimesters (circles to each side), elders and children learning dreamtime stories. The two rivers represent both Aboriginal and Torres Strait Islander culture coming together.





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Executive Summary / Summary

The *Waijungbah Jarjums* model of care has been developed alongside the local Aboriginal and Torres Strait Islander community in collaboration with Gold Coast Hospital and Health Service (GCHHS), Women's Newborn and Children's Service. Waijungbah Jarjums offers continuity of care by a known Aboriginal and/or Torres Strait Islander midwife and child health nurse from conception to the first 1000 days or 2 years of age. The Gold Coast local Aboriginal and Torres Strait Islander community conceptualised a model of care that meets their wants and needs in relation to maternal and child health care and GCHHS has implemented it alongside them, held accountable to Aboriginal and Torres Strait Islander Governance through the Waijungbah Jarjums working group.

The service is guided by two prominent models of care '*Birth on Country*' and the '*First 1000 Days Australia*' and adapted to meet the needs of the local Aboriginal and Torres Strait Islander community, the first time these two models have (through a co-design process) been integrated. The model was conceptualised by the community in June 2019 and implementation began in September 2020 with the first birth occurring in December 2019.

Purpose of the Evaluation

This report presents the findings from a preliminary process and outcomes evaluation of the Waijungbah Jarjums model of care. Specifically, the evaluation sought to understand:

Process

- Awareness and adoption of the model, and if the model was being delivered as intended
- The sustainability of the model of care
- The experience of Waijungbah Jarjums midwives, mothers, HHS staff, the Aboriginal and Torres Strait Islander community, and other key stakeholders of the model of care
- If the model of care is perceived to be accessible and culturally safe

Outcomes

- If the model of care is culturally and clinically safe for mothers and jarjums (babies)
- The effectiveness of the model of care on key clinical outcomes, compared with the mainstream GCHHS services
- The experience and satisfaction of the mothers and their families who engaged in the model of care
- What the key enablers and barriers of the model are

Finally, the evaluation also conducted some preliminary analysis of the cost effectiveness of the model to quantify the costs, comparative to the GCHHS standard services.

Methodology

Both primary and secondary data was collected to provide insight into the effectiveness and outcomes of the Waijungbah Jarjums model. This included quantitative data (e.g. clinical outcomes, validated scales) and qualitative data (e.g. interviews and yarning circles). While the evaluation was not a randomised control trial, where possible comparisons have been made to the standard model of care in the same location, and data was then triangulated from all sources to provide insight into the proposed evaluation questions.

Key Recommendations

Overall, continued investment and long-term, sustainable funding options should be considered for the Waijungbah Jarjums model, which has demonstrated in only a 6-month period outcomes which indicate that it is an effective and cost-effective, clinically and culturally safe model of care. The significant media attention for the model has also been a good indicator of its success. Further, recommendations include:



- Continued investment in the Waijungbah Jarjums model and its iterative design based on best practice, community needs, and the RISE framework
- Scale up of the midwifery group practice so that the model can care for more Aboriginal and/or Torres Strait Islander mothers in the Gold Coast area
- Maintain local community connections and Aboriginal and/or Torres Strait Islander governance in working groups and/or steering committees
- Consider and invest in a one-stop community hub, advertising and growth of the model of care ongoing
- Continue to develop the culturally safe workforce, both within the model of care and in the wider HHS service
- Continue to maintain current partnerships (e.g. YRACA, membership with First 1000 days Australia Regional Alliance) and explore new partnership opportunities (e.g. with local early learning centres)

“So I really think that as midwives, we have a really big job. Then doing that first 1000 days training, and that solidified our role even more. We don’t just have an obligation to this generation of babies, we have the ability to positively impact three or four generations after this baby that we birth. I really believe that through that and through optimal maternity care, that we will change the narrative for our people’s health.”

Waijungbah Jarjums look more into your culture, link you in with cultural ties, follow cultural protocols and create strong babies, strong families and aa strong culture - Waijungbah Jarjums Consumer

“We are so privileged as a service to be honoured with the role of walking beside women and their families as their midwife whilst they bring our future ancestors into the world. The most rewarding part of my work is seeing the massive transformation that has occurred within the HHS over the life of the Project. The fact that now the management of Womens Newborns and Childrens Unit truly acknowledges and see’s First Peoples staff’s innate cultural knowledge’s and supports our ways of knowing, being and doing within a large organisation is a transformation I could have never imagined seeing or being a part of in my life time.”



1. Overview

1.1 Project background

Aboriginal and Torres Strait Islander women's likely experience of healthcare in Australia

There are just under 650 000 Aboriginal and Torres Strait Islander people living in Australia, making up just under three percent of the National population. In 2018, 4.6% of all birthing women in Australia identified as Aboriginal and/or Torres Strait Islander (Australian Institute of Health and Welfare [AIHW], 2020) and nearly 2% of the Gold Coast population identify as Aboriginal and/or Torres Strait Islander (Australian Bureau of Statistics (ABS), 2016), although this assumed to be grossly understated due to an undercount of Aboriginal and Torres Strait Islander Peoples completing the census.

The health of Aboriginal and Torres Strait Islander women and babies is impacted directly and indirectly by the social determinants of health they experience. Factors such as social exclusion, the transgenerational trauma of colonisation, and overt or implicit institutional racism and discrimination (Kildea et al., 2016; Kruske, 2012) all contribute to a maternal morbidity rate nearly two times higher than non-Aboriginal and Torres Strait Islander (Barclay et al., 2014; Homer et al., 2012). For children, health disparities in their early years influence and shape their adult life, impacting their future opportunities and health outcomes.

Aboriginal and Torres Strait Islander babies are more likely to be born prematurely, of low birth weight, require special care nursery admission, and are less likely to be breastfed (AIHW, 2020, WHO, 2007). Pre-existing, treatable and/or preventable conditions such as obesity, hypertension and diabetes (AIHW, 2020), anaemia and urinary tract infections all contribute to a maternal morbidity rate that is twice that of non-Aboriginal and Torres Strait Islanders (Barclay et al., 2014; Homer et al., 2012). On average Aboriginal and Torres Strait Islander childbearing women attend fewer antenatal visits and engage in services later in their pregnancy (AIHW, 2020). Substance use, and teenage pregnancy are amongst the highest contributing factors to a perinatal mortality rate which is 1.7 times higher than non-Aboriginal and Torres Strait Islander (AIHW, 2020). Preterm birth and low birth weight babies are associated with perinatal mortality, long-term neurological disability (including cerebral palsy), admission to neonatal intensive care, severe morbidity in the first weeks of life, prolonged hospital stay after birth, readmission to hospital in the first year of life and increased risk of chronic lung disease (WHO 2012).

Access to high quality midwifery-led continuity of care is impeded by disadvantages in employment, income, education, and housing, as well as higher levels poverty, lower levels of nutrition (AIHW, 2020; Kildea et al., 2016), and increased levels of family and domestic violence (Australian Government, 2013; Blagg, Bluett-Boyd and Williams, 2015). Despite these inequalities Aboriginal and Torres Strait Islanders women are more likely to have a normal spontaneous vaginal birth, less likely to require analgesia during childbirth, have a decreased rate of caesarean section and are half as likely to have an instrumental birth (AIHW, 2020).

Aboriginal and Torres Strait Islander Health and worldview

In Aboriginal and/or Torres Strait Islander culture an individual's relationship to their land, kin group, skin name, and totems are attained through pregnancy and birthing. These important aspects of Aboriginal and/or Torres Strait Islander culture are integral to their holistic view of health, dreaming and laws. It is believed by Aboriginal and Torres Strait Islander Elders and documented throughout literature that failure to provide a culturally safe environment to Aboriginal and Torres Strait Islander women and families is contributing to high maternal and perinatal morbidity and mortality (AIHW, 2020; Kildea & Wardaguga, 2009).

When discussing and evaluating the health of Aboriginal and Torres Strait Islander peoples it is imperative for the evaluation team to acknowledge and recognise the Aboriginal and Torres Strait Islander holistic view of health which includes:



“not just the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole Community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their Community. It is a whole-of- life view and includes the cyclical concept of life-death-life.” (Commonwealth of Australia, 2013, p. 9, as cited in National Aboriginal Health Strategy Working Party, 1989).

Through understanding that Aboriginal and/or Torres Strait Islander health incorporates more than a western view of health, we can acknowledge the vast inequalities we are not addressing through current services, and the impact that not implementing a culturally responsive model will continue to have on the local Aboriginal and Torres Strait Islander community.

Australian maternity care

In Australia, maternity care is provided by midwives, General Practitioners and Obstetricians who work in both the public and private sector as individual care providers or by sharing responsibility (AIHW, 2009). Aboriginal and Torres Strait Islander women experience a number of barriers when accessing these services which vary between remote and urban areas. In this evaluation we refer to standard/fragmented or mainstream care as the usual western, biomedical, maternity services that are available to Aboriginal and Torres Strait Islander women and includes, midwifery clinic, midwifery-led antenatal and postnatal care, GP shared care, Maternal Fetal Medicine care and non-identified midwifery group practice care.

Urban barriers

Urbanised Aboriginal and Torres Strait Islander women have the availability of similar mainstream services provided to non-Indigenous women however they still experience barriers when accessing these services due to their social determinants of health. These barriers include cultural appropriateness, cost and acceptability into services. With the publication of a large systematic review of midwifery-led continuity of care (COC) (Sandall, Soltani, Gates, Shennan, & Devane, 2013) and the National Maternity Services Plan (AHMAC, 2016) both highlighting that all women should have access to midwifery-led COC to increase satisfaction and outcomes, the demand for this model of care has increased significantly. The current demand for this service outweighs the supply which has resulted in difficulty for all women to access the service (AIHW, 2009) and strict exclusion criteria (Kruske, 2012). A large portion of midwifery-led models of care only provide care to low risk women with some even applying exclusion criteria based on a woman’s ethnicity (Kruske, 2012). The increased likelihood of Aboriginal and Torres Strait Islander women having pre-existing health conditions therefore eliminates them from accessing this service (AIHW, 2020).

There is a growing body of literature that outlines the needs of Aboriginal and Torres Strait Islander women as dictated by them in order to inform government documents and policies nationwide. The literature reviewed has highlighted that Aboriginal and Torres Strait Islander women want access to high quality, woman centred continuity of care that is community based and/or community controlled, developed with or by the community and includes both community elders, traditional knowledge and Aboriginal and Torres Strait Islander health care workers in the delivery of services (Brown *et al.*, 2016; Dietsch *et al.*, 2011; Freeman *et al.*, 2014; Homer *et al.*, 2012; Ireland, *et al.*, 2011; Josif *et al.*, 2014; Kildea, Stapleton, Murphy, Low & Gibbons, 2012; Kildea *et al.*, 2016; Kildea, Magick Dennis, & Stapleton, 2013; Kildea & Van Wagner, 2012; Parker *et al.*, 2014).

1.2 Policy Context

The current evaluation exists within a complex political landscape, where there are various health services, primary care, and service improvement initiatives which align with Waijumbah Jarjums overall aim of delivering clinically and culturally safe, quality care to Aboriginal and/or Torres Strait Islander families. In the national space, the legislation for AHPRA registered health practitioners (*e.g. codes of conduct, ethical frameworks, accreditation standards, and profession specific Boards for each of the 16 registered health professions*) and ACHS standards have varying requirements for ensuring culturally and clinically safe care. The focus on First Peoples health is particularly relevant for Aboriginal and Torres Strait Islander communities because of a shared history with health care



practitioners that have led to significant health status disparities (Australian Indigenous HealthInfoNet, 2019) and a significant lack of trust in the health care system to respond to their needs (West et al., 2017). It also aligns with the Queensland Health *Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033* has been developed to coordinate the implementation of initiatives in line with key guiding principles, quality leadership, community engagement and individual service delivery.

These frameworks provide the context in which we can understand the full program of efforts which are underway, all aimed at improving health outcomes, health and social determinants of wellbeing, and the cultural safety of the broader healthcare system. Projects such as the Waijungbah Jarjums model of care aim to be quality, Aboriginal and/or Torres Strait Islander lead, steps forward toward a better outcome for this generation, and generations to come. Projects such as this align with national health strategies including *Growing Deadly Families Aboriginal and Torres Strait Islander Maternity Services Strategy 2019 – 2025* and the strategic objectives of this Queensland Health and the Gold Coast HHS. As mentioned later, this model of care was designed in line with the best practice literature along with the current policy and strategies at national, state and local levels in mind. This means that key recommendations, such as the A healthy start to life, Improving Access and the Patient Journey, and Improving the System priorities in the *Making Tracks towards Closing the Gap in health outcomes for Indigenous Queenslanders by 2033* strategy are all intended outcomes and targets mid to long term. The model aims to improve mother and jarjum outcomes, acknowledge first peoples ways of knowing, being, governing, and health, take a family approach to birthing and care, engage with local communities, and work towards supporting a healthier and culturally safe GCHHS.

1.3 Project aim

To provide a cultural safe model of care for Aboriginal and Torres Strait Islander women, their families and the community that is co-designed and co-led by the local Aboriginal and Torres Strait Islander community and incorporates the 'Birthing on Country' and 'First 1000 Days Australia' strengths-based models of care (MOC).

1.4 Description of the project

In June 2019, the Gold Coast Hospital and Health Service (GCHHS) reached out to Aboriginal and Torres Strait Islander women and families who had accessed its maternal and child health services in the preceding year to join in a yarning circle and share their experiences of accessing GCHHS. The yarning circle was facilitated by an Aboriginal midwife and the Coordinator of Aboriginal and Torres Strait Islander Health. Women were encouraged during this yarning circle to design a maternal and child health service that met their individual needs. This feedback was then used to inform the proposal for the development of an Aboriginal and Torres Strait Islander specific model of care which commenced September 2019 employing 10 Aboriginal and/or Torres Strait Island nurses and midwives to provide culturally safe maternity care.

An important first step in the development of the service alongside the local Aboriginal and Torres Strait Islander community who live on Yugambeh Speaking Peoples Country of the Gold Coast was a name that Yugambeh Language name. *Waijungbah Jarjums* was a name gifted to the service by the Yugambeh Meusem and Traditional Custodians. Waijungbah means place of Mothers/Motherhood, derived from Waijung (Mother). Waijung is also the name of Yugambeh Speaking Peoples heaven, the place where spirits come from and go to, it is derived from Wai (Above) + Jung (Very) = The great above; Jarjums means children. Waijungbah Jarjums meaning place of mothers and children.

The service was co-designed by the local Aboriginal and Torres Strait Islander community and aimed to both improve and scale up the role of the Midwifery Navigator, Midwifery Group Practice (MGP) services and integrate the role across the Maternal and Child Health Service of GCHHS across the first 1000 days.

The model of care incorporated built on the "strong partnership elements" from the National Agreement on Closing the Gap (2020):

Co-design and Partnerships must;





- Partnerships are accountable and representative
- Reimbursement is agreed upon within the working group that values the contributors time and sharing of knowledges
- Decision-making is shared between GCHHS and the local Aboriginal and Torres Strait Islander community working group. Shared decision making:
 - o supports and privileges Aboriginal and Torres Strait Islander ways of knowing, being and doing; for example, no voting on matters – continued conversation until all parties are in agreeance and adjournment if an agreement cannot be made to discuss at a later time
 - o Aboriginal and Torres Strait Islander lived experience is understood and respected
 - o Aboriginal and Torres Strait Islander peoples are respected and a culturally safe space is made through yarning
 - o Aboriginal and Torres Strait Islander people can speak without fear of reprisals or repercussions

The model of care is guided by two prominent models of care, ‘Birthing on Country’ and the ‘First 1000 Days Australia’ and is the first time these two models have been integrated and led by an all Aboriginal and Torres Strait Islander team. Aboriginal and Torres Strait Islander families are linked with an Aboriginal and/or Torres Strait Islander midwife who provides continuity of midwifery care from conception, is on call for labour and birth and continues to provide care postnatally up to 6 weeks, during the antenatal period the woman and her family are also linked in with a child health nurse who provides continuity of care and seamless integrated entry into the child health service across the first 1000 days.

Birthing on Country

Birthing on Country is described as ‘...a metaphor for the best start in life for Aboriginal and Torres Strait Islander babies and their families’ which provides an appropriate transition to motherhood and parenting, and an integrated, holistic and culturally appropriate model of care for all (CATSINaM, 2016).

It is about providing A&TSI women and their families with the best possible start in life. Birthing on Country models are founded on the A&TSI holistic definition of health, are community based and governed, are inclusive of traditional practices, involve connections with land and country, value our ways of knowing, doing and being and encompass risk assessment and service delivery that are culturally competent. The most important aspect of BOC models for me is that above all they are designed, developed and evaluated by A&TSI people. Incorporating these principles means that institutions are no longer telling our mob what we want and need, we are taking control of our own health and wellbeing the way it should be.

First 1000 Days Australia

First 1000 Days Australia is a First Nations model aimed at strengthening all families, so they can give their children the best start in life. We work with Elders, researchers, community members, front-line workers, policy makers and early childhood program developers to provide coordinated, comprehensive, culturally informed interventions to support families in identifying and meeting their own aspirations and those they have for their children (Arabena *et al.*, 2016)

This integrated model of care improves cultural awareness, cultural care, continuity of care, and access to high quality midwifery, maternal care, and child health services. The completion of this project is expected to benefit members of the local Aboriginal and Torres Strait Islander community, Aboriginal and Torres Strait Islander health care professionals within the GCHHS, and non-Indigenous care professionals within the GCHHS region.

Whilst the model of care is aimed at the best start in life for Aboriginal and/or Torres Strait Islander babies, research indicates that women who identify as Aboriginal and Torres Strait Islander suffer disproportionately poorer health outcomes.

This program therefore had the following entry criteria to access the service in order of preference:





1. Women who identify as Aboriginal and/or Torres Strait Islander,
2. Families who Identify as Aboriginal and/or Torres Strait Islander and self-refer,
3. Any referral received from a health care worker, the primary health network or the local Aboriginal Medical Service,
4. Women who no not identify but are giving birth to an Aboriginal and/or Torres Strait Islander baby and have additional risk factors, for example; medical co-morbidities that could affect the health and wellbeing of the baby, alcohol and other drugs, high risk mental health, domestic violence,
5. All other women who no not identify but are giving birth to an Aboriginal and/or Torres Strait Islander baby.

As our key KPI's are focussed on improving the outcomes and experiences of Aboriginal and/or Torres Strait Islander mums this evaluation has chosen to focus on the 45 births to Aboriginal and/or Torres Strait Islander mums as a clear representation of the impact we have been able to make and for benchmarking purposes Waijungbah Jarjums mums were compared to Aboriginal and Torres Strait Islander women who had accessed standard care.

In this evaluation we refer to standard care as the usual western, biomedical, maternity services that are available to Aboriginal and Torres Strait Islander women and includes, midwifery clinic, midwifery-led antenatal and postnatal care, GP shared care, Maternal Fetal Medicine care and non-identified midwifery group practice care.



Elements of the Waijungbah Jarjums Model of Care

The essential components of the program were based on the international Birthing on Country literature review (Kildea & Wagner, 2012), the *Gold Coast First 1000 Days Australia Strategic Plan: Working together to birth our future Elders into culturally strong and healthy families* (available on request) and feedback from the local Aboriginal and Torres Strait Islander community and include:

Overall Model Design and Principles

Governance and ownership

- Aboriginal and/or Torres Strait Islander community co-design and development and responds to the emerging needs of the local community
- Aboriginal and/or Torres Strait Islander governance through Waijungbah Jarjums Working Group
- Genuine partnership with local Aboriginal organisations – Local AMS and Yugambeh Regional Aboriginal Alliance Corporation (YRACA)

Investment in Aboriginal and/or Torres Strait Islander Workforce

- Aboriginal and/or Torres Strait Islander only workforce
- Aboriginal and/or Torres Strait Islander leadership
- Aboriginal and/or Torres Strait Islander cadetship (2 opportunities) and mentorship for midwifery students
- New graduate midwife recruitment and mentorship
- Investment in midwives and child health nurses to work to their full scope of practice - supporting staff with scholarships to complete prescribing for midwives' course
- Support of Registered Nurse to upskill into Child Health Nursing through a scholarship for postgraduate study and mentorship through Child Health Service at GCHHS

Philosophy - The model of care:

- Privileges Aboriginal and/or Torres Strait Islander ways of knowing, being and doing and incorporates culture in every level of service delivery
- Incorporates Traditional Ceremonies into the model including - Welcome Jarjums to Community Event – bi-annual traditional ceremony and event to welcome babies on to Yugambeh Country by local Traditional Custodians and Elders
- Is centred around Aboriginal and Torres Strait Islander connection to country
- Is centred around the Aboriginal and Torres Strait Islander definition of health
- Offers continuity of carer (COC) including a known midwife during pregnancy, birth, postnatal up to 6 weeks as determined by the women – Follow on COC from child health nurse up to 2 years
- Overarching philosophy –
 - Family members are leaders in the development and protection of culture, knowledge and identity in Aboriginal and Torres Strait Islander children.
 - A multigenerational approach, focusing on infants, young people, mothers and fathers, carers and grandparents is needed to promote generational health and wellbeing.
 - We are not only giving birth to a baby; we are giving birth to a future Elder in our community, a sacred responsibility in which men and women have shared roles and responsibilities.
 - With 60,000 years of genius to draw on through our culture, we have the right and the responsibility to hand on this genius in contemporary times.
 - We will embrace the cultural identities of the many nations who live on this land under the banner of *Strong Culture, Different Tribes*.
- **The model uses a strengths-based approach and shifts the focus from a traditional Western deficits based approach – particularly in our language, our engagement, in our organisational policies and our ways of working and relating to people.**



- Recognises, supports and values the roles and contribution of men during the first 1000 days –which will require us to work differently to involve men in early developmental work, antenatal care and the first weeks of infancy.

Key Aspects of the Model of Care / Service Characteristics

- Culturally safe workforce – the development of a massive open online course (MOOC) in Aboriginal and Torres Strait Islander cultural safety across the first 1000 days aimed at engaging ALL maternity and child health staff.
- Aboriginal and Torres Strait Islander Workforce including succession planning and mentorship of Aboriginal and Torres Strait Islander midwifery students through Griffith University
- Culturally Safe Environments – Aboriginal and/or Torres Strait Islander artwork and images of traditional sacred places have been wrapped onto the walls at the entrance of birth suite, the maternity in-patient unit and the neonatal care unit.
- Development of cultural resources - language cards (speech etc) / revitalisation of language
- Equity in access – home visits, community outreach, parking vouchers, taxi vouchers, transport if required
- Community based hub – yet to be established
- Mobile clinic space – to be utilised by Waijungbah Jarjums staff as an additional space for families who require clinical assessment but do not need to present to the hospital, to be utilised as a mobile immunisation clinic
- Aboriginal and Torres Strait Islander Led Antenatal classes that incorporate mindfulness and self-hypnosis for childbirth
- Womens' yarning circles and mums and bubs groups – 6-week rotational immersion in culture including traditional weaving, bush tucker, traditional bush medicine,
- Mens yarning circles – 6-week rotational immersion in culture including learning to play the didgeridoo, learning to make traditional tools for carrying jarjums (coolamons). These yarning circles were developed to build on the strengths of our fathers using culture as a protective factor.
- Family First Aid and CPR course
- Incentive pack for women to attend >5 antenatal visits given at birth; pack stocked with items that support local Aboriginal and Torres Strait Islander businesses.

Evaluation and Quality improvement

- Evaluation is led by Aboriginal and/or Torres Strait Islander people and incorporates Aboriginal and Torres Strait Islander ways of knowing, being and doing – evaluation through Yarning Circles
- Quality improvement data collected monthly and fed-back to Aboriginal and Torres Strait Islander working group for continued governance and improvement.
- Audit activities that include a recall register
- First 1000 days Australia model of care coaching by Professor Kerry Arabeena - Plan to initiate peer research for capacity building

First 1000 Days Principles

Overall, the model is based on the key principles from existing work. Notably, there are six elements in the *Gold Coast First 1000 Days Australia Strategic Plan: Working together to birth our future Elders into culturally strong and healthy families 2020-2021* framework that are critical to the implementation of the model:

- **Connections to Country:** Aboriginal and Torres Strait Islander families have essential relationships with, and responsibilities to look after, Country, which provides nurturing and empowerment to that individual, family and community.
- **Indigenous beliefs and knowledge:** Concepts and experiences include elements of healing, traditional medicine and gendered knowledge systems and practices.



- **Indigenous language:** Language is essential for expressing culture and communicating to others, and for transmitting cultural knowledge to the next generation.
- **Family, kinship and community:** Individuals and families have responsibilities and obligations that confirm and reinforce membership and 'belonging' to their community, which includes obligations to extended family members and responsibilities to be involved in functions, initiatives and political issues.
- **Cultural expression and continuity:** Actions that express attitudes, beliefs, customs and norms, which can take the form of artefacts, symbols, dances, stories, songs, gender and age roles, art and ceremony, use of language, family relations, sharing of food and representation of values.
- **Self-determination and leadership:** Leading and being involved in decision making at the individual, family, community, organisational and political level.

The plan also acknowledges that for agencies to support empowered families, workers need:

- **To shift the focus from deficits to strengths** – particularly in our language, our engagement, in our organisational policies and our ways of working and relating to people.
- **To recognise, support and value the roles and contribution of men during the first 1000 days** –which will require us to work differently to involve men in early developmental work, antenatal care and the first weeks of infancy.
- **To support the development of an ABN (Indigenous business) workforce** – recognising that Indigenous businesses can empower families through employment, procurement and providing professional engagement with like-minded people, and ensuring that our agencies commit to meeting procurement targets.
- **To support families to navigate the 'service-scape'** – in ways that are effective, efficient and provide clear pathways and access points to meaningful services where they live, work and play.
- **To be respectful disruptors** – by providing culturally safe services that are committed to building better relationships and breaking down barriers to generate positive outcomes for children, their families and carers.

Waijungbah Jarjums Theoretical Underpinnings: Thematic Literature Review

A rapid review of current literature identified the following critical aspects that informed the design of the Waijungbah Jarjums model, to ensure that it was an evidenced based model of care.

Woman centred care

The concept of woman centred care is adopted by the midwifery profession and focusses on the woman, her family and their specific wants and needs (Nursing and Midwifery Board of Australia [NMBA], 2018). The core elements to woman centred care are choice, control and continuity of care in order to facilitate empowerment and self-determination. Through a supportive, trusting and safe partnership, the woman centred midwife provides non-judgemental holistic midwifery care that encompasses the woman's "social, emotional, physical, psychological, spiritual and cultural needs and expectations" (NMBA, 2018).

Choice and control

It is well documented throughout literature that Aboriginal and Torres Strait Islander women lack options in relation to maternity care therefore minimising choice. Choice and control in maternity care are intertwined, are integral to the provision of woman centred culturally appropriate maternity care and are vital to encourage self-determination. Choice in relation to maternity care is a knowledgeable selection made by an individual after the mutual exchange of information (Thachuk, 2007).

Continuity of care



One of the strongest themes that emerged throughout the literature reviewed was the importance of continuity of care for Aboriginal and Torres Strait Islander women. Continuity of care/r involves the woman being cared for continuously throughout the child birth continuum by the same midwife or group of midwives (Sandall *et al.*, 2016). The benefits of continuity of care are well documented throughout literature (Sandall *et al.*, 2016). Women who receive continuity of care are more likely to feel in control during labour and birth, have a normal vaginal birth without intervention, less likely to require pain relief during labour, and have a higher rate of birth satisfaction when compared to women who do not receive continuity of care (Sandall *et al.*, 2016).

Research findings demonstrate that Aboriginal and/or Torres Strait Islander women and their families were more likely to engage in a service that offered continuity of midwifery care as they felt it provided; trusting relationships, increased awareness of culture and cultural safety, minimised the risk of feeling “shame” and increased overall satisfaction (Brown *et al.*, 2016; Dietsch *et al.*, 2011; Homer, *et al.*, 2012; Kildea *et al.*, 2012; Parker *et al.*, 2014). They also strongly value access to Aboriginal and/or Torres Strait Islander health professionals in order to feel culturally safe. (Homer *et al.* 2012, Kildea *et al.* 2012).

Community control

Literature outlines that for Aboriginal and Torres Strait Islander specific services to be successful in engaging and maintaining trusting relationships the focus must be on Aboriginal and Torres Strait Islander people controlling their own maternity care (Kildea *et al.* 2012; & Ireland *et al.* 2010). Aboriginal and Torres Strait Islander women and families need to be engaged in the design and delivery of their maternity care in order for it to meet their needs (Parker *et al.* 2014).

Cultural Safety

Culturally safe maternity care is identified as an important factor for Aboriginal and Torres Strait Islander women when discussing their wants and needs surrounding maternity care. Cultural safety underpins midwifery philosophy statements, is detailed in the code of ethics for the midwife and competency standards world-wide (NMBA, 2018). Culture is an integral aspect of every society and is not specific to the beliefs of a particular social or ethnic group but is a learned pattern of behaviours that includes any set of ideals that are followed including family relationships, religion, spirituality, traditions and beliefs (Queensland Government, Queensland Health, no date). Throughout Australia there are over 500 different Aboriginal and Torres Strait Islander tribes plus the Torres Strait Islands, therefore it is important to not generalise Aboriginal and Torres Strait Islander culture as a whole.

Kildea *et al.* (2012) conducted a mixed method analysis of women who attended an Aboriginal and Torres Strait Islander specific model of care compared to women who accessed standard care. Their results concluded that 92% of women attending the Aboriginal and Torres Strait Islander specific service felt ‘mostly understood and respected’ in relation to cultural safety whilst only 47% of women attending birth suite, 31% of women postnatally and 31% of women that attended the Maternal Fetal Medicine unit. Only a small amount of women (14%) felt ‘not at all understood’ in standard care. The majority of Aboriginal and Torres Strait Islander women who were interviewed in this study attributed cultural safety to continuity of care. In another study conducted by Dietsch *et al.*, (2012) all the Aboriginal and Torres Strait Islander participants described situations where they felt disrespected, oppressed or victims of racism.

Investment in Aboriginal and Torres Strait Islander Workforce

It is evident throughout literature that Aboriginal and Torres Strait Islander women want access to Aboriginal and Torres Strait Islander health workers in order to increase cultural safety (Brown *et al.*, 2016; Dietsch *et al.*, 2011; Homer *et al.*, 2012; Ireland *et al.*, 2011; Kildea *et al.*, 2012; Parker *et al.*, 2014). Aboriginal and Torres Strait Islander health workers were seen to provide women with security and innate cultural knowledge whilst also assisting and “supporting the cultural competence of other health professionals who interact with the women” (Homer *et al.*, 2012, p514). Aboriginal and Torres Strait Islander women also attributed a lack of culturally safe maternity care to the concept of shame and avoidance of health care (Dietsch *et al.*, 2011; Hancock, 2006; Ireland *et al.*, 2011; Kildea *et al.*, 2012; Parker *et al.*, 2014). In addition, women report higher levels of satisfaction and cultural safety from



Aboriginal and Torres Strait Islander student midwives (Kelly et al., 2014).

Summary of limitations of the articles reviewed

The following limitations were identified in the current literature:

- 1) Sample size and location characteristics - Small sample sizes decreased the results generalizability and transferability to a wider population.
- 2) that Aboriginal and Torres Strait Islander authors - although some studies employed Aboriginal and Torres Strait Islander people in collecting their research, no studies were led by that Aboriginal and Torres Strait Islander peoples therefore maximising non-Aboriginal and Torres Strait Islander dominant culture bias.
- 3) Limited amount of research available.

We envisage that this evaluation report of the Waijungbah Jarjums model will add more evidence and literature to the enablers and barriers of Aboriginal and/or Torres Strait Islander led care and research in the GCHHS context. The design of the Waijungbah Jarjums model has been informed by the key principles in the above rapid literature review, as described in *Table 1* below.

Table 1. Key Aboriginal and Torres Strait Islander Maternity Care Concerns and Waijungbah Jarjums Design

Maternity Care Concerns	Waijungbah Jarjums Design Characteristics to Address Concerns
Continuity of care (COC):	- Continuity of care from conception to the first 1000 days by a known Aboriginal and Torres Strait Islander midwife, nurse and child health worker. - Midwifery Group Practice (MGP) care that provides care by a known midwife during pregnancy birth and postnatally up to 6 weeks as determined by the woman. - MGP requires a minimum of 4 FTE midwives to provide on call care to a caseload of 30 women per FTE - Integrated seamless transition from midwifery care to Child Health Nurse and Advanced Health Worker care who provide care from 6 weeks to 2 years - Re-establishment of Advanced Child Health Worker from Children's services to Waijungbah Jarjums
Cultural awareness:	- Provision of Aboriginal and Torres Strait Islander beanies and education packs was valued - Provision of specific guidelines for Aboriginal and Torres Strait Islander maternity care - Increase community engagement through media advertisement, wrap on bus of Aboriginal and Torres Strait Islander artwork by local Aboriginal community of the service - Value placed in the relationships formed with Aboriginal and Torres Strait Islander hospital liaison staff - Increase cultural competency of staff
Cultural safety:	- Connection / Working with the Traditional Custodians of the Gold Coast (Danggan Balun and YRACA). - Regular yarning circles to encourage knowledge sharing and increase cultural inclusion – give a sense of belonging - Mums and bubs groups that include partners



Maternity Care Concerns	Waijungbah Jarjums Design Characteristics to Address Concerns
	• Teaching of meditation techniques used in childbirth (Dadirri technique valued) • Provision of culturally safe antenatal and postnatal classes • Increase in the amount of Aboriginal and Torres Strait Islander artwork around the hospital to increase sense of belonging and cultural safety. Valued the Aboriginal and Torres Strait Islander birthing rooms currently available but not everyone could access them. Women stated that Aboriginal and Torres Strait Islander artwork made them feel connected and safe • Opportunities / gaps to increase Hospital Liaison Officer (HLO) service on wards - or an adaptation of Advanced Health Worker / HLO which might be supported by the Health Worker Stream.
Access to services:	• Increase the flexibility of appointments and location, home or community venues preferred over hospital • Option to either have early discharge or be admitted to postnatal ward if wanting. • Provision of affordable parking when admitted to GCUH for birthing or antenatally/postnatally • Ease of transport and location – recommended clinical bus for appointments as it is mobile and will be able to be placed outside areas that have easy public transport access • Staff will work with the existing Aboriginal and Torres Strait Islander Maternal and Child Health Advanced Health Workers • Addressing cultural safety / racism / implicit bias where patients feel unsafe in accessing services and therefore don't access services
Investment in Aboriginal and Torres Strait Islander Workforce	• Aboriginal and Torres Strait Islander midwifery navigator (NRG 7) to provide leadership and project management • Midwifery group practice of 4 FTE midwives (2x NRG 6, 1x NRG 5, 1x graduate NRG 5 MW) to provide continuity of midwifery care, • Child Health Nurse of 2 FTE (1x NRG 6, 1 x graduate NRG 5 CHN) to work collaboratively with the MGP and continue care across the first 1000 days. • Midwifery cadetship x2 mentorship of Griffith University Aboriginal and/or Torres Strait Islander students • Identified Maternal and Child Health Advanced Health Workers re-established position to leadership by Waijungbah Jarjums team • Commitment to the upskilling of midwives, nurses and child health workers to work towards full scope of practice – scholarships for postgraduate studies
Partnership between local Aboriginal and/or Torres Strait Islander Organisations	• Partnership with Danggan Balun and YRACA for custodianship, guidance and support. • Streamlined referral pathways with local Aboriginal Medical Service – Kalwun • Aboriginal and Torres Strait Islander Health Branch

1.5 Purpose and scope of the evaluation

The purpose of the evaluation of the *Waijungbah Jarjums* model of care is to amplify the voice of Aboriginal and Torres Strait Islander mothers, community, and researchers; provide a systematic evaluation of the process and



outcomes of the model of care; and inform ongoing recommendations for the resourcing and adaption of the model in the GCHHS and wider context. The evaluation involved the assessment of *Waijungbah Jarjums* implementation, preliminary outcomes and economic outcomes. The findings generated from the evaluation will allow GCHHS, the Health Service Executive Director of Nursing and Midwifery Services, and other stakeholders within Queensland Health to understand the program's strengths and the ways in which the development of the new model of care has responded to and addressed the unique need to provide quality and culturally safe care to Aboriginal and Torres Strait Islander women and families. We also note that this evaluation has been grounded in the recent draft of the Productivity Commissions *Indigenous Evaluation Strategy*.

Evaluation findings will also provide evidence / strengths for the integration of the Birthing on Country and First 1000 Days Australia models of care that could be replicated across the State / Australia with local adaptation.

Evaluation of the implementation and economic outcomes of the model of care will allow this group to make informed decisions regarding ongoing model of care resourcing and scalability, and to maximise the benefits for all Aboriginal and/or Torres Strait Islander women and families accessing maternity and child health services throughout the state and other key stakeholder groups. The purpose of this evaluation is to:

- Describe the implementation of the Waijungbah Jarjums model of care in GCHHS
- Identify the barriers and enablers of the model of care in the GCHHS setting to make recommendations for any future improvements to the model for the context
- Evaluate the process and preliminary/short term outcomes of the model of care.

2. Methodology / Conceptual approach to the evaluation

This evaluation adopted a participatory developmental approach, informed by the leading best practice about quality Aboriginal and Torres Strait Islander evaluation. A developmental approach is a structured way to provide feedback on the program, providing insights on effectiveness, scalability, and sustainability, as it is being implemented. This approach will allow process and impacts to be fed back, to iteratively adapt the program in an accurate and informed way, to meet its intended objectives. Participatory co-design for the evaluation involves welcoming all stakeholders who run or are beneficiaries of a program to have a voice and be actively involved in the design of its evaluation, including the methodology, data collection activities, and conclusions. Incorporating a participatory approach allows us to collaborate with stakeholders and understand the nuances of a program to identify “*what about the program works for whom, in what circumstances, and why*” (Zukoski & Liliquisen, 2002). This approach is of particular importance for this project as it helps to enable Aboriginal and Torres Strait Islander knowledge and voice in the evaluation (*Productivity Commission 2020 Indigenous Evaluation Strategy Draft*).

“Issues of ownership of knowledge in Aboriginal and Torres Strait Islander research can only be resolved when the power of decision making and self-determination is held by Aboriginal and Torres Strait Islander peoples, communities and/or organisation” (Rigney, 2016 as cited in Brady, 1992)

It was important for the evaluation of the model of care to be governed by Aboriginal and Torres Strait Islander ways of knowing, being and doing and to stay true to cultural custom and protocol. Therefore, the application of Indigenist methodologies was imperative to the evaluation. Rigney (2006) explains that Indigenist research methodology is necessary to strengthen ways of privileging Indigenous voices and challenging the deficit discourse surrounding Aboriginal and Torres Strait Islander people in research and evaluation. Saunders, West & Usher (2010) explain that “Indigenist research is informed by three fundamental and interrelated principles: involvement in resistance as the emancipatory imperative; political integrity; and, giving privilege to Indigenous voices”. The evaluators believe that adopting Indigenist methodologies ensures the evaluation is conducted from a position that values Aboriginal and Torres Strait Islander innate knowledge and recognises the importance of advocacy and social justice (Rigney, 1999) as opposed to using a Western research methodology that is historically linked to the marginalisation of Aboriginal and Torres Strait Islander People (MacDonald, 2017). The transformative paradigm ensures the evaluators are coming from a strengths-based approach and provides a philosophical framework that focuses on advancing the needs of marginalised groups (Mertens, 2012). Rooted in this framework is emancipatory



theory that empowers communities, values collaborative practice and trusting relationships, and is dedicated to social change (Creswell & Plano Clark, 2018).

2.1 Program logic

The program logic approach is part of our wider contribution analysis methodology and gives a detailed understanding of the inputs, processes and outputs, and outcomes. There is usually some logical reasoning behind a capacity building initiative or program that seeks to explain what it is supposed to accomplish, and how. A program logic is an important first *step* in evaluation because it provides a detailed description of the program being evaluated. A program logic model is a road map of how programs achieve their objectives. It outlines the underlying assumptions about how a program will achieve its intended outcomes (*or its intermediate outcomes in the short term*). The model is a systematic and visual way to present and share the relationships among the resources available to operate a program, the planned activities and processes, and the changes or results it hopes to achieve.

The program logic model presented in Appendix A links the project's inputs and outputs to the intended outcomes i.e. to demonstrate the intended causal links for the project.

We also note that the Waijungbah Jarjums project and the program logic of the model of care aligns with several best practice frameworks for midwifery service delivery along with national and local strategies and policies. Notably, the model aligns to *the Quadruple Aim, The Office of the Chief Nursing and Midwifery Officer (OCNMO) strategic plans; the Children's Health Queensland Hospital and Health Service Integrated Care Strategy 2018-22; the Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033, the Queensland Statewide plan for children and young people's health services to 2026; the Aboriginal and Torres Strait Islander Maternity Services Strategy (2019); the Growing Deadly Families Aboriginal and Torres Strait Islander Maternity Services Strategy 2019-2025.*

The quadruple aim refers to the globally established and accepted framework of high value care delivery, that originated as the Triple Aim in the United States (Sikka, Morath, & Leape, 2015) The model, which is integrated in Children's Health and OCNMO strategies broadly empathises the importance of key domains for effective and safe healthcare, namely:

1. **The consumer experience** – improving the experience of care for those who access services
2. **Health outcomes** – improving the quality of care by ensuring services are coordinated and delivered in line with their needs
3. **Cost-effectiveness** – ensuring that services being delivered are effective and efficient use of resources and funding
4. **The staff experience** – where staff are able to engage in meaningful and safe workplace practice

This *Quadruple Aim* was considered and integrated into the program logic, and has been a core aspect of the design, delivery, and evaluation of the Waijungbah Jarjums model of care.

We also note that the model of care has been developed as a tool toward *Closing the Gap*, and we recognise that Waijungbah Jarjums can contribute to the national target that:

“Aboriginal and Torres Strait Islander children are born healthy and strong”

By 2031, CTG aims to increase the proportion of Aboriginal and Torres Strait Islander jarjums with a healthy birthweight to 91 per cent (*National Agreement on Closing the Gap – 2020*).

This is along with other key *Closing the Gap* aims, including the still to date unachieved target to *halve the gap in mortality rates for Indigenous children under five by 2018*, in which maternal perinatal health is a key driver. The main contributing factors for perinatal death are;

- Birth trauma,
- Fetal growth disorders (low birth weight)



- Complications of pregnancy,
- Respiratory and cardiovascular disorders (pre-existing conditions)

As previous stated the social determinants of health are a major contributing factor to the health and wellbeing of Aboriginal and Torres Strait Islander mums and bubs. Perinatal mortality is associated with pre-existing conditions such as hypertension, obesity, and diabetes and behaviours such as smoking and/or alcohol consumption during pregnancy.

Waijungbah Jarjums also contributes to CTG outcome of goal of strong economic participation and development of Aboriginal and Torres Strait Islander people and communities through the employment of all Identified staff and through supporting Aboriginal and Torres Strait Islander small businesses and businesses found on Black Business Finder and registered with Indigenous Business Australia. It was important for the Waijungbah Jarjums team to support and empower their community to assist in self-determination and employment status is associated with greater outcomes for health and social and emotional wellbeing and living standards (Australian Government, 2020)

Evaluation domains and questions

The current implementation and outcome evaluations assess the utility and effectiveness of the Waijungbah Jarjums model across 11 key domains (see Figure 1).

Figure 1 Key Domains of the GCHHS Waijungbah Jarjums Evaluation

<i>Waijungbah Jarjums Evaluation</i>	
Implementation	Outcome
• Acceptability • Awareness and Adoption • Feasibility • Penetration • Costs • Sustainability	• Safety • Effectiveness • Equity • Efficiency

The evaluation questions, key indicators, and data sources are presented in Appendix B, however overall, this evaluation will describe the early outputs of the program (within the first 6 months) looking at:

- Evaluation of the implementation of the model, specifically:
 - Awareness and adoption of the model by key stakeholders, Aboriginal and Torres Strait Islander community, and Aboriginal and Torres Strait Islander mothers
 - Is the model is being delivered and utilised as intended?
 - Are the staff satisfied working in the model of care?
 - Do the staff feel the model of care supports career progression?
 - Is the model sustainable and able to innovate and respond to emerging needs?
 - Do the staff and Aboriginal and Torres Strait Islander community perceive the model of care to be acceptable and culturally safe?
 - To what extent the model is being used routinely by practitioners/consumers in the GCHHS context?
- Evaluation of the outcomes of the Waijungbah Jarjums model of care, specifically:
 - Is the model providing culturally safe care?
 - Do the women accessing the model feel respected? (MOR scale)



- Do the women accessing the model feel empowered to make their own decisions (MADM scale)?
- Are the women satisfied with the model of care? Is the model embedded in a culturally safe service?
- Does the model lead to improved antenatal and birth clinical outcomes (compared to the standard model of care) for both Aboriginal and Torres Strait Islander women and children?
- To what extent does the model improve Aboriginal and Torres Strait Islander women's key Close the Gap KPIs compared to the rest of the service?
- Do Aboriginal and Torres Strait Islander women accessing the Waijungbah Jarjums model of care have higher satisfaction compared to those in standard care?
- Does the model improve the satisfaction of Aboriginal and Torres Strait Islander staff (comparative to standard model of care?)
- What do the staff and Aboriginal and Torres Strait Islander community perceive to be the barriers and enablers of the model of care?
- Evaluation of the economic value of the model of care, specifically:
 - What is the cost per birth in the Waijungbah Jarjums model, compared to standard care?

2.2 Data collection

An indicator framework was developed (*see Appendix B*) for the Waijungbah Jarjums evaluation. Various primary and secondary data sources were utilised in the evaluation to assess the model of care, with consideration to the complex and policy saturated healthcare sector in which the program operates.

It is important to acknowledge the complex challenges to both baseline and current data collection within the GCHHS space. During the evaluation, several challenges and issues emerged that limited the quality and utility of the secondary data analysed from existing GCHHS data sources and systems. Specifically:

Data was unable to be disaggregated by Aboriginal and Torres Strait Islander identity

Some data was not able to be disaggregated by Aboriginal and Torres Strait Islander identity, due to information system and data collection and storage issues. While the new iEMR data can be disaggregated, it was noted that the data was of a poor quality, as many people (women, jarjums and staff) did/were not identified accurately. This may be due to a number of complex factors such as:

- consumers not being willing to self-identify (due to ongoing issues such as intergenerational trauma and attitude toward the healthcare system)
- staff not asking the question correctly (due to issues such as lack of confidence, or cultural awareness training)

This is an ongoing issue facing many Aboriginal and Torres Strait Islander programs and evaluations and highlights the important need for wider systemic change in order to enable quality, effective evaluations of programs such as the Waijungbah Jarjums model of care. To address these issues in this project, the data sets received for Aboriginal and Torres Strait Islander women accessing GCHHS were cross matched against the allocation data kept by the service. Of a total of 45 women who identified as Aboriginal and/or Torres Strait Islander 40 were identified correctly in the data collection system, the other 5 women's data had to be manually collated via UR number.

Another issue that was faced due to issues with the identification of women and jarjums is that historically the antenatal referral received by the GP to the antenatal clinic did not have the Identification of the woman and/or baby on the form, this meant that there was initially a delay in receiving referrals into the service until the issue was identified and forms were updated to include Aboriginal and Torres Strait Islander status.

Delays to the Project Commencement limited the time for Adequate Data

It is also important to acknowledge there were a number of institutional barriers that were faced at the beginning of the project which contributed to delays in the identification of positions through lawful discrimination, the recruitment of staff into Identified positions and therefore the implementation of the service.



One impact of these delays is that the data collected, especially data assessing the outcomes of the model, only captures a maximum of six months' worth of program data. While these have been reported, it is challenging for any evaluation to adequately assess effectiveness, utility, sustainability, or feasibility in such a short time frame. It is anticipated that the outcomes of the model of care will continue to be evaluated going forward, however this report presents the *preliminary findings* of the model's impact.

Data sources

The evaluation made use of both existing data (e.g. GCHHS and activity data) along with new data collected for the evaluation.

2.2.1 Existing Data Sources

The existing data sources utilised in this evaluation included:

- Perinatal Data Collection (PDC)
- QLD Health Analytics database
- Allocation data for the Waijungbah Jarjums service
- Waijungbah Jarjums Birth Statistics and outcomes – self kept to align with QLIK data

2.2.2 Primary data sources

There was also new data collected as part of this evaluation, which was registered as a quality improvement project with the *Women's, New-borns, and Children's Service Quality Improvement Activity Register* for GCHHS. This data collection was undertaken with key stakeholder groups for the evaluation, in order to understand their perspectives, experience, and understanding of the model of care. The stakeholders consulted as part of this project are outlined in *Table 2* and the key data collection activities undertaken are described below.

Table 2 Waijungbah Jarjums GCHHS Evaluation Key Stakeholders

Stakeholder Group	Description
Key project management staff	Responsible for the overall management and implementation of Waijungbah Jarjums in GCHHS. Manage the program, timelines, funding, and evaluation. Responsible for coordinating data collection and collation, and report to Director of WNC and Project Sponsor.
Waijungbah Jarjums Aboriginal and Torres Strait Islander Midwives and Child Health Nurses	10 Aboriginal and/or Torres Strait Islander midwives and child health nurses were staff on the current project. Advanced Maternal and Child Health worker re-directed position to Waijungbah Jarjums team (1.4FTE)
Mothers who participate in the model of care and their kinship (extended family network)	Aboriginal and/or Torres Strait Islander mothers, mothers whose partner identified as Aboriginal and/or Torres Strait Islander and the kinship of families who have accessed the Waijungbah Jarjums model of care



Project advisors

There were several advisors, both informal and formal, for the Waijungbah Jarjums model of care

Traditional custodians and Aboriginal and Torres Strait Islander community members

Traditional Custodians, Elders and the local community working group were engaged in relation to the outcomes that they would like to be recorded from the program and to determine the key priorities and recommendations

Online Survey

At the completion of the initial rollout of the Waijungbah Jarjums program at GCHHS a survey was sent out to the Aboriginal and Torres Strait Islander women who engaged in the model of care and the staff who developed and delivered the model. The survey was hosted on an online platform (RedCap). In total:

- 9 staff completed the survey
- 44 mothers completed the survey

Two validated scales were also included in the mothers' survey, described below.

The Mothers Autonomy in Decision Making (MADM) scale

The scale was developed in consultation with women to measure the construct *autonomy in decision-making during maternity care*. The shared decision-making component measured is a core factor of person-centred care and is the only validated scale to measure mother's autonomy. The scale psychometric properties have demonstrated reliability in previous studies (Vedam, et al., 2017a).

The Mothers on Respect Index (MORi)

A scale was also included to evaluate mothers' experiences with their maternity care, focussing specifically on disrespect and discrimination. This is based on well documented issues and abuse of human right for mothers during childbirth, especially for at risk populations. The scales psychometric properties have been demonstrated in previous studies, and the index is a reliable, patient informed quality and safety indicator for childbirth care (Vedam, et al., 2017b).

Semi-Structured Yarns

Semi-structured yarns were also conducted with the project management staff and key project advisors. In total, 3 yarning interviews were conducted and thematically analysed as part of the evaluation.

Yarning Circles

It was important for the Waijungbah Jarjums team to acknowledge and privilege Aboriginal and Torres Strait Islander ways of knowing, being and doing and to incorporate these knowledges in every step along the projects journey, including the gathering of feedback for the evaluation. Yarning circles were therefore conducted to gather Aboriginal and Torres Strait Islander perspectives and experiences from both consumers and staff. A Dadirri approach was used during yarning circles to ensure a respect and reflexivity. Dadirri is the act of deep contemplative listening in a reciprocal relationship (West, 2012).

"The Philosophy of Dadirri is a 'way of being with people' name by Miriam Rose Ungunmerr-Baumann, an Aboriginal woman from the Daly River, Northern Territory, Australia (Atkinson, 2002). As claimed by Atkinson (2002), Dadirri is more a way of life that encompasses practices associated with the importance of community, reciprocity, reflectivity, and trustworthiness. Ultimately, Dadirri means listening to and understanding the self in relationship to other; the notion of truly listening to other is pivotal to the methods"
(West, 2012; as cited in Atkinson, 2002)



Yarning circles were developed alongside the local community at the conception of Waijungbah Jarjums and incorporated immersion in culture and yarning simultaneously. There were separate men's and women's yarning circles held weekly on a drop-in basis to ensure cultural customs were adhered to when facilitating the sharing of cultural knowledges, and also a joint family yarning circle held monthly on a Sunday.

Additional to the weekly yarning circles we held two separate semi-structured yarning circles for staff and families to provide feedback on the service for the purpose of this evaluation. This yarning included sharing food and yarning about their experience in the service and ways we can move forward to develop the service to continue to meet their needs.

2.3 Ethical considerations

It is important for this project to recognise, acknowledge, and apply ethical guidelines and principles for Aboriginal and Torres Strait Islander focussed evaluation, notably:

- Australian Institute of Aboriginal and Torres Strait Islander Studies' Guidelines for Ethical Research in Aboriginal Indigenous Studies (GERAIS)
- NHMRC Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research

We also note that the Productivity Commission has recently released a draft of its upcoming *Indigenous Evaluation Strategy*. It is designed to provide a whole-of-government framework for use when selecting, planning, conducting, and using evaluations of policies and programs affecting Aboriginal and Torres Strait Islander people. The Strategy urges the identification of policies and programs which will affect Aboriginal and Torres Strait Islander people and employing best practice evaluation methods throughout the design, implementation, and follow-up stages. The Draft outlines that best practice evaluation should be guided by the overarching principle of considering Aboriginal and Torres Strait Islander people, perspectives, priorities, and knowledge at every possible step. The Strategy also list key priority areas for evaluations to occur and recommends including Aboriginal and Torres Strait Islander people in policy and program design, implementation, and evaluation wherever possible. This is an important priority for us in this project and has been a key consideration in the design of the evaluation team and planning phases.

As mentioned above, this evaluation was also registered and approved as a quality improvement project with the Womens, Newborns and Children's Service Quality Improvement Activity Register for GCHHS.

3. Implementation evaluation findings

3.1 Awareness and adoption

3.1.1 Are Aboriginal and Torres Strait Islander community aware of, accessing and engaging in the model of care?

A total of 56 Aboriginal and/or Torres Strait Islander babies¹ were born in the Waijungbah Jarjums model of care from December 2019 until 30th June 2020. Of those babies, 45 were born to Aboriginal and/or Torres Strait Islander women and the remaining 11 babies were born to women whose partner identifies as Aboriginal and/or Torres Strait Islander.

During the same time period (December 2019 – June 2020) there were 52 Aboriginal and/or Torres Strait Islander women in the mainstream service in GCHHS (see *Table 3*).

Difficulties with awareness and adoption:

¹ Note: there were no multiple births, and therefore 56 also represents the number of mothers who accessed the service in this timeframe.



Waijungbah Jarjums faced many difficulties with awareness and adoption as the service was declined access to a social media platform to engage with the community and until May of 2020 was considered a high reputation risk for the HHS as there was no guarantee of continued funding.

The project relied solely on;

- referrals from the local AMS,
- key stakeholders within the HHS referring into the service, and
- the Midwifery Navigator reviewing a daily report of Aboriginal and Torres Strait Islander women accessing GCHHS for antenatal care and calling women individually to offer the service

In May 2020 the project lead was named “Australian Midwife of the Year” - which drew media attention and exposure to the service and drove up the referral rate for the next financial year.

Of the 52 women who did not access Waijungbah Jarjums 19 women were on the waitlist, 1 declined the service to birth with the midwife who had birthed her previous 3 babies in MGP and the remaining women can be assumed to have not known about the service.

Table 3. Number of women accessing the service, MGP Capacity, Waitlisted women, and Declines

Month	Women accessing MGP service	MGP Capacity for FTE	Waitlisted	Declined and reason
January	6	6	2	-
February	10	9	4	-
March	8	7	9	-
April	12	12	2	-
May	11	12	2	-
June	9	9	-	1: <i>already booked with MGP midwife who has birthed their last three babies.</i>
Totals	56	55	19	

The engagement of women in antenatal care for mothers who access Waijungbah Jarjums was also compared to Aboriginal and/or Torres Strait Islander women in mainstream GCHHS services accessing the standard model of care. Notably, women in the Waijungbah Jarjums model were:

- more likely to engage in antenatal care before 12 weeks gestation (95.6% vs 59.6%), and
- more likely to attend >5 antenatal visits (100% vs 71.2%).

Qualitative data collected in the evaluation also provides insight into accessibility and engagement by the mothers who were part of the model at the time of the evaluation. Most of the answers to the survey question “*Were there any challenges of barriers that you faced accessing Waijungbah Jarjums care?*” suggested there were no extensive issues in accessibility. Some of the mothers also noted factors that were external to the project, such as COVID-19 as being barriers to accessing care. However, most of the answers to the survey questions seems to indicate that mothers were **not aware** of Waijungbah Jarjums initially.



Several mothers noted that they had applied for the Midwifery Group Practice (MGP) and were then told about the program.

- “I didn't know of this I just applied for MGP via email and was contacted very soon after”
- “I didn't know Waijungbah Jarums existed. I applied through MGP and was passed to Waijungbah Jarums”

One mother noted that their experience in the mainstream service, in their view, did not respect their culture and was a barrier to their access. The mother reported that it took multiple attempts to be referred to a culturally relevant service.

“I had been triaged through the normal system of GP shared care, I had to explain 3 times during my hospital visit that I was Aboriginal as it was not shown on the paperwork, and if there was any other help I can gain for myself being an Aboriginal and/or Torres Strait Islander client.”

This issue seems to highlight the broader issues with Aboriginal and/or Torres Strait Islander identification data initially identified in the methodology section. Specifically, that there are numerous system and people based barriers which mean that data on cultural identification is often not asked, collected, or stored accurately.

3.1.2 Are key stakeholders aware of, accessing, and engaging in the model of care?

The following table shows the number of referrals that were made, and where they originated from in the timeframe of the current evaluation (See Table 4).

Table 4. Waijungbah Jarjums Referrals and Referral Sources January 2020 – June 2020

Month	Total number of women WJ	Total number accessing women referred	Referral Origins				
			Kalwun	Hospital Safestart (high risk mental health and AODS)	QLIK data	Self - referral	Antenatal clinic/ hospital staff
January	6	6	1	-	1	1	2
February	10	9	1	6	1	-	3
March	8	7	1	5	-	-	2
April	12	12	-	4	2	-	4
May	11	12	2	4	4	1	2
June	9	9	1	2	1	1	4
Total	56	55	6	21	9	3	17

- Discrepancies in number of women referred into the service and the number of women who accessed the service is due to the service capacity
- **GCHHS staff held the highest numbers of referrals into Waijungbah Jarjums with approximately 10% of referrals coming from AMS**

Waijungbah Jarjums has also been able to establish a partnership with the Yugambeh Regional Aboriginal Corporation Alliance, YRACA. YRACA is a Traditional Owner, membership based Corporation that is supporting the Waijungbah Jarjums model of care with a partnership that includes cultural mentorship, cultural awareness sessions, Welcome to Country for Traditional events, Men's yarning groups, Ochre ceremonies and cultural advice adherent to cultural protocols. The support of Traditional Custodians and Elders is evidence of key stakeholders engaging in the model of care.

Anecdotal evidence in the mothers and staff surveys also seems to suggest that healthcare workers outside of the program are aware of its existence and do refer Aboriginal and/or Torres Strait Islander women onto the service.



However, there is also evidence of lag times between the start of formal maternity care within the GCHHS system and referral to Waijungbah Jarjums. As the survey data did not collect any information about when each respondent started the program, it is difficult to determine if this is due to an access/referral issue, or just a side effect of the model of care only commencing in January. It was noted that an initial barrier that was overcome in data collection was the Identification of women and jarjums on the initial referral into GCHHS, which may account for or contribute to the observed lag in referral times.

3.2 Fidelity

3.2.1 Is the model being delivered by the Waijungbah Jarjums staff and utilised by the HHS and by Aboriginal and Torres Strait Islander women and their families in the way it was intended?

As discussed in [section 1.4](#) Waijungbah Jarjums was designed in line with best practice understanding and approaches to Aboriginal and/or Torres Strait Islander focussed programs. There were several key considerations in the design of the Waijungbah Jarjums model that worked to ensure the final model was:

- Community led and co-designed
- Promoted Aboriginal and/or Torres Strait Islander workforce, governance, and ways of knowing
- Promoted and developed cultural safety of the HHS and non-indigenous workforce

The design of the service included the local Aboriginal and/or Torres Strait Islander community, and worked to integrate into existing systems and models of care (e.g. scale up Midwifery navigator, Midwifery Group Practice services, integrate the role across Maternal and Child Health Service of GCHHS and co-locate / integrate the team including existing staff (Health Workers). We also note that the co-design approach to evaluation ensured there was engagement with Aboriginal and/or Torres Strait Islander staff, families, and communities at all points in the project, including its design.

When considering if the model is being delivered as intended, it is important to review the initial purpose of the project. As mentioned previously, the purpose was to:

Provide a cultural safe model of care for Aboriginal and Torres Strait Islander women, their families and the community that is co-designed and co-led by the local Aboriginal and Torres Strait Islander community and incorporates the 'Birthing on Country' and 'First 1000 Days Australia' strengths-based models of care (MOC).

Survey and yarning responses from consumers strongly indicated that, in their view, there was a high level of cultural awareness, and they experienced the model as one that was culturally safe. Further consideration to the cultural safety of the model for both mothers, families and staff is given in outcome evaluation questions.

Another aspect of the intended model was the alignment with the birthing on country model and first 1000-day model of care.

In order to evaluate how the model aligns to with the Birthing on Country model, we consider the RISE framework (figure 2), which is a phased approach to the implementation of birthing on country services in the Australian context (Kildea et al., 2019).



Potential implementation phases of the RISE Framework

	Standard Care	Phase 1	Phase 2	Phase 3	Phase 4
R edesign health service	Routine care in community or hospital	Specific Aboriginal and/or Torres Strait Islander antenatal/postnatal programs	Continuity of carer with caseload midwifery and Aboriginal and/or Torres Strait Islander workers	Integrated community-based caseload midwifery and wrap around holistic services	Integrated Service/ Hub/ Birth Centre Choice of birth place
I nvest in health workforce	No Aboriginal and/or Torres Strait Islander identified positions Workforce with limited cultural understanding	Identified positions Cultural capabilities training	Career pathways and support for Aboriginal and/or Torres Strait Islander staff Measures of organisational progress of cultural capability	Aboriginal and/or Torres Strait Islander workforce pipeline Comprehensive mentoring and support New minimum standards for culturally safe workforce	Culturally and clinically capable (exceptional) workforce
S trengthen families' capacity	Ad hoc or non-Aboriginal and/or Torres Strait Islander antenatal/parenting programs	Formal strategies to engage families in maternal and infant health programs	Wellbeing framework to strengthen family capacity	Community developed cultural strengthening antenatal and parenting programs	Strong resilient families
E mbed community governance and control	No Aboriginal and/or Torres Strait Islander engagement strategy	Multi stakeholder engagement e.g. Community Consultation	Formal system of governance e.g. Advisory Group	Transformative and strategic governance e.g. Steering Committee	Aboriginal and/or Torres Strait Islander ownership

The Four Pillars of the RISE Framework

Figure 2. RISE Framework. From Kildea et al. (2019) *Implementing Birthing on Country services for Aboriginal and Torres Strait Islander families: RISE framework. Women and Birth.*

The project manager assessed the Waijungbah Jarjums model against the RISE framework, which is outlined below in Table 5.

Table 5. Waijungbah Jarjums assessment against RISE Framework Components

Re-design health services	Invest in health workforce	Strengthen families' capacity	Embed community
Phase 3	Phase 4	Phase 3	Phase 3

Importantly, the project officer noted that:

- Re-design health services – Waijungbah Jarjums may have achieved **phase 4** given the implementation of the community hub (discussed below)
- Embed community governance and control – may have achieved **phase 4** with the implementation of the community hub and Aboriginal and/or Torres Strait Islander ownership of the space.

We note that there were significant barriers in the design and implementation of the Waijungbah Jarjums model that meant the proposed community hub was not progressed, including the delayed establishment of a Waijungbah Jarjums specific cost centre, meaning the project lead did not have delegation over funds until mid project. Including delays in community engagement due to Covid-19 restrictions. Regardless of these barriers, it is important to note that, given the experience of the project officer with other similar birthing on country models in this area, the Waijungbah Jarjums model appears to be *at or above* the level of other, more established programs.

Regarding alignment with the Aboriginal and Torres Strait Islander First 1000 days model, we highlight the aspects of the program that were identified in the 2015 symposia which considered the applicability of the 1000 days model in the Australian context with Aboriginal and/or Torres Strait Islander families. Participants at the symposia identified that any 1000 days models should align with seven core principles. These principles, and the alignment of the Waijungbah Jarjums model are outlined in Table 6.



Table 6. Evidence of 1000 Day Principles in the Waijungbah Jarjums Model

Key Principles of 1000 Days	Evidence for alignment in the Waijungbah Jarjums model
A focus on comprehensive primary health care	The integration of the model of care with the wider Gold Coast Hospital and Health Service.
Maternal and child nutrition and early life literacy	Working towards the recruitment of an Identified Dietician and social worker to be able to meet this key principle. Currently the Waijungbah Jarjums service refers to a non-Indigenous dietician
Community governance	The project had a working group, consisting of 10-who were the key members - This working group enables community involvement in the Waijungbah Jarjums model care. Significant co-design -implementation and evaluation undertaken with Aboriginal and/or Torres Strait Islander community. Community governance and ownership with Waijungbah Jarjums Working Group As noted above. There are ongoing efforts towards enabling community ownership and implementing a steering committee to lead the program moving forward
A family-based model –that include all caregivers, fathers, grandparents and other relatives	As described in the evaluation methodology, there were several yarning circles completed as part of this project. These included circles that engaged fathers and kinship* in the model of care. We also recognise that, as identified in stakeholder consultations, often the staff and mothers noted they had familial ties which were not always immediately realised. This was seen as a positive and valuable experience by both midwives and the mothers. Innovative family-centred care is enabled by aspirations-focused support in which goals are articulated by families, not imposed on them. Aspirations-focused support is driven by a shared vision and holistic understanding of health and family, and shared local knowledges and resources.
Increasing antenatal and early years engagement	As described earlier in 3.1.1, women and families are more likely to engage in antenatal care before 12 weeks gestation (95.6% vs 59.6%), and more likely to attend >5 antenatal visits (100% vs 71.2%). It is difficult to determine early years engagement as we are evaluating the first 6 months of Waijungbah Jarjums model of care, longitudinal data needs to be collected to determine if we have met early years engagement.
Building capacity with both parents and families that recognises language, location, and cultural diversity	The model included home visits by the WJ midwives. Mother feedback indicated that these visits helped make them and their families feel more safe, secure and able to ask questions about their child's care. They noted that the midwives, more than the standard service (e.g. for those who



	interacted with other areas such as NICU) was personalised, understood them and their context, and supportive. Yarning circle attendance can also be seen as evidence of capacity building activities, in line with the <i>First 1000 Days Australia Strategic Plan</i>. Men's groups and yarning circles have been shown in previous literature to improve wellbeing and result in better health outcomes, but connecting parents and families with their culture, community and local services (Southcombe, Cavanagh & Bartram, 2015). Men and women are supported to identify their aspirations and strengths and are provided with culturally safe solutions to help them carry their child in a pristine pregnancy. This requires services to focus on responding to and meeting family aspirations rather than deficits, and engaging with local Indigenous knowledge, culture, families and workforce to put into place new strengths-based supports and family mentoring. Specific attention will be given to father-inclusive practices during the early formation of men's families.
A focus on scientifically robust and decolonised evidence base for measuring outcomes	We note that the fact this evaluation is occurring, and is led by Cassandra Nest, a Ngunnawal woman who grew up on the Yugembeh and Bundjalung Country, recognises the importance of First People researchers. The model of care decolonises the traditional Western way of developing, implementing and delivering care. It privileges Aboriginal and Torres Strait Islander ways of knowing being and doing and is underpinned by the notion that knowledge is relational, created and shaped by the relationships we have with each other, the community and the land. We also acknowledge the inclusion of validated scales and the evidence-based approach to the design, implementation, and evaluation of the model provides further evidence to the commitment to a robust project.

As will be discussed further in **Section 4.1** this project was also intended to include components that worked to build the cultural safety of the wider GCHHS workforce, including non-indigenous staff of the project. Cultural safety is about issues of access to quality services and communication and mitigating the service barriers, both formal and informal, that reinforce inequity and systemic racism. Importantly, in like with the AHPRA definition in the *National Scheme's Aboriginal and Torres Strait Islander Cultural Safety Strategy: 2020-2025*, cultural safety is:

- a) Determined by Aboriginal and/or Torres Strait Islander individuals, families, and communities
- b) Culturally safe practice is "*the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practicing behaviours and power differentials in delivering safe, accessible and responsive health free of racism*".

Cultural safety requires strategic and institutional investment in multiple strategies to remove barriers to quality and safety healthcare and optimal health and wellbeing outcomes for Aboriginal and/or Torres Strait Islander people. Step one on this journey is to invest in raising awareness of the concepts and power differentials that exist across and throughout services from individual behaviours through to systems that reinforce barriers and inequalities faced by Aboriginal and/or Torres Strait Islander people. In the Waijumbah Jarjums model of care, the initial proposal included the provision of a mixed method training module on *Aboriginal and/or Torres Strait Islander Maternal and Infant Health and Cultural Safety across the First 1000 Days* which would be required training for the project and recommended training for all of Women's, Newborn and Children's service. However, significant barriers to implementing this training were faced during the initial stages of the project. Notably, in the procurement of Griffith University services to undertake the development. GCHHS procurement initially declined the proposal as it was seen to be a "consultancy proposal", the proposal had to be re-written and was resubmitted.



again and despite escalation to the WNC Executive Director was not signed off in time for the work to be completed by the end of the project. The table below (*Table 7*) compares the proposed, recruited FTE and the rationale for the recruited FTE.

Table 7. Number of Aboriginal and/or Torres Strait Islander staff in original proposal vs recruited

Role	FTE	FTE and Position Recruited	Rationale
Midwifery Navigator	1 FTE	0.6 FTE	
Clinical Midwife (CM)	2 FTE	1 FTE	Unable to recruit to second CM – limited applicant pool of senior midwives
Registered Midwife (RM)	2 FTE	3 FTE	Over established position as unable to recruit to 1 FTE CM
New Graduate Midwife	-	0.9 FTE	Employed utilising underspend of delayed recruitment
Registered Nurse	1 FTE	0.6 FTE	Employee request – upskilling into child health
Clinical Child Health Nurse	1 FTE		Advertised for recruitment x 2 with no Identified applicants. Change of scope submitted to hire a RN/CN as the First 1000 days Regional Implementation Co-ordinator
Clinical Nurse – First 1000 Days Australia Regional implementation coordinator	1 FTE	1 FTE	Change of Scope – recruited to in June 2020

Staff in the Waijungbah Jarjums model noted the importance and value of having an all Aboriginal and/or Torres Strait Islander team.

“Having a team of all Aboriginal and/or Torres Strait Islander midwives has made the service what it is. It has enabled safety for both the midwives and midwifery students/cadets to feel comfortable to work within their scope with less resistance and it has enabled women to feel culturally supported and cared for within this model.”

Staff in the program also noted that it has given them good career opportunities, experiences, and opportunities to learn new skills and new (or rediscovering old) ways of delivering care. *“I think it's been, a very good career opportunity. I think it's been a really good opportunity to build ourselves up in that spiritual way as well.”*

But what we tend to do is benchmark the way we work against dominating non-indigenous ways of working. But that's [building strong relationships with mothers] an indigenous way of being. The way that you connect. That's an indigenous way of being. That goes back 60,000 years. That's not new.”

Key Project Stakeholder in Yarning Circle with Waijungbah Jarjums Midwives

Importantly, the Aboriginal and/or Torres Strait Islander midwives also raised the informal role that they play as midwives who role model to future generations. Many of the midwives in the model highlighted how their experience with another Aboriginal and/or Torres Strait Islander midwife was what first initiated their interest in the program, and that they have had similar experiences working in the model with family members of mothers.



saying they were now interested in midwifery. We note that this seems to suggest informal benefits to the model, in that it is role modelling for a new generation of midwives.

Further, for the Aboriginal and/or Torres Strait Islander midwives, this model was a safe space that, for some, meant they were less likely to drop out of the practice.

When comparing working in Waijungbah Jarjums to working in a standard/fragmented model of care, one midwife shared:

"I would rather not have a job.... after experiencing what I've experienced, I know for a fact that I would be that person that doesn't continue midwifery. I just know that that would have been me. I know that - I don't - after experiencing working with these guys, I don't ever want to work in a fragmented model of care, where there is no cultural safety"

Regarding Aboriginal and/or Torres Strait Islander ways of knowing, mothers and families accessing the service noted in yarning circles that they thought the Waijungbah Jarjums midwives looked at things holistically *"They address everything that is going on for you to make sure you are comfortable and healthy"*. This aligns with the Aboriginal and/or Torres Strait Islander wholistic definition of health, and demonstrates how the Waijungbah Jarjums model, in practice, applies Aboriginal and/or Torres Strait Islander knowledge to midwifery care.

"That's a very Aboriginal thing again. The Aboriginal definition of health is about mothers. It's families and community. So social, emotional, spiritual wellbeing for the whole community. "

Cultural Practice Program Training

A recent report run on the CPP program within the HHS has identified that WNC have a completion rate is 53%. It has been identified as a recommendation from this report that WNC strives for a completion rate of 80% by December 2021.

Table 8: Percentage of staff who have completed the CPP program within the HHS by division

Division	Sum of Total staff completed %
Capital Works	88%
Chief Executive	33%
Clinical Governance, Education And Resea	68%
Corporate Governance and Strategic Comm	90%
Digital Transformation Services	93%
Finance Services	79%
Ops Allied Health	78%
Ops Diagnostic And Subspecialty Services	67%
Ops Integrated And Ambulatory Care Servi	63%
Ops Mental Health And Specialty Services	76%
Ops Office Of The Chief Operations Office	61%
Ops Surgical, Anaesthetics And Procedura	49%
Ops Womens, Newborn and Childrens Services	53%
People And Corporate Services	30%
Strategic Communication And Engagement	100%
Strategic Planning And Assets	86%



Courageous Conversations About Race Beyond Diversity foundational training

The former Anti-Discrimination Commission Queensland (ADCQ) now the Queensland Human Rights Commission (QHRC), *'Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander People in Queensland's Public Hospital and Health Services'* report identified that there are significant institutional barriers impeding the effective delivery of health services to Aboriginal and Torres Strait Islander people. The report identified that all HHS's were either in the very high to extreme levels of evidence of institutionalised racism rating, with the Gold Coast Health in the *'extreme level'* scoring 17.5 out of a possible 140. The report allows for the acknowledgement and addressing of institutional racism in healthcare to move towards a more positive future for health equity for Aboriginal and Torres Strait Islander people.

In November 2019, the Minister for Health and Minister for Ambulance Services, introduced the Hospital and Health Boards (Health Equity Strategies) Amendment Regulation 2020 Health Legislation Amendment Bill 2019 (Bill). This pending Bill will make a range of amendments to health portfolio legislation, including amendments to the *Hospital and Health Boards Act 2011*. This includes a commitment from HHS Boards to strengthen the capability and development of strategies for achieving health equity for Aboriginal and Torres Strait Islander people. This legislation was passed on the 13th August 2020.

At the time of the *'Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander People in Queensland's Public Hospital and Health Services'* report (released end of 2017), the GCHHS did not have any training or frameworks to introduce race and racism into healthcare practice. The Cultural Practice Program (CPP) training is mandatory for all Queensland Health Staff, however CPP training is a cultural program and the curriculum does not provide staff with the ability to address race and racism.

As an authentic strategy to address Institutional racism the GCHHS has commenced the delivery of the Courageous Conversations™ About Race (CCAR) Beyond Diversity program and has embarked on a training model with six staff licensed as facilitators. Courageous Conversations about Race Beyond Diversity is an award winning, innovative, internationally recognised, protocol for effectively engaging, sustaining and deepening interracial dialogue. CCAR operates on the principle that an organisation cannot achieve cultural responsiveness and inclusion in professional practice until they can explicitly talk about race and racism. The CCAR protocol provides an opportunity to enhance Clinical Practice for working with Aboriginal and Torres Strait Islander peoples by reorienting clinicians and other health staff towards a practice that acknowledges the impact of race and racism in a clinical context.

CCAR is building Staffs understanding of how race impacts their lives, work and communities by providing tools that affect change contributing to health improvements for our First Peoples' and people of all races - moving Gold Coast beyond diversity to racial and health equity and organisational transformation.

Through this framework for Systemic Racial Equity Transformation, CCAR supports the GCHHS to address persistent racial disparities intentionally, explicitly, and comprehensively. By engaging in a sustained partnership, we have the opportunity to create a space for all staff to have conversations that transform beliefs, behaviours, and results so that our staff of all races can achieve at their highest levels and live their most empowered and powerful lives.

The GCHHS is leading the way to achieving systemic equity transformation through the work undertaken thus far. The development and embedding of a training plan, through this project will not only enable the GCHHS to preemptively identify and develop meaningful actions, it positions the GCHHS to be a transformative leader both nationally and internationally in the space of equitable health outcomes for the Aboriginal and Torres Strait Islander Peoples. This work will ensure that GCHHS is prepared and one step ahead with planned and developed preemptive actions that will form part of a future strategy to support the implementation of the upcoming Health Equity Legislation.



As part of the CCAR Project recently undertook a Needs assessment survey for staff who have undertaken the training that yielded approximately 77 respondents. Of the respondents, 16% (n=12) indicated that they worked within the WNC Directorate which was one of the top three directorates where staff responded to the survey and participated in the program.

Experience of the Model

Overall, there was significant positive feedback received on the model of care and the experiences of both staff, mothers, and their families and that this experience aligned with what was intended in the design of the model. Overall, survey responses from consumers to the question *“Can you please share a positive experience you had with Waijungbah Jarjums?”* indicate that cultural awareness, safety, providing information, supporting decision making, and continuity of care are common, and highly valued, parts of the experiences they had with the service. Further descriptions regarding the experiences of the mothers is described in the outcome evaluation.

Continuity of Care

Most mothers expressed they experienced a strong level of continuity of care, which is discussed in a later section. However, even in cases where this was not possible, the mothers noted that, compared with hospital staff, all the Waijungbah Jarjums midwives provided respectful, caring, and valued care (even if they were not the primary midwife for that mother).

Accessibility

There were some concerns raised about the accessibility of the service.

Waijungbah Jarjums caters for women all over the Gold Coast, with most women living central and northern Gold Coast. Unlike the Hospital’s existing MGP which is location based Waijungbah Jarjums covers from the QLD/NSW boarder to Pimpama. Therefore, this poses a unique challenge for staff attending home visits, their ability to attend multiple visits throughout the day is limited and KM travelled per day averages around 150-200kms, driving up costs of mileage claims.

Another barrier which was raised by a few mothers was that parking was an issue to accessing the service with long overnight admissions, although Waijungbah Jarjums support 5 parking tickets, one overnight stay is not covered by the parking voucher and by the time of admission women had already used up the majority of their parking vouchers accessing care antenatally due to community space issues.

Staff also noted that the lack of a community space was an issue for accessing culturally safe care.

“Access to our own culturally safe community space for women and families.”

“Our families and staff would greatly benefit from our own community premises.”

“The biggest barriers to Waijungbah Jarjums being able to achieve outstanding care for the community is its own stand-alone community space. This has been highlighted and escalated numerous times throughout the journey of the project and continues to be blocked each time. This is institutional racism, we are not a burden, we are not a ‘reputational risk’. We are the oldest living culture in the world.”

“The community want a stand-alone community space that that they feel culturally safe accessing instead of us having to have a dingy room in a venue that we feel like we are visitors in. We, the Traditional Custodians of the land, feel like visitors and a burden to the HHS having to constantly fight for rooms and spaces. The growth of the service, our ability to be at Phase 4 across the RISE model of evaluation depends solely on our ability to provide the community with what they want – A stand-alone community venue”

Cultural Practices



Waijungbah Jarjums provides culturally safe care to women throughout the birthing journey. This includes encouraging women and their families to partake in traditional birthing practices during the pregnancy, hospital admission and postnatally.

Waijungbah Jarjums has worked closely with Yugambeh Traditional Custodians and local Elders to develop the Welcome Jarjums to Community Event. The event is a modern take on Traditional Ceremonies for welcoming jarjums to country once they are in the physical world. The ceremony was postponed due to Covid-19 but will be held to welcome all Aboriginal and Torres Strait Islander jarjums on to the traditional lands of the community in which they are born and living, but also connect the child's family with other families, Elders, local agencies and the community.

Welcoming a new baby into Aboriginal and Torres Strait Islander communities is a cultural practice that involves the whole community - men, women, children and extended families. For thousands of years, Aboriginal and Torres Strait Islander peoples have held 'Welcome Jarjums to Country' ceremonies to acknowledge an infant's connection to the lands on which they are born and these practices are diverse and unique to each community across Australia.

It was noted in one interview that this involvement was critical for not only cultural practice, but as an important mechanism for ensuring that the traditional custodians and local community are engaged, and supportive, of the program.

"One of the things I am most proud of with the development of Waijungbah Jarjums model of care is the involvement that the local Aboriginal and Torres Strait Islander community and Yugambeh Traditional Custodians and Elders have had in the development of the model. The partnership we have been able to form with YRACA - the local Aboriginal Elders Council has pretty much cemented for me that Waijungbah Jarjums is a success. It's not just about the improved outcomes, it's about the community involvement, building that trust and getting that true support."

Safety and Care

A critical component of safe care in childbirth has been established in relevant literature as respectful care, which is important for a quality, safe, and positive birthing experience (Vedam et al., 2017b). To assess the experience of care, an adapted version of the Mothers on Respect (MOR) scale was administered to the Aboriginal and/or Torres Strait Islander mothers in the Waijungbah Jarjums model of care (from January – June 2020). We note that the item "During my pregnancy I felt that I was treated poorly by my midwife because of my type of health insurance or lack of insurance" was removed, as it was not relevant in the Australian healthcare context.² We note that further research in this space may work to validate the 13-item version in Australia, and that no reliability or validity statistics were calculated in the current study (meaning scores should not be interpreted beyond this current project).

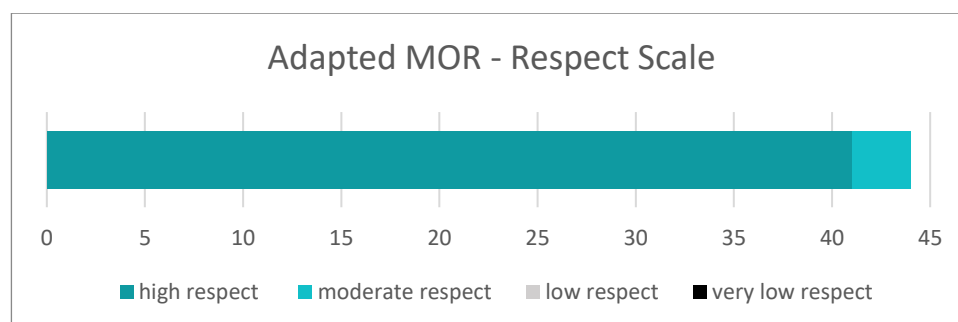


Figure 3. Adapted MOR – Mothers on Respect Scores

² Note: Quartiles were adjusted to reflect the new score range and the cut-offs used for this interpretation were Q1=13-28, Q2=29-45, Q3=46-61, Q4=62-78.



All of the mothers rated their perception of respectful care in the Waijungbah Jarjums model as either high respect (93%) or moderate respect (7%). This indicates that the Waijungbah Jarjums model (and the midwives in the model) respect mother choices, safety, and human rights. The full write-up for the MOR items is presented in Appendix C.

Autonomy

The Mothers Autonomy in Decision Making (MADM) scale was also administered to the mothers who were engaged with the model of care. The validated scale measures the perceived autonomy of mothers in making decision about their care. Importantly, we note that the scale administered was an adapted version. It was determined that the item “My midwife asked me how involved in decision making I wanted to be” did not fit with the Australian context and approach to midwifery practice. That is because mother-led practice is the core principle of the model.

We note however that this does limit the interpretability of the validated scale and the need to validate the 6 – item scale in the Australian context and confirm its factor structure.³ The data presented below should not be interpreted beyond the context of this study and is not comparable to other MADM scores. The full writeup of all six items for the MADM scale are also presented in Appendix D.

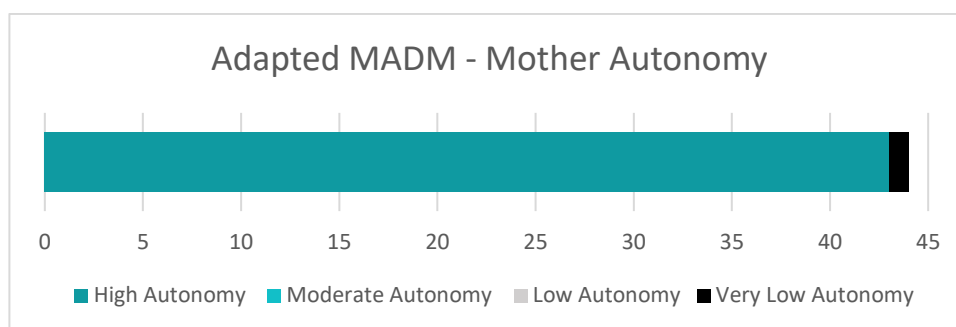


Figure 4. Adapted MADM – Mother Autonomy Scores

Most of the mothers in the Waijungbah Jarjums model indicated they felt they had high autonomy (98%) with one mother indicating that they felt they had very low autonomy in their care. Overall, it seems that for most mothers the model of care is one that enables their involvement in decision making. This was supported in qualitative data collected as part of the evaluation, “The Waijungbah Jarjums midwives talk to you like you are a mate, part of your family. This makes you feel comfortable to follow your birthing wishes and not just what you are advised to do by the doctors.”

3.3 Acceptability

3.3.1 Does the Aboriginal and Torres Strait Islander community and HHS staff perceive the model of care to be acceptable?

Community members in general had positive views of the model of care. They did however note that, as was experienced in the implementation, there are many wider systemic barriers that limit the ability for innovative models such as Waijungbah Jarjums. They noted that the model of care highlighted covert and overt racism and discrimination and the staff were seen as somewhat of a target for ignorance when addressing issues of equity versus equality and the importance of Aboriginal and Torres Strait Islander people looking after their own mob.

“We’ve had a few (non-Indigenous) staff come through courageous conversations, so I can see that they are challenged and so you see how uncomfortable the staff are, that don’t understand why they can’t for the service. So already there’s this narrative of, oh well, it’s not fair to me, because I can’t work there. Therefore, I

³ Note: Quartiles were adjusted to reflect the new score range and the cut-offs used for this interpretation were Q1=6-13, Q2=14-20, Q3=21-28, Q4=29-36



don't have those same opportunities they're getting more opportunity. So people are just not seeing that the reason we need this program...."

*It should be noted that WNC staff have been nominated to attend the Courageous Conversations About Race – Beyond Diversity Training. Where staff feel that they have been told to go our observation is that this is faced with resistance. Courageous Conversations About Race provides staff with some tools to have conversations. However, if staff are not willing to engage, sustain and deepen the conversations about race and to have a safe conversation it is difficult to move forward.

Some key stakeholders also reflected on their interactions with the community related to the Waijungbah Jarjums model. When asked how the Aboriginal and/or Torres Strait Islander community feel about the model, key stakeholders noted:

"I think that they're happy. I think that they really are.... it's what people want when they come to the service. You know, like they want to be treated with equity, they want to be treated equally, they want to be treated, you know, preferably by their own mob. Um, but you know, that basic human interaction when you come to a place where you don't want to be a hospital, or a health service, you're coming because you need some help and some assistance and some care. And so, you know, I mean, the literature, I mean, there's lots of research and we know that our people get treated better by our own people."

"The fact that we have total community buy in with a partnership with YRACA highlights to me that the Aboriginal and Torres Strait Islander community perceive the model of care to be acceptable and exemplary, otherwise we wouldn't be supported – I think this is severely under estimated by non-Indigenous staff. Non-Indigenous people cannot possibly understand the significance that having Traditional Custodian support and local Elders support means for the service. Without their support, and you have to be seen to be truly working in partnership to achieve this, Waijungbah Jarjums wouldn't be what it is."

GCHHS Perceived Acceptability

It is difficult based on the data collected to ascertain the perception of the model of care from wider HHS staff. We do describe further in the report that there were several situations where Waijungbah Jarjums midwives faced discriminatory or racism from other HHS staff (either their own experience, or interactions witnessed by the mothers accessing the service). While this indicates that the HHS staff may perceive the model to not be acceptable, it seems this is more due to racial biases and stereotypes than any issue or concern with the model itself. As some staff noted, they often had to explain to other HHS staff that the model was not about "giving women things for free" – "it is about providing equity in access" Another staff members also noted that "not a day passes when I enter the hospital setting that I don't have to educate non-Indigenous staff on the difference between equity and equality and the importance of mob caring for mob".

One key stakeholder notes, "there are multiple levels of acceptance with staff in a HHS setting. HHS executive team seem to fully support Waijungbah Jarjums and have even nominated Waijungbah Jarjums for the Magnet award, only 1 program was nominated from the HHS and it was us. Past middle management is where I see the resistance, in the frontline workers. That's where the staff face discrimination and racism. I always knew this was going to be one of the barriers we would face in being part of an innovative service, in driving change and in providing equity for Aboriginal and Torres Strait Islander People, but it doesn't make it any easier when it happens to you."

"As Indigenous practitioners in a HHS we walk between two worlds and are the bridge between these worlds for both Aboriginal and Torres Strait Islander staff and community and non-Indigenous staff and community. It's a difficult task, but I didn't come into this program to be liked or accepted by non-Indigenous people or even thinking



that non-Indigenous HHS staff would accept the service. I am here for my mob and to develop with them a service that they see themselves in to increase their satisfaction with maternal and child health care in the HHS”.

3.3.2 Do the Aboriginal and Torres Strait Islander community perceive the service to be culturally safe?

Consumers were asked to indicate whether Waijungbah Jarjums respected their cultural beliefs. Most consumers strongly agreed with this statement (37, 84%), while others agreed (5, 11%), somewhat agreed (1, 2%) and strongly disagreed (1, 2%).⁴

Most consumers strongly agreed (39, 89%) that Waijungbah Jarjums provided them with culturally safe care. Other consumers agreed (4, 9%) and somewhat agreed (1, 2%) with this statement (see Figure 5). Further, from the MORi (See Appendix C) most mothers either strongly agreed (41, 93%) or agreed (3, 7%) that their cultural preferences were respected.

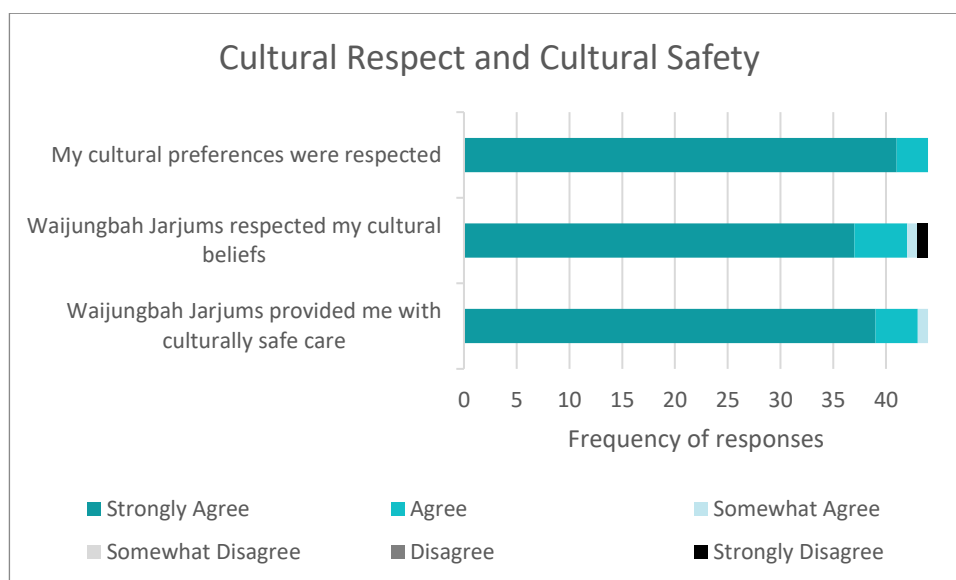


Figure 5: Cultural safety of care

Together, these findings suggest that most mothers had a culturally safe experience when accessing Waijungbah Jarjums. This was supported by an abundance of qualitative data from the mothers experiencing the service.

“I didn’t know how much I needed an Aboriginal midwife until I had one and it made such a difference for my family feeling comfortable and feeling listened too. She became part of the family too.

It was so deadly to be surrounded by strong Aboriginal staff within Waijungbah Jarjums and deadly to see they are making way for our future midwives and nurses too. We really valued having a midwifery student for additional support.

“The ladies always made me feel comfortable and the information that was shared was very informative. I always felt like I was in a safe space to ask questions and to not be shame. I was lucky and grateful to be able to make a connection with my midwife and her partner Midwife and the midwifery student. This helped with the labour as I had change over with my midwife. The care from my midwives was exceptional and I was very proud

⁴ All percentages are rounded to zero decimal places. As such, sometimes these values do not sum to 100%.



And grateful to be part of such an amazing program. It's deadly to have care from other strong Aboriginal women.

"The care from my midwives was exceptional and I was very proud and grateful to be part of such an amazing program. It's deadly to have care from other strong Aboriginal women."

3.3.3 Do the Aboriginal and Torres Strait Islander staff perceive the service to be culturally safe?

A survey to the staff asked their perceptions on the cultural safety of the service. All staff strongly agreed (9, 100%) that Waijungbah Jarjums provides culturally safe care to women and their families (see Figure 6).

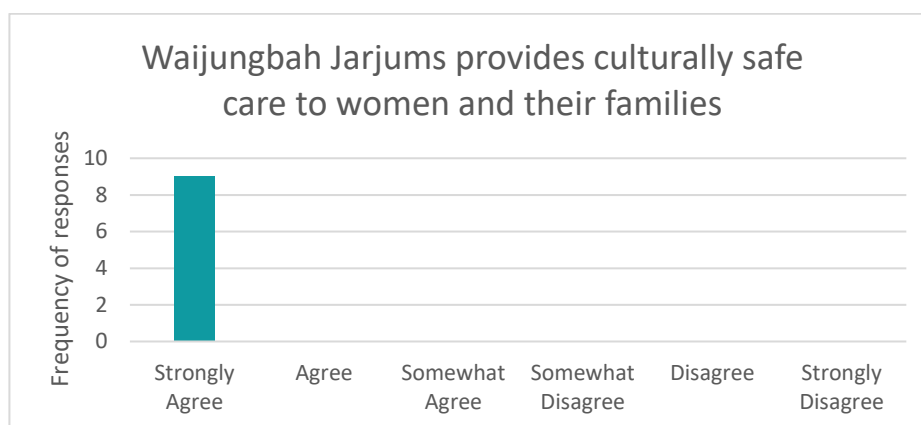


Figure 6: Cultural safety of Waijungbah Jarjums

All staff either strongly agreed (7, 78%) or agreed (2, 22%) that they feel culturally supported within the Waijungbah Jarjums team (see Figure 7).

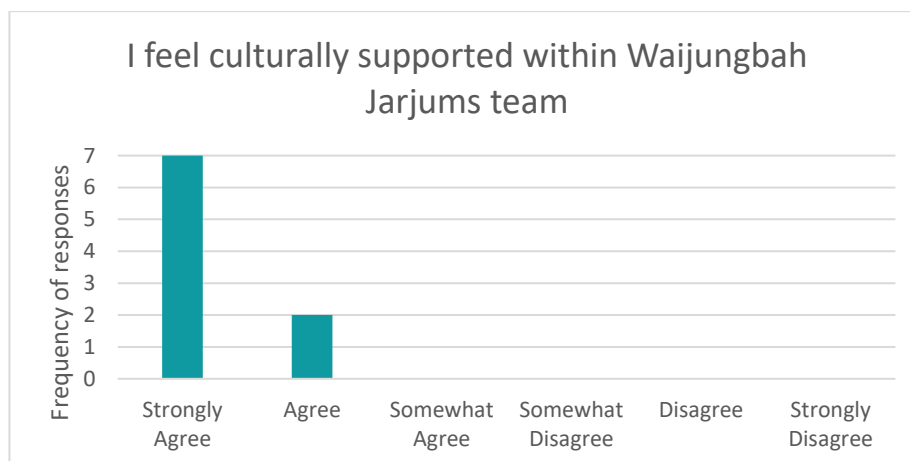


Figure 7: Staff support

These thoughts were reinforced in qualitative data, where the staff of the Waijungbah Jarjums model discussed some of the key tensions they faced, highlighting how the model gave them a strong base from which they felt more able to tackle some of the issues they experienced in work. They noted that, by having a team of Aboriginal and/or Torres Strait Islander midwives and nurses, they had a cultural support from which to discuss and debrief.

"I think the connection, the cultural connection, I definitely feel heaps supported when I'm around these fellas. But also even just having - when you work in - when we're working in the hospital and you hear people say



things. Everybody is on the same page as you. So you can go and bounce things back and go that was a bit racist. I've got that someone to go to and be like that was terrible. It actually makes it a lot easier for me. "

3.4 Penetration

3.4.1 To what extent is the model being used routinely by practitioners and/or consumers?

Both *Table 3* and *Table 4* above provide information on the number of women who accessed the service and the referrals from other key stakeholders for the time period covered by the evaluation.

In relation to the model is being routinely used by practitioners, of the 108 Aboriginal and/or Torres Strait Islander women or Aboriginal and/or Torres Strait Islander families in GCHHS from January to June 2020, 48% were referred to the Waijungbah Jarjums model of care by practitioners or other services (i.e. Kalwun, Hospital Safestart, QLIK data, Antenatal clinic/hospital staff). Additionally, 3% of women self-referred into the service.

Consumers also seem to be regularly engaging with the model of care, with 52% of the Aboriginal and/or Torres Strait Islander women across GCHHS in the evaluation period engaged in the model of care. Importantly, for 5 of the 6 months the model was running the **MGP was at or above capacity**, and there were women on wait lists in all 6 months.

Taken together, this data indicates that the model of care is being used routinely to the full extent of the current staffing and resourcing capacity.

3.5 Sustainability

3.5.1 Are the staff satisfied working in the model of care?

Staff were also asked to indicate their agreement with a series of questions about their professional skills and job satisfaction. All staff either strongly agreed (6, 67%), agreed (2, 22%) or somewhat agreed (1, 11%) that they are more satisfied in their current role in Waijungbah Jarjums than in other models of care they have worked, indicating improved job satisfaction. Most staff strongly agreed (7, 78%) and others agreed (1, 11%) or somewhat agreed (1, 11%) that Waijungbah Jarjums has offered them the opportunity to upskill as a practitioner. In addition, most staff either strongly agreed (6, 67%) or agreed (2, 22%) that Waijungbah Jarjums has allowed them to work their full scope of practice. Although, one staff member (1, 11%) disagreed with this statement (see Figure 8).

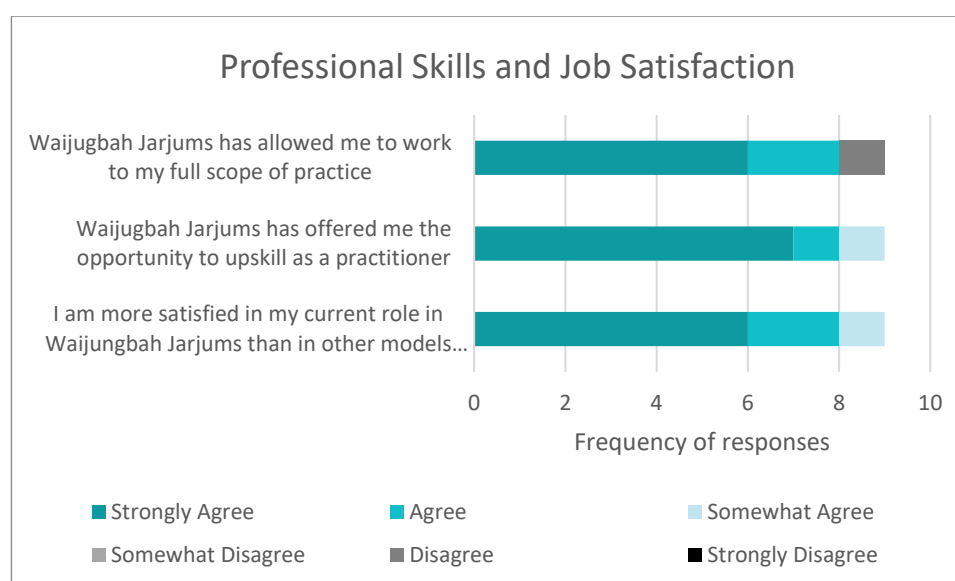


Figure 8: Professional skills and staff job satisfaction



Qualitative data also supported these overwhelmingly positive ratings by staff, and the team noted that there were several aspects of working within Waijungbah Jarjums that were positive enablers for them. Waijungbah Jarjums supported the upskilling of 2 midwives into practice as a prescribing midwife, allowing them to work to their full scope of practice as a midwife and encouraging the development of clinical and leadership skills. This was seen as beneficial to the midwives who completed the study by supporting their career progression and taking the financial burden of postgraduate studies away from them. One staff member who completed postgraduate studies stated that *“Waijungbah Jarjums has allowed me to progress into a meaningful career working with mob that I otherwise may not have had the opportunity to do”*.

Context was also given to the one staff member noting they could not work to the full scope of their practice, as they were aware of the limitations and limits on their scope of practice when accepting the role.

A focus on Aboriginal and/or Torres Strait Islander Health, Workforce and Outcomes

Most of the staff noted that the value of the clear focus on Aboriginal and/or Torres Strait Islander health, workforce development, culture, ways of knowing, and ultimately improving outcomes was critical. They emphasised the value of the all Aboriginal and/or Torres Strait Islander team working in the model *“A deadly team of identified staff”*.

Many of the staff noted that working with Aboriginal and/or Torres Strait Islander women and families was valuable, and a source of support for them. They also noted that the involvement of the Aboriginal and/or Torres Strait Islander community in the development of the service was another key way that the program continued to demonstrate its commitment to Aboriginal and/or Torres Strait Islander knowledge, governance, and outcomes.

“Being guided by community to develop services - By mob for mob”

“The team, an understanding manager and working with mob”

Job Characteristics

Some staff noted key job characteristics which are known to increase meaning in work, and subsequently the positive organisational outcomes (e.g. effectiveness; Oldham & Hackman, 2010). Notably, they felt that their work had strong significance and that they had autonomy in how they worked, two of the key characteristics that contribute to meaningfulness at work.

“Having the room to work in a way that I want to and having autonomy over my work.”

Meaning and Impact

The staff working in the Waijungbah Jarjums model of care emphasised that their experience providing women-centred care meant that they felt they were able to make real, significant difference to the women, their families, and the whole community.

“Knowing our service is greatly improving outcomes for mums and bubs in the area. Hearing positive feedback from women and their families and creating a connection with the families we care for on a level I know doesn't occur in a fragmented model of care”

While overall staff seem to be satisfied working in the model, they did note in feedback that there were some distinct challenges of being a Waijungbah Jarjums midwife.

Role clarity and teamwork

Many staff noted that the new role meant there were some challenges early on in defining the scope of their role and understanding the expectations of what their work looks like. They also noted that there were challenges



working together as a team, and a need to ensure that their communication was always optimal, timely, and proactive *“Being a newly established team, building the trust of other staff members on the frontline.”*

Further, as discussed below (section 3.5.3) they also noted that the constant threat of non-funding for the service made it difficult to progress work and invest fully into the model.

3.5.2 What are the barriers and enablers to the development and implementation of the model of care?

Stakeholder consultations and the survey identified several barriers and enablers to the implementation of the Waijungbah Jarjums model of care for both staff and consumers. More discussions regarding the access and equity barriers is presented in [Section 4.3.1](#).

Barriers Faced

Racism and Cultural Practice

Many of the staff spoke about key racial barriers they faced in the delivery of care. Some examples included:

- *“experiencing racism and the “us and them” mentality from other MGP and core staff.”*
- *“Institutional racism, Overt and covert racism and discrimination. The attitudes of the other staff in the hospital towards what we are establishing and not being supported by them. Constantly having to educate staff that our women “aren’t just getting stuff for free” that we offer equity in access and then having to educate other staff about equity vs equality.”*
- *“Navigating a lot of institutional racism”*
- *“The biggest challenge is working within a healthcare system that is dominated by a white Western worldview. The challenges of implementing a black service into a white system cannot be underestimated, I have wanted to quit the role so many times and the only thing that keeps me going is thinking about why I am in the position I am in and how I got here. 60, 000 years of strong black ancestors pull me back in line... but I do not think that a non-Indigenous person has to face the same challenges I do in leadership. Every decision I make is questioned on a cultural level and other Aboriginal people are then consulted within the HHS that have nothing to do with the program. No one black person speaks for every black person, no one black person, in a service, on a board, in the community should speak on behalf of all black people. That’s not the way we do things, and white people thinking they can just pick to consult with their favourite black person needs to be challenged and changed”*

They also noted that they often were expected by wider service staff to operate in a cultural brokerage or Health Liaison Officer role for women who were not part of the Waijungbah Jarjums model of care. The expectation that providing culturally appropriate care is only the responsibility of Aboriginal and/or Torres Strait Islander workers was noted *“Having others assume our midwives are available to provide cultural support in a way similar to a HLO for women not in our care.”* They also noted that, even just in their own model, the additional energy and investment in providing cultural support to the mothers (while rewarding) was an additional stressor.

“Challenges working with Waijungbah Jarjums have been providing cultural support to women as well as appropriate midwifery care. The trust between women and the hospital system is lacking so I have noticed we a bridge between the women and access to healthcare. This comes with a feeling of immense responsibility and can require more effort when needing women to engage.”

“It’s a tough job, you don’t just get to go home and take off your Aboriginal shirt and that’s the end of your day as a midwife and your commitment to the community. You live and breathe the service, you are always an Aboriginal midwife even when you’re not “on shift” and you are always held to account by the local community, this is the way it should be though. This is how we do things. This is our cultural responsibility – but this isn’t understood by non-Indigenous people and its difficult to explain”



"It's highly political as well... so that raises a lot of – I know some of the challenges that the team have had to deal with is, why do Aboriginal people do this, why do we not get this stuff, why do we not get the shirts, why do – so a lot of those assumptions and biases have been brought to light because of the program, which at times has been challenging for the midwives and the relationships between the Indigenous and the non-Indigenous programs."

Key stakeholders address the difficulty in implementing an Aboriginal and Torres Strait Islander program into a non-Indigenous system that does not have any formal structure of Aboriginal and Torres Strait Islander cultural protocols that are followed. Challenges outlined in implementation and design include systematic challenges with;

- Procurement
- Recruitment
- Finance: The development of an individual cost centre for the model of care was delayed

One recommendation that came out of key stakeholder engagement was the establishment of an Aboriginal and Torres Strait Islander Consumer Advisory Group for the HHS that reports directly to the board. This ensure that the community as a whole are informing any decision to be made about Aboriginal and Torres Strait Islander health as opposed to the previous individual approach.

Enablers Identified

Many of the staff spoke about culture and the sisterhood that has been formed through the development of Waijungbah Jarjums as a protective factor and enabler of implementing the service:

"I think that's the most amazing thing is the sisterhood around that you need your sisters, you need your tribe....you know, you need your people to ... who are going to be there to support you ... and I'm so grateful that we were all on the same page. We wanted it for our community and um, we wanted it for our, you know, for our people and health improvement"

"The enablers of the program have been the mentorship and guidance of 2 strong Aboriginal women to guide me in my journey and stepping up into leadership. I feel so fortunate to have had you both to turn to and lean on when things are challenging. I have learnt from your life lessons and lived experience as Aboriginal women navigating a white Western system and feel very privileged to have had you both to build me up when faced with barriers and challenges. I honestly could not have done it without you both beside me"

"The model of care wouldn't be what it is today without the support of a culturally safe DON and ADON. If I have any issues or concerns, I can approach them directly, I guess I look at them as unofficial mentors as well. I like the way they do things. They have this sort of sisterhood alliance together and they are straightforward in their approach and I respect that, they don't back down and they fully trusted in my ability to do this role when I wasn't even sure I could do it"

"The thing that kept coming up is the risk. Everyone kept focusing on the risk, the risk of reputation, the clinical risk, but no one ever focused on now we need cultural to be central, these guys are putting cultural central, you're looking at that as a risk rather than as this is a protective factor. They really flipped it and was using this as a protective factor, yet the system identified it as a risk."

This sense of connection and bond building identified by the staff with each other in the service as an enabler was also an important enabler identified by the mothers as something that helped them receive quality care.

3.5.3 Does Waijungbah Jarjums have the capacity to sustain workforce and infrastructure, to innovate and respond to emerging needs?

Given the data collected in this evaluation and the ongoing instability of external factors such as the programs funding and resourcing means that it is difficult to answer the question about sustainability at only six months of



full operation. This was reiterated in calls from staff to provide most predictable funding to support the model. Additional funding has now been sourced to retain and grow the model.

Birthing on Country and First 1000 Days Australia models of care are innovative stand-alone MOC's and integrating the models (the first time in Australia) is innovative and responding to the Strategies (numerous) and GCH is leading the way in this work.

"Recurrent funding of the service to allow full development and growth of a service that has unlimited potential, ground-breaking and is an exemplar for future models."

"The difficulty to progress work with the constant threat of non-funding of the service and staff. Despite improved outcomes and positive media and interest of the service. This provides difficulty in establishing roles, responsibilities, team morale and culture."

Some anecdotal evidence for capacity for the project's flexibility is also reflected in the barriers to implementing the intended model which were noted above. However, even faced with these delays and barriers, the project was implemented, and appears to be operating as intended. As will be discussed further in the following section, there are also good indicators of the positive outcomes and cost efficiencies in the model of care.

"Now that the service is in its implementation phase we need to look at things that can ensure the service is sustainable for the future. We came into Waijungbah Jarjums having an understanding, but not being fully aware, of the complexities that the women accessing the service would face and need assistance with. A lot of our women have transgenerational trauma and a dislocation from culture that present themselves as mental health issues. The service needs to grow with more senior midwives and another Midwifery Navigator to be able to address and support both the women and staff when navigating these pre-existing conditions"

"The service needs to be a stand alone community hub if it is to continue to grow, be sustainable and respondent to the needs of the local Aboriginal and Torres Strait Islander community"

4. Outcome evaluation findings

4.1 Safety

4.1.1 Is the model of care providing culturally safe care?

As discussed above, in [section 3.3.2](#), survey data suggested that most mothers had a culturally safe experience when accessing Waijungbah Jarjums. This was further supported in the qualitative data collected as part of the evaluation. Mothers in yarning circles completely agreed that their culture was respected, and that they experienced culturally safe care in the Waijungbah Jarjums model.

"Waijungbah Jarjums understood culture and respected culture. They encouraged me to let them know if we had any cultural considerations that they would be followed. The encouraged me to go back to my family and find out if I had any traditional birthing practices that I knew of."

They noted that midwives were respectful of any relevant practices, e.g. *"The Waijungbah Jarjums midwives respected my placenta arranged it in a special way and stored it for us."*

"[Waijungbah Jarjums Midwife] provided professional and culturally supportive care that made me feel at ease and connected to her as a woman as well as my culture."



It is also critical to note that culturally safe practice is not just a ‘nice to have’ for many Aboriginal and/or Torres Strait Islander people, it is a critical determinant of health and quality care. It is a necessity, and without culturally safe care, you have clinical negligence.

Waijungbah Jarjums aligns with the new Aboriginal and Torres Strait Islander specific National Safety and Quality Health Standards (2017);

- Working in partnership – Waijungbah jarjums has built and formed strong partnerships with the local Aboriginal and Torres Strait Islander community, YRACA, Kawlun and the Aboriginal and Torres Strait Islander branch
- Addressing health needs of Aboriginal and Torres Strait Islander Peoples – See outcomes
- Implementing and monitoring targeted strategies – Evaluation and built in evaluation for the future to continue to build on and strengthen service
- Improving cultural competency – see cultural competence
- Creating a welcoming environment – Aboriginal and Torres Strait Islander artwork in wall wraps at entrances to services to show a visual recognition of traditional custodians, wall wraps in birthing spaces, SCN/NICU and the postnatal ward.
- Identifying People of Aboriginal and/or Torres Strait Islander origin – working to education staff on the importance of identification through in-services, changing referral paperwork and changing paperwork for babies at birth to explicitly ask the question of identification

“As an Aboriginal woman who has faced multiple issues with standard Doctors and have had major medical negligence occur to me. Having my child through Waijungbah Jarjums with Cassie and the women who all gave me close care and attention was above and beyond.”

4.1.2 Is the model embedded in a culturally safe service?

As will be discussed in [section 4.2.4](#) the mothers noted several anecdotal experiences of racism, racially prejudiced care, and culturally unsafe practice they experienced in the mainstream system. They also identified several issues where lack of communication, care and handover by the maternity inpatient unit and maternity assessment unit to their Waijungbah Jarjums midwife meant that results were sometimes delayed, and optimal care was not received. Several cases were discussed where, without the intervention of the Waijungbah Jarjums midwife, they could have been serious impacts and implications for both mother and baby health and wellbeing. All women agreed that admission to the maternity inpatient unit was the most stressful part of the pregnancy and noted that along with all the issues raised above, they also felt inhuman when being treated in the mainstream service.

It was highlighted by multiple community members during the yarning circles that their solution to address this issue was to have Waijungbah Jarjums staff members placed on the ward to provide culturally safe care and advocate for the women during their admission. Whilst this does not fit with the current model of care and on call midwifery ways of working, it is noted that an option to be explored in the future would be the presence of a Waijungbah Jarjums staff member on the maternity inpatient unit.

Commenting on the experience of the general health sector in GC, including in midwifery education, the staff noted that they often perceive culturally insensitive or unsafe care.

“Yeah. I would say that they (non-Indigenous staff) can be pretty awful to women. But I think that there is a different kind of awful to Aboriginal and Torres Strait Islander women. I often hear about women having been left in a room for hours. I'm like how could you do that? The way they speak... it's particularly awful for Aboriginal women, I think.... it's insinuated that something is going on for them because they're black.”



This perception was discussed in detail during a yarning circle with the Aboriginal and/or Torres Strait Islander Waijungbah Jarjums midwives. They discussed how often there is an issue in the Gold Coast context where the staff fundamentally do not seem to understand how to work with their Aboriginal and/or Torres Strait Islander mothers.

“In a recent report released on institutional racism in QLD health services, GCHHS was seen to be extremely racist. Since the release of this report the executive team have supported the roll out of “Courageous Conversations About Race- Beyond Diversity Training” to provide staff with the tools to be able to have these difficult conversations and call out racism. The only issue I see with this is that it is not mandatory. Staff can chose if they want to attend, and in many instances the staff that do attend have come away from the training and approached Waijungbah Jarjums staff with racist comments exhibiting their White Fragility. The HHS is definitely not culturally safe. But Waijungbah Jarjums is, and having us in the HHS inherently improves the cultural safety of other staff in WNC – the only problem with that is that it’s the 3% educating the 97% on how to be decent humans and respect human rights... That’s a challenge”

4.1.3 Is the care in the model clinically safe?

There was no mortality or morbidity recorded during the timeframe of the evaluation (January – June 2020) in the Waijungbah Jarjums model of care, and there was one fetal death in the mainstream services standard model of care. Therefore, it is not possible for this evaluation to answer this question with such limited data. However, we do note that women who accessed Waijungbah Jarjums had better clinical outcomes across the boards than women in standard care. We conclude that, based on the evidence available at the time of the evaluation, the Waijungbah Jarjums model is arguably a more clinically safe model than standard care especially when taking into consideration the Aboriginal and Torres Strait Islander view of holistic health care.

Ngarraghai mirindjin (pregnant women) and Jarjums (child) who accessed Waijungbah Jarjums clinical outcomes were improved across the board.

Women and Jarjums Outcomes:

Women receiving WJMGP care were:

- more likely to experience a spontaneous vaginal birth (71.1% vs 48.2%)
- less likely to have an assisted birth (6.7% vs 13.5%)
- less likely to have a caesarean section (22.2% vs 38.5%)

Jarjums born to mothers who received WJMGP care were also:

- nearly 6 times less likely to be born prematurely (4.4% VS 21.2%)

Jarjums born in the standard model of care (compared with Waijungbah Jarjums) were comparably:

- nearly 5 times more likely to be admitted to SCN (19 vs 4)
- 14 times more likely to be admitted to NICU (14 vs 0)

The average length of stay jarjums born in standard care and admitted to SCN was more than double of babies born in WJMGP (12.3% vs 5.2%).

Finally, whilst no jarjums from Waijungbah Jarjums were admitted to NICU, the rate of admission for standard care was 26% with the average length of stay being 31.2 days.

Postnatal Outcomes

There were also benefits to postnatal outcomes for women and jarjums in the Waijungbah Jarjums model of care.

Women who accessed Waijungbah Jarjums were more likely to be breastfed their jarjums at birth (86.7% vs 61.5%). Further, the breastfeeding rate on discharge (at 6 weeks) for Waijungbah Jarjums was 66.7%. This rate is on par



with the non-indigenous average for QLD of 69.6% which is calculated on an average length of stay and discharge from the hospital at 2.5 days compared to 6 weeks discharge from Waijungbah Jarjums (Queensland Health, 2020).

We note that in the GCHHS context it was difficult to compare breastfeeding rates on discharge from the service between Waijungbah Jarjums and standard care. This is because Waijungbah Jarjums mothers are *discharged at 6 weeks* and standard care are *discharged at an average of 3-5 days* postnatally with no additional follow up care. However, we highlight that in the mainstream service, the breastfeeding rate at discharge (on day 3-5) dropped to 48.1% (compared with 61.5% at birth).

Supporting breastfeeding

Exclusive breastfeeding is recommended and evidence suggests it has health, nutritional and developmental benefits for jarjums. Waijungbah Jarjums is committed to the development of midwifery skills in best practice lactation advice and ensures mothers and jarjums have the best possible start to life by supporting families of jarjums that are at risk of needing to substitute with infant formula with a week supply of pasteurised human donor breastmilk from *The Mothers Milk Bank*. The partnership Waijungbah jarjums has formed with *The Mothers Milk Bank* has reduced admissions to SCN for jarjums at risk of hypoglycaemia and allowed mums and bubs to not be separated, the lifelong benefits of this for mums and jarjums cannot be underestimated.

Finally, the MORi scale that was administer has been previously validated as a measure of childbirth quality and safety. The scores of the adapted version of the MORi that was administered to the mothers in the Waijungbah Jarjums model provides evidence for the safety of the model, with all mothers scoring in either high or moderate respect ranges.⁵

4.2 Effectiveness

4.2.1 To what extent does the model of care improve Aboriginal and Torres Strait Islander women's antenatal and birth clinical outcomes within Waijungbah Jarjums compared to the rest of the service?

A number of statistical analyses were run to compare the outcomes for Aboriginal and Torres Strait Islander mothers and jarjums to Aboriginal and Torres Strait Islander births in the mainstream model during the evaluation period (January – June 2020).

Chi squared test was used (with $\alpha = .05$) to evaluate if the model of care was related to each of the clinical outcomes. There was a significant difference in almost all of the outcomes measured, with p-values reported in *Table 9* below. Odds ratios are also reported to show how likely an outcome is in the Waijungbah Jarjums model of care, compared to the mainstream standard model of care.⁶

For the significant results, it is noted that for this sample it seems that⁷

- Mothers in the WJ model were around 19 times more likely to attend more than 5 antenatal visits, and 14 times more likely to have an antenatal appointment within 12 weeks of gestation
- Mothers in the WJ model were around 11 times less likely to have a low birth weight baby
- Mothers in the WJ model were around 5 times less likely to be admitted to SCN and 17 times less likely to be admitted to NICU

⁵ Again, as noted above these scores are based on an adapted version of the scale which was administered.

⁶ Please note, where there were 0 instances of an outcome, the Haldane-Anscombe correction was used

⁷ Please see Grimes, D., & Schulz, K. (2008). Making Sens of Odds and Odds Ratios. *Obstetrics & Gynecology*. 111, 423-426. For a discussion of the limitations and biases inherent in odds ratios and relative risk calculations.



- Mothers in the WJ model were around 4 times more likely to breastfeed at birth
- Mothers in the WJ model were approximately 5 times less likely to have a premature birth

However, we note that the high percentages of outcomes for the WJ model mean that these odds ratios should be interpreted with caution (see Grimes & Schulz, 2008 for a discussion). Given the lack of randomised control trial study design or matched data sources, these numbers are just descriptive indicators of the difference between the outcomes seen in the current evaluation. A full data table is provided in Appendix E.

A t-test was also run to compare babies weight at birth between the Waijungbah Jarjums model births and the mainstream service. The average birth weight for Waijungbah Jarjums births (3451.8g) was significantly higher than the birthweight in standard care (2927.4g)⁸.

Table 9. Waijungbah Jarjums Antenatal and Birth Clinical Outcomes Compared with the GCHHS Mainstream Model of Care

	Waijungbah Jarjums Model of Care		Mainstream Service (<i>standard model of care</i>)		Significance (p-value)
Total mothers accessing MOC2	45		52		
Total Mothers with > 5 Antenatal Visits	45	100.0%	37	71.2%	<.001***
Total Mothers with Antenatal Apt <12wks Gestation	43	95.6%	31	59.6%	<.001***
Babies with low birth weight (< 2500 g)	1	2.2%	11	21.2%	.005**
Spontaneous Vaginal Births	32	71.1%	25	48.1%	.070
Assisted Births	3	6.7%	7	13.5%	
Caesarean Births	10	22.2%	20	38.5%	
Average Length of Stay Mother	2.2		3.38		T-test p-value = 0.128
Mothers who discharged against medical advice	0	0.0%	2	1.3%	.184
Admission to SCN	4	8.9%	19	36.5%	.001***
Admission to NICU	0	0	14	26.9%	<.001***
Average Length of Stay Baby SCN	5.21		12.23		
Average Length of Stay Baby NICU	0		31.12		
Stillbirth	0	0.0%	1	1.9%	.352
Breastfed at Birth	39	86.7%	32	61.5%	.005**

⁸ t(81)=3.288, p<.001.]



	Waijungbah Jarjums <i>Model of Care</i>		Mainstream Service (<i>standard model of care</i>)		Significance (p-value)
Breastfed at Discharge	30	66.7%	25	48.1%	.065
Incomplete Feed at Birth	0	0.0%	21	40.4%	<.001***
Incomplete Feed at Discharge	0	0.0%	14	26.9%	NA ⁹
Premature babies	2	4.4%	11	21.2%	.016*

*** $P \leq 0.001$, ** $P \leq 0.01$, * $P \leq 0.05$

All staff either strongly agreed (7, 78%) or agreed (2, 22%) that Waijungbah Jarjums has improved the clinical outcomes of the women and babies they have cared for (see Figure 9).

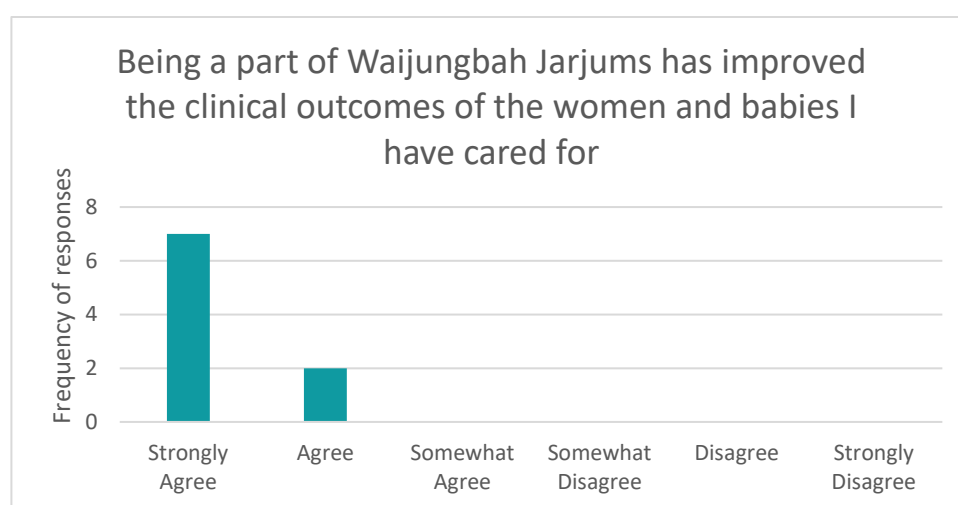


Figure 9: Clinical outcomes

Overall, there were clear clinical outcomes noted both in the data collected and the perceptions of both mothers and staff.

4.2.2 To what extent does the model of care improve Aboriginal and Torres Strait Islander child health clinical outcomes within Waijungbah Jarjums compared to the rest of the service?

As discussed above, there were significant time restraints and issues faced in the recruitment stage of the project. Notably, it was not possible to recruit a Child Health Nurse, and the project was instead rescoped (see discussion in the implementation evaluation). As such, it is not possible for this evaluation to look at the child health outcomes as initially intended.

⁹ Given the significant time difference between discharge for standard care and the Waijungbah Jarjums model, this has not been reported.



4.2.3 To what extent does the model of care improve Aboriginal and Torres Strait Islander women's key *Closing the Gap* KPIs compared to the rest of the service?

Some of the key Closing the Gap KPIs were available to the evaluation. We note that the critical drivers of inequality in health outcomes include:

- Proportion of mothers who smoke during pregnancy (any time, or after 20 weeks) by age groups – I don't have this data divided into the two models?
- Proportion of mothers who consume alcohol during pregnancy by age groups
- Proportion of pregnant mothers with a pre-existing health condition (gestational diabetes, obesity, hypertension, other)
- Use of antenatal care by pregnant women:
 - proportion with five or more antenatal visits
 - proportion with at least one antenatal care visit in the first trimester
- Proportion of pre-term births

The data available to the evaluation shows significant differences between the following closing the gap KPIs for Waijungbah Jarjums model compared to standard care.

Table 8. Closing the Gap KPIs in the Waijungbah Jarjums Model of Care

Outcome	Waijungbah Jarjums		Standard Care		P-value
	Number	Percent	Number	Percent	
>5 AN visits	45	100.0%	37	71.2%	<.0001
First Trimester AN visit	43	95.6%	31	59.6%	<.0001
Preterm births	2	4.4%	11	21.2%	<.0001

4.2.4 Does the model care improve Aboriginal and Torres Strait Islander women's satisfaction compared to standard care?

Consumers were asked to indicate their agreement with statements about their satisfaction with the care received through Waijungbah Jarjums.

- Most consumers strongly agreed (38, 86%) or agreed (4, 9%) that they were satisfied with the care they received from the Waijungbah Jarjums midwives.
- Some consumers somewhat disagreed (1, 2%) and disagreed (1, 2%) with this statement.

Consumers either strongly agreed (28, 80%), agreed (6, 16%) or somewhat agreed (1, 3%) that they were more satisfied with Waijungbah Jarjums than other models of care they had experienced during previous pregnancies (see Figure 10). These findings suggest that overall, most consumers were satisfied with the care received. This was supported throughout the qualitative findings, as the women who were part of the model expressed their comfort and positive experiences with the model.

"[the WJ midwives] made me feel comfortable to say what I wanted to say and when I was uncomfortable, they listened to me."

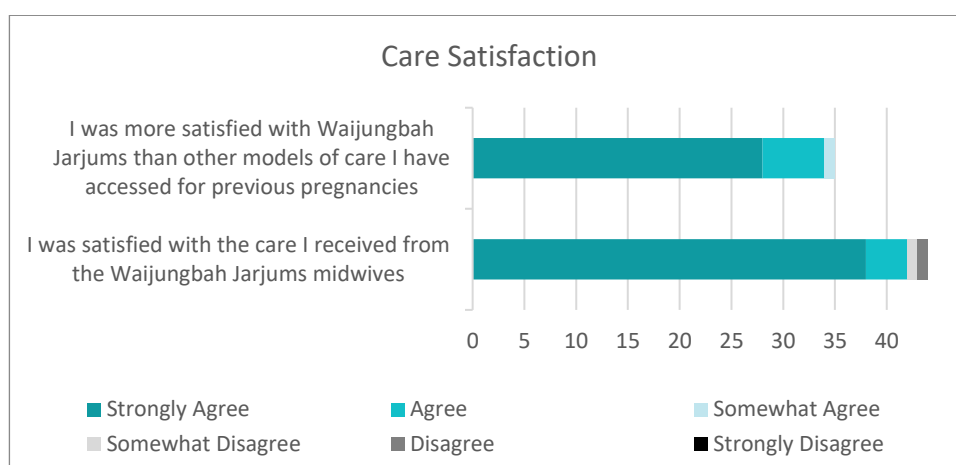


Figure 10: Satisfaction with care

Key Themes about Satisfaction with Care

The following section outlines some of the key themes relating to the mothers' experiences of, and satisfaction with, the care they received from the Waijungbah Jarjums model of care.

Experiencing Wider System Barriers

One factor that was raised which impacted on the mother's experience of care was the communication between the maternity ward and the Waijungbah Jarjums. Lacking communication pathways between services, or effective multi-disciplinary communication was noticed by many of the mothers in yarning circles.

"The communication from the maternity ward to Waijungbah Jarjums was awful. They didn't pass messages on and because of the communication the maternity ward isolated me"

"They did not communicate or handover care and it was expected that the Waijungbah Jarjums midwife would just find the information from the notes, sometimes notes weren't available from scans in time which caused a delay in treatment."

It is important to note that this barrier seems to be an organisational level, or system wide barrier, and not something that is within the scope of the model to fix. Ongoing work to coordinate and align the Waijungbah Jarjums model with the mainstream service and determine where this new model fits into the GCHHS context may be needed. However, we anticipate that this lack of communication is in part expected 'growing pains' for a new offering, and that ongoing investment and communication of the value and purpose of the model would help to mitigate these challenges.

Beyond simply the issues that may emerge from a new service, several of the mothers also noted that they had witnessed events which meant they thought the hospital midwives were rude toward the Waijungbah Jarjums midwives and did not trust their judgement. This was seen as a key issue with the care the mothers received, and an improvement ongoing.

"Maternity assessment unit need to communicate with the Waijungbah Jarjums staff. It shouldn't be the womans responsibility to give a handover to their midwife about what has happened if they needed to attend the hospital. "

The evaluator notes that this barrier is reflective of wider concerns and issues within the health service as a whole and is difficult for the Waijungbah Jarjums project to address.

An Engaged Midwife and Continuity of Care



One aspect of the model was also to promote continuity of care (e.g. midwifery-led model of care) to help establish positive relationship building between the midwife and the mothers, improve satisfaction and outcomes. In general however, the mothers emphasised the level of interaction, engagement, and relationship building between them, their families, and their midwife as being a valuable and important aspect of the model.

“Beautiful model, I valued the home visits. The Waijungbah Jarjums midwives were interactive with the kids, included them in the pregnancy and the new baby, they had an interactive relationship with the whole family. This was especially important during Covid. I felt safe and secure with the midwife.

It was reassuring having visits at home. I loved having the same person looking after you each visit, I didn’t have to repeat my story and build a relationship with a random stranger. The WJ midwives made me feel comfortable to ask questions and had lots of time for me and my family.

I valued to immediate contact to a responsive midwife who knows you and your situation. This makes all the difference, there isn’t a long waiting period to see someone else like in the hospital which is really important for people with a more complex story.”

They noted that this relationship helped them feel more comfortable discussing their care, and for some, was an important support when faced with lacking communication from the wider hospital service (e.g. NICU).

“I rang the midwives crying multiple times not know what was happening with my care or the care of my baby and they would calm me down and then make some phone calls and call me back with a plan of what was happening.”

Part of this, as mothers and other key stakeholders highlighted, was the midwifery Group Practice (MGP) aspect of the model. Continuity of care was an important aspect of the value mothers saw in the program, especially compared with standard services.

“Before Waijungbah Jarjums care I was with mainstream care and I got sick of repeating myself every time. In Waijungbah Jarjums everyone knows my story without me even saying anything. The communication within the team was amazing.”

There was one case described where multiple midwives were frequently involved in the care of one woman in the program, which does not align with the intended caseload approach. It is beyond the capacity of the evaluation to determine why this may have been the case, however, we note that there are many reasons why continual care may not always be feasible. Given that only one case was described, it seems reasonable to conclude that the model is, overall, delivered in a way that promotes continuity of care (*when feasible*). Further consideration by the project management staff going forward may be given to understanding in what circumstances continuity of care may be compromised and developing mitigation strategies to adapt to them. The mothers also noted however that, even when continuity of care was not possible, the whole of the Waijungbah Jarjums team was competent and, most importantly, willing to help.

“The Waijungbah Jarjums Team as a whole is really strong and work together, if you can’t get your midwife another midwife will answer but already knows about you and can help you.”

Acknowledging Birth as Family Business

This was especially important for the families in the Waijungbah Jarjums model, as they noted that, in their experience, mainstream services often did not acknowledge the fathers as parents or as critical members of the birthing process *“Waijungbah Jarjums was the only service that listens directly to me as the dad...”*

The mothers felt much more comfortable and engaged by the Waijungbah Jarjums midwives who acknowledged the importance of family and partner involvement in the birthing journey.



"The Waijungbah Jarjums midwives were the only ones who included my partner in the care. He was treated like part of the furniture by the other midwives and doctors."

"The Waijungbah Jarjums midwife become part of my family and included everyone in my family, it's not like a clinical rigid visit, she shared her own experience and made us comfortable. It was so important for my family to have this connection."

Autonomy and Respect in Care

As noted above, the mothers indicated they felt they had high and very high experiences of autonomy in decision making and received respectful care (as measured by the adapted MORi and MADM scales). However, what is also important to acknowledge is that in qualitative data the mothers identified this experience was one that was uncharacteristic of their care and treatment in the mainstream service.

"On occasions I felt the Drs and midwives were clinical and rude, no one was listening to me and I was no longer a person. The Waijungbah Jarjums team were not like this. They would stop the other midwives or doctors and make sure I understood the options of care I was being recommended. They actually took the time to listen to me."

Waijungbah Jarjums as an Advocate

Several mothers also noted various times in their care where their Waijungbah Jarjums midwife acted as an advocate for them.

"The WJ service has your back and advocated for us"

"The midwives have continually advocated for me when dealing with other departments of the hospital and have always made sure I'm up to date and in the know when it comes to other appointments and tests I've needed when the departments communication is very poor and last minute."

Importantly, the women noted several experiences of racism, racially prejudiced care, and culturally unsafe practice they experienced in the mainstream system. This included services or doctors questioning their Aboriginality, having stereotypical and biased assumptions (e.g. unfounded assumptions of drug abuse), and generally unsafe care. However, they also noted that the advocacy of their Waijungbah Jarjums midwives on behalf of them and their families was a protective factor. All Participants agreed that, in their experience, racism was rife within the hospital system but felt safe with the advocacy and support of the Waijungbah Jarjums midwives.

"I had a complication during my pregnancy and had a large baby on board as well. I knew something was wrong and went into the hospital for assessment, [Waijungbah Jarjums midwife] wasn't there. The hospital said I was fine and sent me home. I then saw [Waijungbah Jarjums midwife] the next day who said to come in and assessed me again because I was still in pain."

I ended up having an emergency caesarean section and my baby was unwell. If I didn't have [Waijungbah Jarjums midwife] it would have been a bad outcome for me and my baby. [Waijungbah Jarjums Midwife] was the only one who listened to me and the Waijungbah Jarjums staff. I was really disappointed by the hospital staff."

Knowledge of the Local Services and Navigating the System

Several mentions throughout the yarning circle and survey responses from the mothers also highlighted several times where their Waijungbah Jarjums midwives were able to provide most useful, accurate, and cost-effective recommendations for other allied health and support services, compared with the mainstream services.



The Waijungbah Jarjums midwives also provided general guidance and support for the mothers in navigating the complex health system, to ensure they are getting the best quality care.

"[Waijungbah Jarjums Midwife] was amazing, someone I can build rapport and continuity with a familiar face and someone to help me navigate the system."

This included support when making complex medical decisions, and the mothers noted that when they felt like they were being pushed into an option by other practitioners, their Waijungbah Jarjums midwife would answer their calls, explain the options, and help them to make an informed decision.

The overall positive experience of the mothers (even considering some of the raised barriers to care) was reiterated by the staff involved in the model. All staff strongly agreed (9, 100%) that Waijungbah Jarjums has improved the satisfaction of the women and families they have cared for (see Figure 11).

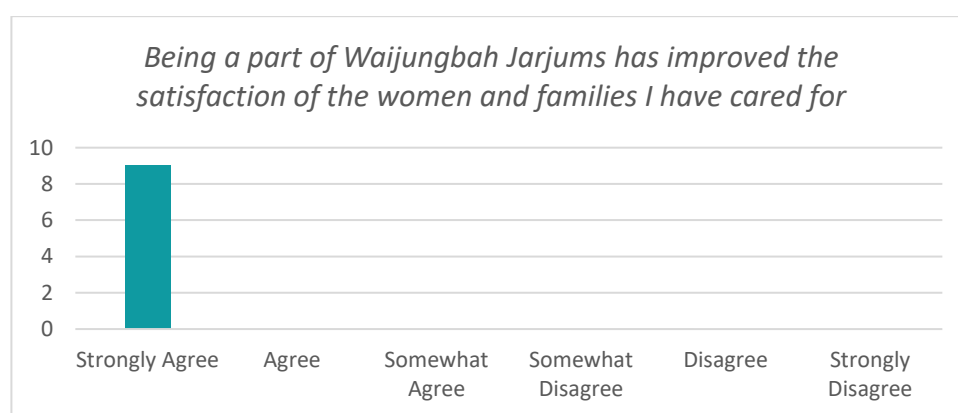


Figure 11: Staff perceptions of consumer satisfaction

4.2.5 Does the model of care improve the satisfaction of Aboriginal and Torres Strait Islander staff?

Section 3.5.1 describes the experience and satisfaction of staff working in this model of care. Strong qualitative responses from staff indicated that they feel more supported, engaged and culturally safe working in the Waijungbah Jarjums model compared with other standard or fragmented models of care. All staff either strongly agreed (6, 67%), agreed (2, 22%) or somewhat agreed (1, 11%) that they are more satisfied in their current role in Waijungbah Jarjums than in other models of care they have worked, indicating improved job satisfaction.

Overall, as previously discussed, it seems that Aboriginal and Torres Strait Islander Waijungbah Jarjums staff did have improved meaningfulness in their work and job satisfaction in the model.

"The wants and needs of Aboriginal and/or Torres Strait Islander women, families and community in relation for maternal and infant health have been well documented, yet continuously the dominant culture are the ones implementing services for us. This service gives our mob a voice, empowers them to be self-determining and involves them in every step along the way. It is satisfying being a part of something that is the first of its kind, knowing you are making a difference to generations of future elders to come by providing a responsive service and playing an active role in dismantling institutional racism is so rewarding – challenging, but rewarding"



4.3 Equity

4.3.1 Are there any enablers and barriers to accessing care?

Some of the mothers in the program identified a few barriers they faced whilst accessing the Waijungbah Jarjums program.

Car Parking and Access

Several mothers noted that it was difficult and expensive to access care at GCHHS. The main barrier they identified was the cost of parking when admitted postnatally. The mothers recommended instead that a community space close to public transport would be better for both access, for supporting the sense of community they felt in the model of care and for providing a culturally safe space they could attend when needing.

Advertising

The other key barrier that the mothers identified was that they did not know about the model of care, and that there was no clear advertising for Waijungbah Jarjums. In the future, they thought more communication about the model of care would be beneficial, especially for those who faced racial barriers to accessing the model (as has been previously discussed).

5. Economic Evaluation

5.1.1 Is Waijungbah Jarjums a more cost-effective model of care for Aboriginal and/or Torres Strait Islander women and jarjums compared to the standard model of care?

A cost-effectiveness analysis was conducted to examine the direct costs on the maternal and child health care services and the associated outcomes. The average costs per mother/baby pair was calculated between Aboriginal and/or Torres Strait Islander women who accessed Waijungbah Jarjums and compared with the average costs for Aboriginal and/or Torres Strait Islander women who did not access Waijungbah Jarjums. The reference period between December 2019 and June 2020. Costs were calculated across the continuum of care from the initial booking in appointment with the hospital up to 6 weeks postpartum for mothers. These outcomes were then compared to standard care outcomes during this time to determine the cost effectiveness of the Waijungbah Jarjums model of care.

The results showed that women who accessed Waijungbah Jarjums were more likely to access care earlier in their pregnancy (95.6% vs 59.6%) and on average attend more antenatal visits than women accessing standard care (11 vs 8), this is therefore reflected in a higher average antenatal cost per episode compared to standard care (\$339 vs \$291).

Postnatal costs associated with Waijungbah Jarjums were also slightly higher (\$284 vs \$249) as the model of care extends postnatal care from the normal 1 week received in standard care to 6 weeks. Overall Waijungbah Jarjums women had a 6% less chance of failing to attend their appointments.

Labour and birth costs for Waijungbah Jarjums were significantly less than standard care (\$6,886 vs \$9,474). Length of stay and birth outcomes being a driver of this difference with WJ having a length of stay of 2.2 days and the non-WJ having 3.4 days. Newborns of women in the Waijungbah Jarjums model of care are 8 times less likely to spend time in SCN or NICU, and if they do their length of stay is lower than that jarjums in standard care. This can be attributed to a marked decrease in the incidence of low birth weight jarjums.

The average length of stay for jarjums born in standard care and admitted to SCN was more than double of jarjums born in Waijungbah Jarjums (12.23 vs 5.21). Whilst no jarjums from Waijungbah Jarjums were admitted to NICU, the rate of admission for standard care was 26% with the average length of stay being 31.2 days. In total this has released over 417 cot days in the Newborn Care Unit and has conservatively reduced over \$1.5m of costs.



Waijungbah Jarjums demonstrates higher costs for both antenatal and postnatal care with access to continuity of care as opposed to GP shared care and continued postnatal from the standard 1 week to 6 weeks postnatal. The intrapartum care for Waijungbah Jarjums women and jarjums results in a significant lower cost, this can be attributed to the improved outcomes, reduce length of stay and reduce admissions of jarjums to SCN/NICU. Without calculating the specific costs associated with babies' admissions postnatally due to data restraints, Waijungbah Jarjums and the standard model of care are comparable. When taking into consideration the opportunity to release beds and cot days in NICU and SCN and the savings associated savings, the Waijungbah Jarjums seems to be the more cost-effective service.

Finally, it is important to recognise the potential cost-savings for the wider intended and unintended positive and negative benefits to the communities engaged in the service. Given the focus of the model on Aboriginal and/or Torres Strait Islander health determinants and wellbeing, this model in of its focus may lead to wider systemic cost savings and improvements.



6. Conclusions and Recommendations

Overall, the Waijungbah Jarjums program was clearly highly valued by mothers, staff, the community, and key stakeholders. The evaluation cannot accurately convey the significance, personally and culturally, that the program clearly had on those who interacted with it, and its value should not be understated. We note that the following conclusions and recommendations are made in the context of this overwhelmingly positive perception of the model of care in the GCHHS context.

"I don't know. I get emotional. I start crying. I don't know what takes over. But it's nice to - you look back on it and you go - a lot of women come up to you and go oh my God it was so good having you there....You just go and you do what you need to do and you're just there for them.

I am not sure everyone fully understands the impact the Waijungbah Jarjums has had on the community. The trust it has built where there has previously been none in 6 months of being up and running is so deadly.

The health care system emphasizes Aboriginal and Torres Strait Islander incapacity and our identity is framed in a narrative of negativity causing disempowerment which needs to change. The only way this is going to change is by having more mob in health care, more mob running services for our mob. It is rare that in an institution where the power and structure is dominated by aspects of white culture, that our mob feel like they have a voice or can impact on models of care as the counter narrative, this is what we have achieved in Waijungbah Jarjums

The feedback is very comforting to know. It makes you go wow, that must be a really big thing (for them). I still remember my birth story. I still talk about this midwife no-one even knows. It's like you forget until you're reminded about how important it was for somebody else. It's pretty comforting to know that you are there for the first breath."

Aboriginal and/or Torres Strait Islander midwives – discussing their experience with Waijungbah Jarjums

Overall, the model of care appears to be an effective, cost-effective, and culturally safe model for Aboriginal and/or Torres Strait Islander women. The Aboriginal and/or Torres Strait Islander midwives and nurses collaborative approach enables mothers to feel comfortable, connected and able to honestly discuss their care and make informed decisions.

The key recommendations for the model include:

1. Invest in the continuity of the Waijungbah Jarjums model

- a) To improve Aboriginal and Torres Strait Islander women and jarjums outcomes it is imperative that key stakeholders invest in longitudinal and sustainable funding for the Waijungbah Jarjums service to reach its full potential – Longitudinal and sustainable funding has now been sourced for the continuation of the service
- b) Move the current Aboriginal and Torres Strait Islander Working Group to more formalised Aboriginal and Torres Strait Islander Steering Committee to lead the governance of Waijungbah Jarjums
- c) Scale up midwifery group practice to be able to provide care for more of the Aboriginal and Torres Strait Islander women accessing GCHHS
- d) Continue to develop the model of care alongside the community to align with the intended purpose of Waijungbah Jarjums, the RISE framework, and Aboriginal and/or Torres Strait Islander best practice

2. Health Service redesign

- a) Strengthen collaboration and partnership with local Aboriginal Medical Service that is focussed on providing the local Aboriginal and Torres Strait Islander community with options of quality maternity care – In line with Aboriginal And Torres Strait Islander best practice principles, Gold Coast First 1000 Days Australia Region Plan and the findings of the success of the Waijungbah Jarjums model to provide self-determination and choice to the community.



3. One Stop Community Hub

- a) Procurement of a stand-alone community hub to ensure culturally safe and equitable access to services
- b) Integrate Waijungbah Jarjums midwives and nursing staff with allied health to address the social determinant of health including Identified Social Worker and Identified Dietician
- c) Re-distribute positions from Womens, Newborns and Children's services to include Identified Admin assistant and Advanced Child Health Worker

4. Advertising and increasing awareness

- a) GCHHS to support Waijungbah Jarjums with a QHEPS home page
- b) GCHHS media to support Waijungbah Jarjums to have a social media presence

5. Investment in a culturally safe workforce

- a) 70% of Women's, Newborns and Childrens service to attend CPP program by December 2021
- b) Waijungbah Jarjums to chair a Multi-agency/stakeholder Steering Committee to work collaboratively to deliver culturally safe, evidenced based and high quality womens' and jarjums services.
- c) Waijungbah Jarjums continues to invest yearly in the upskilling and education support of 1 x Aboriginal and Torres Strait Islander Nurse or Midwife within the program (up to the value of \$5000)
- d) Waijungbah Jarjums to support the development of a Aboriginal and Torres Strait Islander CAG
- e) Increase HLO service on wards - or an adaptation of Advanced Health Worker / HLO which might be supported by the Health Worker Stream.
- f) Continue partnership with Griffith University First Peoples Health Unit and Midwifery at Griffith Team to ensure streamlining of Waijungbah Service offering;
 - yearly New Graduate MGP position
 - continued preceptorship and mentorship to Aboriginal and/or Torres Strait Islander midwifery students
 - continuation of partnership with AFL SportsReady Indigenous Midwifery Cadetships

6. Evaluation and Research

- a) Maintain monitoring and evaluation of the model of care and evaluate short, mid, and long-term outcomes
- b) Consider future opportunities for the dissemination of findings and research

7. Developing Partnership

- a) Continue partnership with YRACA
 - Development and re-invigoration of Language
 - Development of Yugambah language resources – align with CTG strategy of increased number and strength of Aboriginal and Torres Strait Islander Languages being spoken by 2031
- b) Continue membership with First 1000 days Australia Regional Alliance
- c) Explore partnership with local early learning centres or other health services to connect women with the service

"For the first time A&TSI women, families and the community can see themselves in a maternal and infant continuity of care model within GCUH. Central to the innovation of the Waijungbah Jarjums model of care is Aboriginal and Torres Strait Islander community led engagement and consultation across all stages of the innovation process including conception, design, conduct/implementation, reporting and dissemination of findings ensuring self-determination and community governance over service delivery."



7. Acronyms

Term	Description
MOC	Model of Care
WJ	Waijungbah Jarjums
GCHHS	Gold Coast Hospital and Health Services
CTG	Closing the Gap
KPI	Key Performance Indicators
MGP	Midwifery Group Practice
BoC	Birthing on Country
OCNMO	Office of the Chief Nurse and Midwifery Officer
MOR	Mothers on Respect
MADM	Mothers on Decision Making



Appendix A – Program Logic – Waijungbah Jarjums

	Briefly describe the reason for the project:	Assumptions
Rationale	The health of ABORIGINAL AND TORRES STRAIT ISLANDER women and babies is impacted directly and indirectly by the social determinants of health they experience. Disadvantage in employment, income, education, inadequate housing, poverty, inadequate nutrition, and an increase in family and domestic violence create barriers and inequity in access to high quality midwifery led COC. Additional factors such as social exclusion, the transgenerational trauma of colonisation and overt or implicit institutional racism and discrimination all contribute to a lack of access and engagement with services and a maternal morbidity rate nearly two times higher than non-Aboriginal and Torres Strait Islander . On average ABORIGINAL AND TORRES STRAIT ISLANDER childbearing women attend fewer antenatal visits and engage in services later in their pregnancy. Pre-existing, treatable and/or preventable conditions, substance use and teenage pregnancy are amongst the highest contributing factors to a perinatal mortality rate which is 1.7 times higher than non-Aboriginal and Torres Strait Islander . ABORIGINAL AND TORRES STRAIT ISLANDER babies are more likely to be born prematurely, of low birth weight, require special care nursery admission and are less likely to be breastfed. These disparities in health in a child's early years influence and shape their adult life impacting on their future opportunities and health outcomes.	
Exclusions	What is out of scope? Capital funding to provide mobile clinic space. Non-Indigenous staff. Non-Indigenous families. MGP offers care from conception to 6 weeks postnatally.	<i>Assuming qualified staff are available</i>
Constraints	What are any limiting factors that may affect the delivery of the project? Community venue, population, identified staff onboarding, speed of implementation, continued funding - AO project assistance, Health worker assistance, ABORIGINAL AND TORRES STRAIT ISLANDER evaluation. Elders community support. Local ABORIGINAL AND TORRES STRAIT ISLANDER health service support. Level of scope of practice of clinicians we want to attract of scop of practice, lived experience, MGP experience. The support for on call MGP from service (when out of hours to do they divert to). How to run MGP model, team and how on calls are worked. Attitudes of current staff. Cultural capability of all staff. Women feeling comfortable accessing hospital care. Promoting service. Limited caseload - community	



population. MFM women, who is appropriate carer. sustainability - changing re-existing positions (NAV position). Inability to find Child Health Nurse with appropriate qualification.

Outline the Governance for the project

Assumptions

Governance

Indigenous control, community development approach, shared vision cultural guidance & oversight. OCNMO > CEO > ED
- Anita Bamford-Wade; Patrick Turner > Waijungbah Jarjums Governance Working Group <> Waijungbah Jarjums Community Working Group

Budget Requirements

Inputs

Financial Year	2019-20	2020/21	Total
Labour Budget	\$541805	\$227721	\$769526
Non-labour Budget	\$341250	\$156500	\$497750
Total	\$883055	\$384221	\$1267276

Staffing Requirements

Number of Existing Staff (FTE)	3
Number of Additional Internal Staff (FTE)	1
Number of Additional External Staff (FTE)	4

List the activities the project will undertake

Activities

- Development of Waijungbah Jarjums community working group
- Recruitment and retention of ABORIGINAL AND TORRES STRAIT ISLANDER staff
- Development of cultural capability micro-credential
- Development of Yarning Circles - Antenatal education + Postnatal support and education



- Staff accredited to teach Indigenous Hypnobirthing Childbirth Education
- Staff developing education plan for antenatal and postnatal care
- Development of work instruction for parking vouchers, taxi vouchers
- Seek out community venue for temporary hire
- Procurement of local ABORIGINAL AND TORRES STRAIT ISLANDER artwork
- Wall wraps in birthing services and MIPU to provide culturally safe space
- Procurement of gifted QAS Ambulance
- Fit out of gifted QAS Ambulance
- Facilitate education of midwifery staff to complete midwifery prescribing course, implanon training, cervical screening, child and family health training, sexual health course, mental health first aid
- Credential midwifery staff to be able to offer extended scope of practice
- Development of midwifery cadetship for ABORIGINAL AND TORRES STRAIT ISLANDER Griffith Bachelor of Midwifery student/s
- Develop welcome baby to country x2 per year

What will be produced through these activities

Assumptions

Outputs

- Development of ABORIGINAL AND TORRES STRAIT ISLANDER model of care co-designed by the community
- Increase in ABORIGINAL AND TORRES STRAIT ISLANDER workforce
- Development of culturally safe workforce
- Yarning Circles - Antenatally and Postnatally
- Culturally specific childbirth education addresses ABORIGINAL AND TORRES STRAIT ISLANDER definition of health
- Address equity in access to HHS
- Culturally safe community venue
- Culturally safe mobile clinic venue

Ability to find venue



- Midwifery and Nursing staff who can work to full scope + extended scope of practice to meet communities needs in a culturally safe way
- Provide career pathways for ABORIGINAL AND TORRES STRAIT ISLANDER midwifery students (*e.g. cadetships*)
- Welcome baby to Country event

Students want cadetships

Elder support

What changes of benefits will result from the project

- Increase in ABORIGINAL AND TORRES STRAIT ISLANDER women accessing GCHHS
- Increase in ABORIGINAL AND TORRES STRAIT ISLANDER women and communities satisfaction with GCHHS
- Increase in KPI outcomes - LBW, smoking cessation before 20K, 5 or more AN visits with 1 in first trimester, DAMA, address social determinants of health
- Increase ABORIGINAL AND TORRES STRAIT ISLANDER staff - KPI 3% - recruitment and retention
- Increase in skilled ABORIGINAL AND TORRES STRAIT ISLANDER workforce
- Increase employability of ABORIGINAL AND TORRES STRAIT ISLANDER workforce
- Improving experience of ABORIGINAL AND TORRES STRAIT ISLANDER staff (retention)
- Increase cultural capability of WNC
- Reduce burden on GCHHS through COC and early engagement - financial
- Benchmark Waijungbah Jarjums KPIs against non-Indigenous population
- Benchmark Waijungbah Jarjums against ABORIGINAL AND TORRES STRAIT ISLANDER QLD KPIs

Outcomes

Short Term

Mid Term

Long Term

Quadruple Aim Consumer

Aboriginal and/or Torres Strait Islander community are:

- aware of the model of care
- accessing the model of care
- engaging in the model of care

Aboriginal and/or Torres Strait Islander women state that they receive timely care in an appropriate setting

All women receive culturally safe and competent care



Women feel able to self-refer to Wajiungbah Jarjums

Aboriginal and/or Torres Strait Islander women have a coordinated and seamless experience across 1000 days

Experience Outcomes

Aboriginal and/or Torres Strait Islander women and children are satisfied with WJ and GCHHS

Community engage and support the program

Short Term

Mid Term

Long Term

Quadruple Aim Health Outcomes

There is improved uptake of health related behaviours

Improve child health outcomes

Engagement of at risk families with Child Safety (DOCS)

Women book into GCHHS within first 16 weeks

Improved infant developmental milestones

Decrease in CTG outcomes

Improve maternal and infant morbidity and mortality rates

Short Term

Mid Term

Long Term

Quadruple Aim Staff Experience Outcomes

Increase in skilled Aboriginal and/or Torres Strait Islander workforce who can work to their full scope of practice

Staff feeling that non-indigenous staff value Aboriginal and/or Torres Strait Islander ways of knowing, being and doing of Aboriginal and/or Torres Strait Islander culture

Increase in Aboriginal and/or Torres Strait Islander workforce leadership capability

All GCHHS staff actively promote MoC to women, the community.

Aboriginal and/or Torres Strait Islander staff are satisfied with the model of care

WJ staff share positive stories with other Aboriginal and/or Torres Strait Islander staff.

Local healthcare practitioners refer to the model of care – are pathways streamlined?

Increase cultural capability of WNC accelerated career pathways for Aboriginal and/or Torres Strait Islander staff and students

Working in partnership with relevant stakeholders

WNC promote MOC



WJ staff facilitate mentorships with GU Bachelor of Midwifery Students

Quadruple
Aim Cost
Efficiency
Outcomes

Short Term	Mid Term	Long Term
Less burden of HHS Shorter length of stay on MIPU Less SCN + NICU admissions Reduction in DNA appointments	-	Change the way costing is allocated to reduce perverse incentives related to interventions



Appendix B – Indicator Framework

Evaluation question	Indicator/s	Data sources
a) Implementation		
b) Awareness and adoption		
Are ABORIGINAL AND TORRES STRAIT ISLANDER community aware of and accessing the model of care?	Number of women: Eligible to access MOC Accessing MoC Waiting list to enter MoC Declined MoC	Allocation data KPI data >5 AN visits
Do ABORIGINAL AND TORRES STRAIT ISLANDER community engage with the model of care	At least 5 AN visits At least one AN visit in first trimester	KPI data >5 AN visits
Are key stakeholders aware of, accessing and engaging in the model of care?	Referral into model of care by midwives, GPs, obstetricians (? Other staff)	Allocation data
Fidelity		
Is the model being delivered by the Waijungbah Jarjums staff and utilised by the HHS and by ABORIGINAL AND TORRES STRAIT ISLANDER women and their families in the way it was intended?	Where referral originated Number of staff in original proposal vs number of staff recruited staff skill mix as per proposal Training provided Seamless care across first 1000 days	Allocation data Risk register Risk register Staff engagement with training provided Risk register – status reports
Sustainability		
Are the staff satisfied working in the model of care?	Feedback	Yarning circles Semi-structured interviews?



Evaluation question	Indicator/s	Data sources
Does Waijungbah Jarjums have the capacity to sustain workforce and infrastructure, to innovate and respond to emerging needs?	Feedback	Yarning circles Semi-structured interviews?
Acceptability		
Does the ABORIGINAL AND TORRES STRAIT ISLANDER community and HHS staff perceive the model of care to be acceptable?	Feedback from staff Feedback from WJ families	Yarning circle – women Staff – surveys? Yarning
Do the ABORIGINAL AND TORRES STRAIT ISLANDER community perceive the service to be culturally safe?	Feedback from WJ families and community members	Yarning
Do the ABORIGINAL AND TORRES STRAIT ISLANDER staff perceive the service to be culturally safe?	Feedback from staff	Surveys/yarning
Penetration		
To what extent is the model being used routinely by practitioners and/or consumers?	Referrals	Allocation data
Outcome evaluation		
Safety		
Is the model of care providing culturally safe care?	Perception of cultural safety - Women - Staff	Yarning
Is the model embedded in a culturally safe service?	25% of staff in key areas (ANC, BS, MIPU, CHILD HEALTH, SCN, NICU, OBSTETRIC, WNC EXECUTIVE) and 100% new starters completed the online microcredential cultural safety course	Micro-credential completion rate
Is care in the model clinically safe?	Maternal and infant mortality and morbidity compared to standard care ABORIGINAL AND TORRES STRAIT ISLANDER data	Clinical data – ieMR and WJ data



Evaluation question	Indicator/s	Data sources
Effectiveness		
To what extent does the MOC improve ABORIGINAL AND TORRES STRAIT ISLANDER women's antenatal and birth clinical outcomes within Waijungbah Jarjums compared to the rest of the service and WHA data (peers)	Meet KPI clinical data - LBW - Smoking cessation <20K - AN visit in first trimester - >5 AN visits - DAMA - Preterm birth - BF at 6 weeks, 6 months, 9 months, 12 months, 18 months, 2 years.	Clinical data - iEMR
To what extent does the MOC improve ABORIGINAL AND TORRES STRAIT ISLANDER child health clinical outcomes within Waijungbah Jarjums compared to the rest of the service?	Achieving development milestones at each recognised key milestones at: 0-4 6-8 6m 9m 12m 18m 2yrs - Gross motor - Fine motor - Social and emotional - Speech and language - Deafly hearing program Home visiting - Toys in the home - Books in the home SIDS compliance BF rate Holistic Family health assessments completed Vaccination rates	? how is this currently collected



Evaluation question	Indicator/s	Data sources
To what extent does the MOC improve ABORIGINAL AND TORRES STRAIT ISLANDER women's key CTG KPI compared to the rest of the service?	- Perinatal and infant mortality rates - Birth weights - Smoking rates in pregnancy - 5 or more ante-natal visits - Rates of anaemia in pregnancy - Rates of gestational diabetes - Breast feeding rates - Levels of childhood obesity - Injury rates in children - Hearing loss in children - Educational attainment - Rates of out of home care - Rates of risky alcohol consumption - Rates of teenage births - Numbers of child health checks	Combination? Of ieMR and CH data – we might need to do some data linkage
Does the MOC improve ABORIGINAL AND TORRES STRAIT ISLANDER women's satisfaction compared to standard care	Satisfaction compared to our knowledge of satisfaction with standard model	yarning
Does the model of care improve the satisfaction of ABORIGINAL AND TORRES STRAIT ISLANDER staff	Satisfaction compared to our knowledge of satisfaction with standard model	yarning
Equity		
Are there any barriers to accessing care?	Enablers and barriers of accessing care?	Yarning staff + WJ families
Economical evaluation		
	Comparing ABORIGINAL AND TORRES STRAIT ISLANDER women accessing - Standard care - MGP - Waijungbah Jarjums MGP And their outcomes and the costs/costs savings	Emily Callander ieMR data + MATIS Evidence – COSMOS, MANGO, COCHRANE



Appendix C - Full Write-up of the MORi Scale

The MORi Scale validation study demonstrated three factors (*however due to cross-loadings and domain sizes, the scale is unidimensional*) and the results are presented under these factor headings below.¹⁰

Autonomy and Comfort

Mothers were asked to indicate their agreement with a range of statements about the sense of autonomy and comfort they had when receiving care. All mothers either strongly agreed (41, 93%) or agreed (3, 7%) that they felt comfortable asking questions. All mothers either strongly agreed (41, 93%) or agreed (3, 7%) that their cultural preferences were respected. All mothers also either strongly agreed (39, 89%), agreed (4, 9%), or somewhat agreed (1, 2%) that they felt comfortable accepting the options for care that my midwife recommended.

Most mothers felt comfortable declining care that was offered (84% strongly agree [n=37], 9% agree [n=4], and 5% somewhat agree [n=2]) however, one mother strongly disagreed with this statement (2%). Most also either strongly agreed (37, 84%), agreed (5, 37%) and somewhat agreed (1, 2%) that they chose the care options they received, while one mother disagreed (2%) with the statement. When mothers rated if their personal preferences were respected, most rated that they strongly agreed (36, 82%), agree (6, 14%), however two mothers somewhat disagreed (1, 2%) or disagreed (1, 2%) with the statement. Finally, there was one reverse coded item in this factor, and most of the mothers rated that they strongly disagreed (33, 75%), disagreed (8, 18%), and somewhat disagree (1, 2%) that they felt pushed into accepting the options their midwife suggested. Two mothers did however strongly agree (1, 2%) or agreed (1, 2%) with the statement.

These options suggest that most of the mothers in the Waijungbah Jarjums model felt comfortable and had a sense of autonomy in relation to their care.

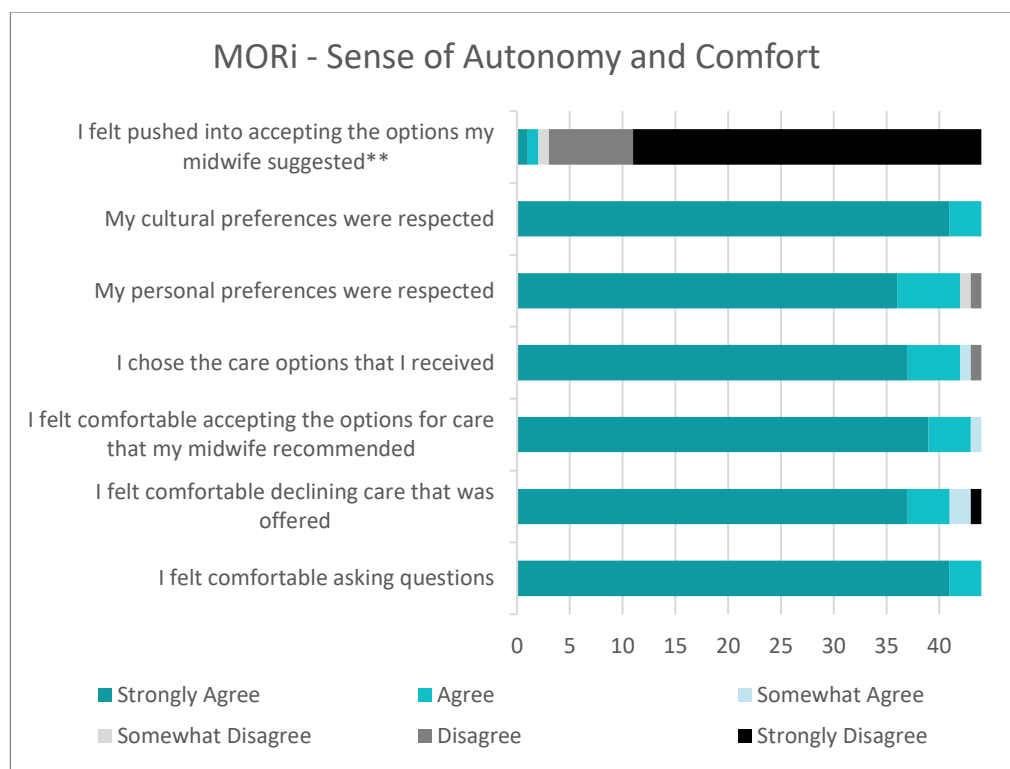


Figure 12. MORi – Sense of Autonomy and Comfort Factor

¹⁰ Factor Structure loading as per Vedam., et al. validation study



Perception of Discrimination

Mothers were asked to indicate their agreement with a range of reverse coded statements about their perception of discrimination in their care. Across all three items, the majority of women either disagreed that they had experienced discrimination during their care.

Specifically, in response to the question *“during my pregnancy I felt I was treated poorly by my doctor or midwife because of race, ethnicity, cultural background, or language”* the majority of mothers rated they strongly disagreed (41, 93%) or disagreed (2, 5%). One mother rated that they strongly agreed with this statement (2%).

In response to the question *“during my pregnancy I felt I was treated poorly by my doctor or midwife because of my sexual presentation and/or gender identity”* the majority of mothers rated they strongly disagreed (41, 93%) or disagreed (2, 5%). One mother rated that they strongly agreed with this statement (2%).

In response to the question *“during my pregnancy I felt I was treated poorly by my doctor or midwife because of race, ethnicity, cultural background, or language”* the majority of mothers rated they strongly disagreed (41, 93%) or disagreed (2, 5%). One mother rated that they strongly agreed with this statement (2%).

Finally, the majority of mothers strongly disagreed (32, 89%) or disagreed (2, 5%) that *“during my pregnancy I felt I was treated poorly by my doctor or midwife because of a difference of opinion with my caregivers about the right care for myself or my baby”* however 3 women either strongly agreed (2, 5%) or agreed (1, 2%) that they felt the difference of opinion related to poorer midwifery care.

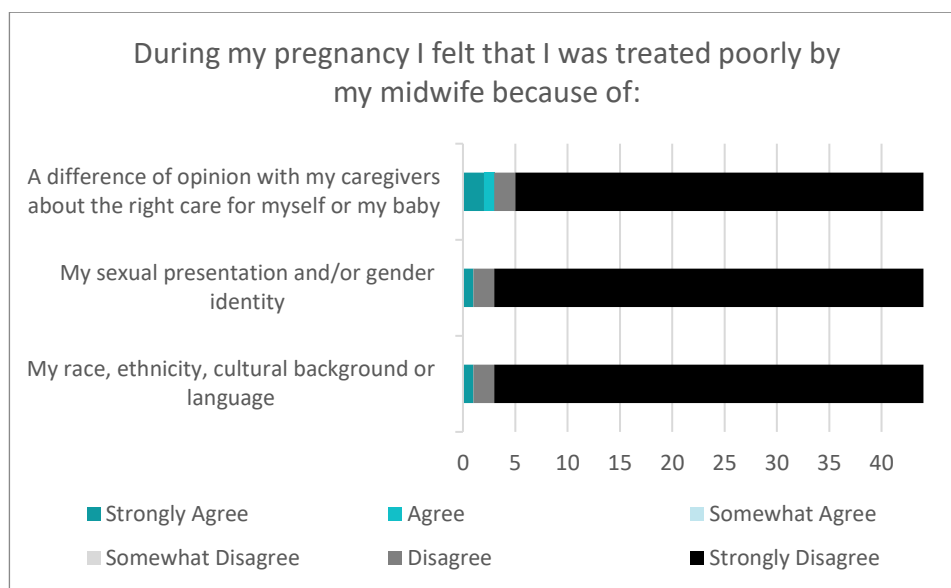


Figure 13. MORi Scale Perception of Discrimination

Modified Behaviour

Mothers were asked three items that related to their perception of modifying their behaviour (specifically holding back questions or discussing concerns) due to an aspect of their midwifery care in the Waijungbah Jarjums model.

Most mothers indicated that they did not modify their behaviour due to their midwifery care, notably:

- 89% disagreed that they modified behaviour because they thought their midwife was being difficult (82% strongly disagreed [n=36], 5% disagreed [n=2] and 2% somewhat disagreed [n=1]).
- 96% disagreed that they modified behaviour because they wanted maternity care that was different from what their midwife wanted (91% [n=40] strongly disagreed and 5% disagreed [n=2])



- 95% disagreed that they modified behaviour because their midwife seemed rushed (89% strongly disagreed [n=39] and 5% disagreed [n=2])

However, some mothers indicated that they did feel they changed their behaviour due to these factors, notably 4% (2% strongly agreed [n=1] and 2% agreed [n=1]) it was due to their midwife seeming rushed, 5% agreed (n=3) it was due to wanting maternity care different from what the midwife recommended, and 12% agreed (7% agreed [n=3] and 5% somewhat agreed [n=2]) it was due to feeling their midwife might think they were being difficult.

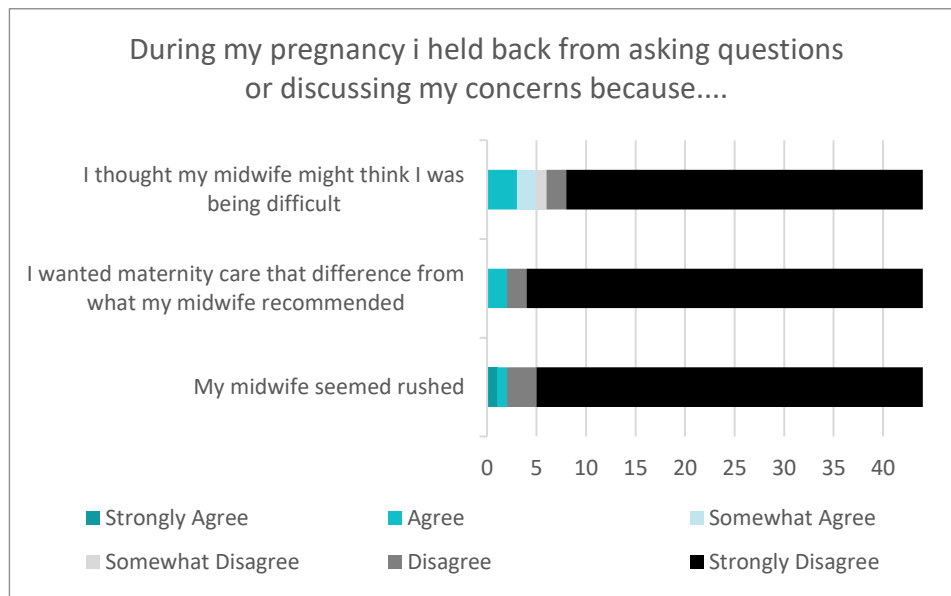


Figure 14. MORi Scale – Modified Behaviour

Overall, these results suggest that, for most mothers in the Waijungbah Jarjums model, they did not think they held back asking questions or discussing concerns with the midwives in the model.



Appendix D – Full Writeup of the MADM Scale

Mothers were asked to indicate their agreement with a range of statements about the information provided and the choice they had when receiving care. All mothers either strongly agreed (40, 91%) or agreed (4, 9%) that the midwife respected their choices. Most mothers strongly agreed (37, 84%), agreed (4, 9%) or somewhat agreed (2, 5%) that they were able to choose what they considered to be the best option for their care. Although, one consumer (2%) strongly disagreed with this statement. Most mothers strongly agreed (39, 89%), agreed (3, 7%) or somewhat agreed (1, 2%) that they were given enough time to thoroughly consider the different options. Again, one consumer (2%) strongly disagreed with this statement.

Almost all mothers either strongly agreed (40, 91%) or agreed (3, 7%) that the midwife helped them understand all of the information. One consumer (2%) strongly disagreed with this. Most mothers strongly agreed (35, 80%) or agreed (8, 18%) that their midwife explained the advantages and disadvantages of the options; and strongly agreed (36, 82%) or agreed (7, 16%) that their midwife told them there were different options when discussing their pregnancy, labour, birth and post-natal care. One consumer (2%) disagreed with both of these statements (see Figure 15). These findings suggest that most of the time, mothers feel that they are given information about the different options of care and choice to decide what works best for them.

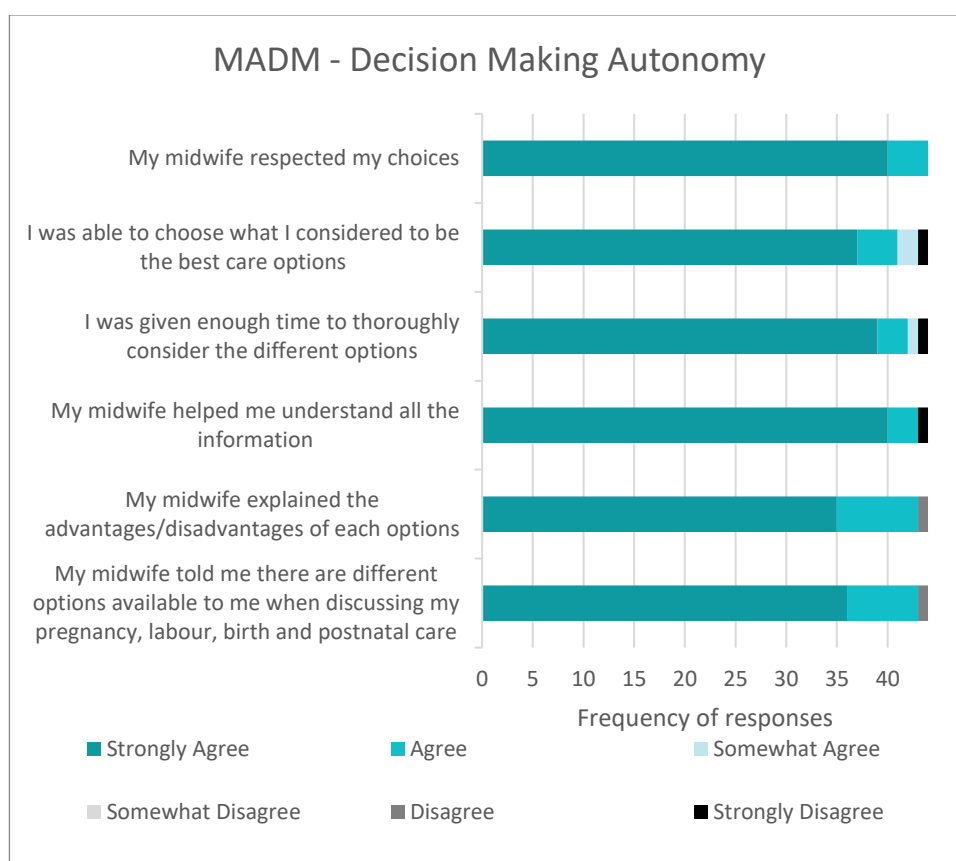


Figure 15: MADM Decision Making Autonomy



Appendix E – Chi Square Test and Odds Ratio Data

	Waijungbah Jarjums <i>Model of Care</i>			Mainstream Service <i>(standard model)</i>			Significance (p-value)	phi	Odds Ratio (OR)	CI Lower	CI Upper	Inverse Ratios ¹¹
Model of Care Total	45			52								
	Yes	No	%	Yes	No	%						
Total Mothers with > 5 Antenatal Visits	45	0	100.00%	37	15	71.20%	0.000	0.398	19.368 ¹²	2.46	152.80	
Total Mothers with Antenatal Apt <12wks Gestation	43	2	95.60%	31	21	59.60%	0.000	0.421	14.565	3.18	66.74	
Babies with low birth weight (< 2500 g)	1	44	2.20%	11	41	21.20%	0.005	-0.287	0.085	0.01	0.69	11.76
Spontaneous Vaginal Births	32	13	71.10%	25	27	48.10%	0.070	0.234 ¹³				
Assisted Births	3	42	6.70%	7	45	13.50%						
Caesarean Births	10	35	22.20%	20	32	38.50%						
Admission to SCN	4	41	10%	19	33	58%	0.001	-0.324	0.169	0.053	0.547	5.92
Admission to NICU	0	45	13%	14	38	14%	0.000	-0.382	0.057 ¹²	0.007	0.447	17.54
Mothers who discharged against medical advice	0	45	0.00%	2	50	1.30%	0.184	-0.135				
Stillbirth	0	45	0.00%	1	51	1.96%	0.352	-0.046				
Breastfed at Birth	39	6	86.70%	32	20	61.50%	0.005	0.283	4.063	1.46	11.32	
Breastfed at Discharge	30	15	66.70%	25	27	15.80%	0.065	0.187				
Incomplete Feed at Birth	0	45	0.00%	21	31	13.30%	0.000	-0.489	0.032 ¹²	0.00	0.25	31.25
Incomplete Feed at Discharge	0	45	0.00%	14	38	8.90%	0.000	-0.382	0.057 ¹²	0.01	0.45	17.54
Premature babies	2	43	4.40%	11	41	7.00%	0.016	-0.245	0.173	0.04	0.83	5.78

¹¹ Reciprocal inverse calculated

¹² Haldane-Anscombe correction used for the Odds Ratio calculation to correct for the variable frequency of 0

¹³ Cramer's V used for this 3x2 design



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Images from the program – consent obtained



First 1000 Days Regional Planning and Education



Waijungbah Jarjums Staff Welcome to Yugambeh Country Smoking Ceremony with Traditional Custodian Luther Cora and Family



**Waijungbah Jarjums
and Griffith
University First
Peoples Midwifery
Students and
Traditional Custodian
Lutha Cora and his
family**



**Blessing and
smoking of
Coolamon by
Traditional
Custodian Lutha
Cora for Welcome
Jarjum to
Community Event**



Deadly Dads Mens Group facilitated by Glenn Barry and Mark Williams – Didgeridoo Playing and yarning about Coolamon making



Mum and jarjum who attended the Women's Yarning Circle, Yarning and painting hand and foot prints



Infant Massage mum and jarjum participant in Womens Yarning Circle



Reconnection to Country Map

Jarjums born within the Waijungbah Jarjums Service