







Stronger connections for better outcomes: Exploring the views and experiences of midwives working in a culturally tailored caseload midwifery model for women having a First Nations baby in Australia

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ABSTRACT

Background: Culturally safe maternity care is a key strategy to reduce health inequities for Australian First Nations mothers and babies. Midwifery-led continuity of care (i.e., caseload) is associated with improved perinatal and psychosocial outcomes compared to other models and has been shown to improve women's experiences of care. Little is known about midwives' views and experiences of working in these models.

Aim: We aimed to explore midwives' experiences of providing care in a new culturally tailored caseload model for women having a First Nations baby at three tertiary maternity services in Melbourne, Australia.

Methods: Using a descriptive qualitative design, 20 semi-structured interviews were conducted with midwives working in the new model and analysed thematically.

Findings: The global theme 'Stronger connections for better outcomes' comprised four sub-themes: Strengthened connections between woman and midwife; Strengthened connections to navigate systems and services; Strong connections amongst caseload midwives; and Strong connections and sustainability require responsive systems and management.

Discussion: The connections between women and midwives provided a greater understanding of culture and the context of women's lives, and the model facilitated co-ordination and navigation of complex services. The strong connections were jeopardised when the organisational support and resources required to provide care in the model was not provided.

Conclusion: Midwives reflected positively about working in the model that they believed made a difference for First Nations families. Sustaining midwives in this model requires cultural training and support, a caseload that accommodates clinical and psychosocial contexts of the women, and organisational commitment and support.

Statement of significance

Problem or issue

Mainstream maternity care systems that do not meet the needs of First Nations women and babies have contributed to disproportionate adverse perinatal outcomes.

What is already known

Midwifery-led continuity is associated with improved perinatal and psychosocial outcomes compared to other models, and when offered to First Nations families has been shown to improve women's experiences of care, but there is little known about midwives' experiences of working in these models.

What this paper adds

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This paper addresses the evidence gap related to midwives' experiences of working in a culturally tailored caseload model and further informs strategies for upscaling.

Introduction

The impact of colonisation in Australia [1] and mainstream maternity care contributes to disproportionate adverse perinatal outcomes, including maternal mortality and preterm birth [2], for Aboriginal and Torres Strait Islander (hereafter called First Nations) families [3]. Numerous reports have recommended strategies to improve health outcomes for First Nations mothers and babies [2] to close this gap [4]. The Australian Government's 'National Aboriginal and Torres Strait Islander Health Plan 2021-2031' identifies the importance of a good start to life as key to a lifecourse of health and wellbeing for First Nations peoples [2], supporting the National Strategic Directions for Australian Maternity Services [5] call for the provision of culturally safe, accessible perinatal care for First Nation's women.

The term 'Birthing on Country' (BoC) reflects an approach to holistic, culturally appropriate care that offers First Nations families "the best start in life" [3] and is recognised as best practice maternity care for First Nations families [6]. The RISE framework identifies four key pillars that support services working towards BoC [3], with the first 'Redesigning health services' recognising the value of introducing midwifery-led continuity of care models [3].

Midwifery-led continuity of care is associated with improved perinatal and psychosocial outcomes for mothers and babies compared to other models [7]. Models such as caseload offer a known primary midwife, supported by back-up midwives, who provide care to a woman during pregnancy, labour, birth and the early postnatal period and being on-call for the woman 24h per day [8]. The development of the midwife-woman relationship is central to the model, giving rise to experiences of trust and empowerment [9] and increased satisfaction with care [10]. While earlier Australian caseload models were generally offered to women of low obstetric risk [11], approximately 50% of caseload models across Australia are now all-risk models [12]. An integrative review of caseload care for women with complex pregnancies reported positive experiences and outcomes regardless of risk status [13].

Eleven percent of the available caseload models in Australia are specifically for First Nation's women [15], and have been associated with positive outcomes including increased antenatal care attendance [14,15], reduced rates of preterm birth [15,16], and improved breastfeeding rates [15,17].

There is a growing body of evidence that working in a caseload model has benefits for midwives. A qualitative systematic review on midwives working in caseload identified positive aspects including developing meaningful relationships with women and families, working across the full scope of practice, and satisfaction in a role that feels more than just a job [18]. Similar reports of high job satisfaction among midwives have been found in models that provide care for women of all pregnancy risk levels [6,19–22]. Conversely, challenges such as being on-call [23,24], lack of work-life balance [22,25,26], and conflict with the wider maternity care system when offering continuity of care [22–24,27] have been reported. It is unclear if work is challenging for midwives when working in models that provide care for women with additional or complex needs, but it has been reported that providing continuity in the context of inequity or disadvantage can increase workload and emotional impact for midwives [28].

Midwives' experiences of working in caseload models specifically for First Nations families are not well understood. Two studies exploring the establishment of caseload models for First Nations women reported that midwives felt their work improved health and well-being for families [29] and provided opportunities to make a difference to women by

knowing them beyond just their medical history [30], however neither study explored the nature of the work in the models.

Context

Baggarrook Yurrongi (Woiwurrong language meaning 'Woman's Journey') was a project undertaken between 2017 and 2021. The collaborative project between La Trobe University, the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and four Victorian maternity services aimed to assess service capacity to implement, embed and sustain an all-risk culturally tailored caseload midwifery model of care for First Nations women and non-Indigenous women having a First Nations baby [31]. Three of the four sites (all large hospitals in metropolitan Melbourne) were able to successfully implement the model and offered care to 844 women during the study period. The fourth site, in regional Victoria, was unable to implement the model as intended due to significant staff shortages [31].

The establishment and operation of each model differed by hospital (Fig. 1) and is described elsewhere [32]. Cultural awareness training was provided to the midwives when they commenced their role (by either VACCHO or the hospital Aboriginal Health Unit[AHU] staff), providing information on the impacts of colonisation, skills to implement cultural safety into practice, respectful terminology, trauma-informed practice, and working in partnership with women and the First Nations health sector [32].

One of the key aims of Baggarrook Yurrongi was to explore midwives' experiences of providing care in the new culturally tailored model for women having a First Nations baby using surveys [32] and semi-structured interviews. This paper reports on data from interviews that explored the experiences of midwives working in the model, how they perceived their role, and their views on model sustainability.

Participants, ethics and methods

Design

A descriptive, qualitative design using semi-structured interviews was used to explore the views and experiences of caseload midwives.

Participants

All midwives who were working in the culturally tailored model at one of the three sites during the project were invited to participate in an interview six-months after commencement in their role, after two years, at the end of the project, or if they resigned from the model.

Recruitment

Midwives were emailed a link to an invitation to participate and a Participant Information and Consent Form. Once the consent was returned, the midwives were contacted by a research midwife to arrange an interview.

Data collection

Semi-structured interview guides were developed to explore general themes around the work in the model, informed by previous work undertaken by the research team [33,34]. The six-month interview explored midwives' motivation to work in the model, differences in working in the culturally tailored model compared to previous roles, and views on introduction of the model, training, support, and management. Interviews at two years and the end of the project explored views about the organisation's ability to provide culturally tailored care to First Nations families, and their views on model sustainability. Resigning midwives were also asked to describe their reasons for leaving. Piloting of the interview questions was conducted with caseload midwives from

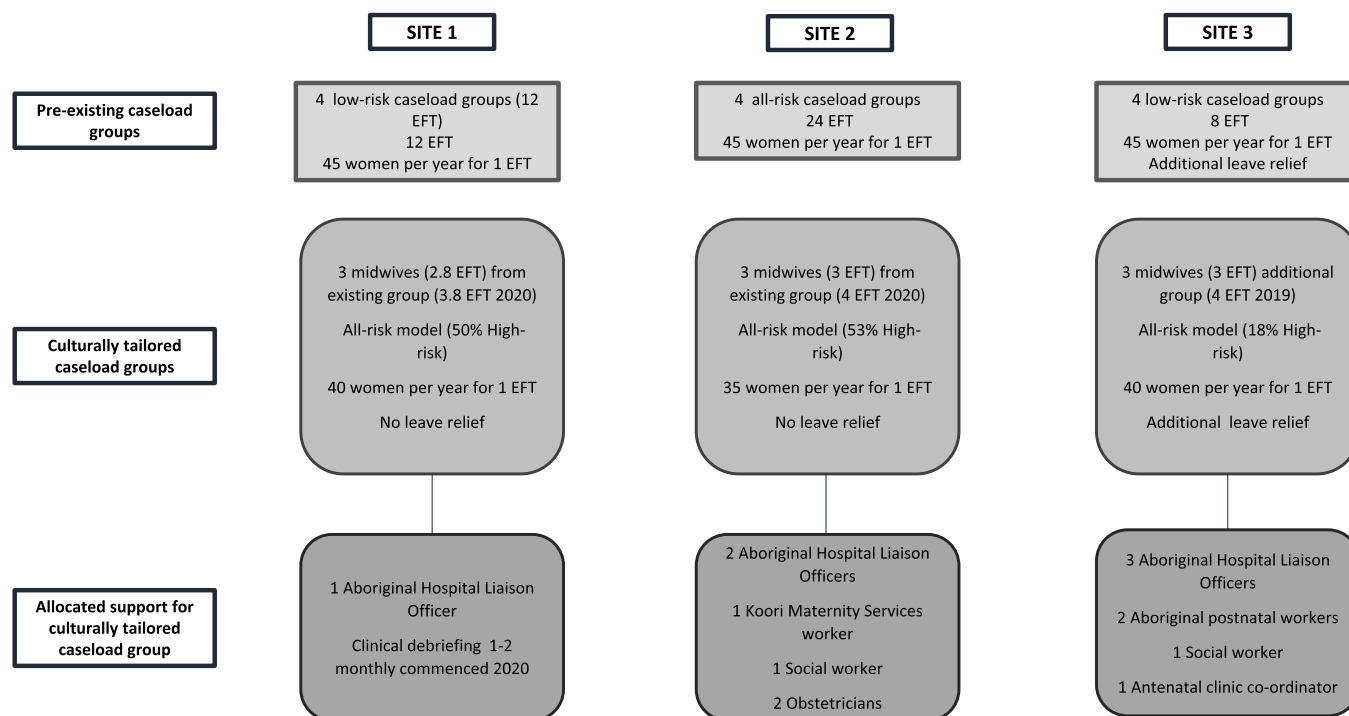


Fig. 1. Pre-existing caseload groups and newly formed culturally tailored models by site.

non-participating hospitals, their feedback was provided and no changes to the interview schedule were required.

Data collection commenced as each organisation introduced the model; Site 1-January 2018, Site 2- June 2018, Site 3- November 2018. The final interview was in February 2021. Interviews were conducted by a member of the research team at a location chosen by the participant. All interviews after March 2020 were conducted by phone or video-conference due to COVID-19 pandemic restrictions. Interviews were audio-recorded, transcribed verbatim, then checked against the audio-file. Errors in transcription were corrected and transcripts were deidentified.

Data analysis

Inductive thematic analysis was undertaken on interview transcripts following a four stage process of data immersion, coding, categorising and generation of themes as described by Green and colleagues [35] and other qualitative coding literature [36,37]. An initial sample of two transcripts were coded separately by two of the authors (authors 1 and 2) and discussed, before coding of the remaining transcripts by author 2. Regular meetings were held throughout the analysis between authors 1 and 2 to address questions arising from the data. Further cross-coding was conducted on a random sample of 9 of the transcripts during ongoing analysis by author 2 and 7. Discrepancies were resolved through discussion and consensus between authors 1, 2 and 7 before final agreement of codes, categories and themes amongst the wider research team.

Reflexivity

Reflexivity extends our understanding of the influence that the researchers exert on analysis, including their positionality, values and interests, adding credibility to the findings [38]. The research team are multidisciplinary, with backgrounds in clinical and academic midwifery and public health research, and reflecting both First Nations and non-Indigenous backgrounds, which enhanced the research, bringing multiple perspectives, and questioning the assumptions of the

researchers conducting the analysis and in the generation of themes and interpretation of findings. The primary analysis was undertaken by non-Indigenous members of the authorship team (Authors 1, 2 and 7), with an Indigenous academic (Author 4) and other non-Indigenous authors contributing to data interpretation and drafts of the manuscript.

Ethics

Ethics approval was granted by St Vincents Hospital Melbourne (HREC16\SVMH\233) and La Trobe University (HREC 195/16).

Results

Fifteen midwives working in one of the First Nations caseload models at the three sites participated in interviews at different times throughout the study (six-months after commencement in their role ($n = 10$), after two years ($n = 2$), at the end of the project ($n = 4$). Seven midwives resigned over the duration of the project and four of these participated in exit interviews. In total 20 interviews were conducted. Of the 15 midwives interviewed, 14 had completed a survey at 6 months (reported elsewhere [32]) that included the collection of personal characteristics (Table 1).

The global theme generated from the data was 'Stronger connections for better outcomes', which reflected the connections that were made in the model that enabled it to function and improve outcomes for women and families. The global theme comprised four themes, each with a series of sub-themes (Fig. 2). Table 2 presents illustrative quotes notated by the participant identification number, site and timing of the interview.

Theme 1. Strengthened connections between the woman and midwife

Theme 1 identified that features of the culturally tailored model provided opportunity for relationships to be formed between the women and midwives. This theme was informed by five sub-themes.

Table 1
Participants.

	n	%
	n = 15	
Age (n = 14)		
20–29 years	6	43
30–39 years	5	36
40–49 years	1	7
> 50 years	2	14
Identifies as Aboriginal and/or Torres Strait Islander origin (n = 14)		
Yes	1	7
Years of midwifery experience (n = 14)		
< 5 years	9	64
6–10 years	3	21
11–15 years	-	-
> 15 years	2	14
Years working as a caseload midwife (n = 13)		
< 1 year	8	62
1–5 years	4	31
6–10 years	1	8
Work hours (n = 14)		
Full time	13	93
Part time	1	7
Hospital (n = 15)		
Site 1	7	47
Site 2	5	33
Site 3	3	20
Number of interviews participated in (n = 15)		
One	11	73
Two	3	20
Three	1	7

A model designed for First Nations families

Midwives believed there was a need for a model tailored to First Nations families that provided supportive and culturally appropriate maternity care. They recognised challenges that impacted women

accessing the caseload model, such as correctly identifying First Nations women and babies, or keeping places available for late referrals. Therefore, having a model specifically for First Nations women (and non-Indigenous women having a First Nations baby) that could accommodate these factors would facilitate access to the model for as many First Nations families as possible.

Providing flexible and individualised care

Midwives described supporting women’s individual needs and building a relationship over time. Women didn’t need to repeat their stories at each visit because their midwife knew them, their background and personal context. The all-risk inclusion in the model meant some women required more support and resources due to medical, obstetric or social complexities. Midwives created a flexible, individualised model using strategies such as text or phone communication between appointments, flexibility with appointment times and coordinating visits with other health care team members.

Making a difference to outcomes for women and babies

Midwives described the positive impact of the model on outcomes for women and babies with the model enhancing their ability to support women to feel empowered and respected. Their view was that this ultimately increased trust in the health care system and improved women’s access to, and satisfaction with maternity care. Midwives saw their role as creating a safe and supportive physical, organisational and emotional space in the hospital setting. Midwives relayed positive accounts from women who had received care in the model that acknowledged their support and advocacy, and their efforts to make care individualised and culturally appropriate and saw women returning to the model in subsequent pregnancies, or seeking care in the model based on recommendations from friends and family.

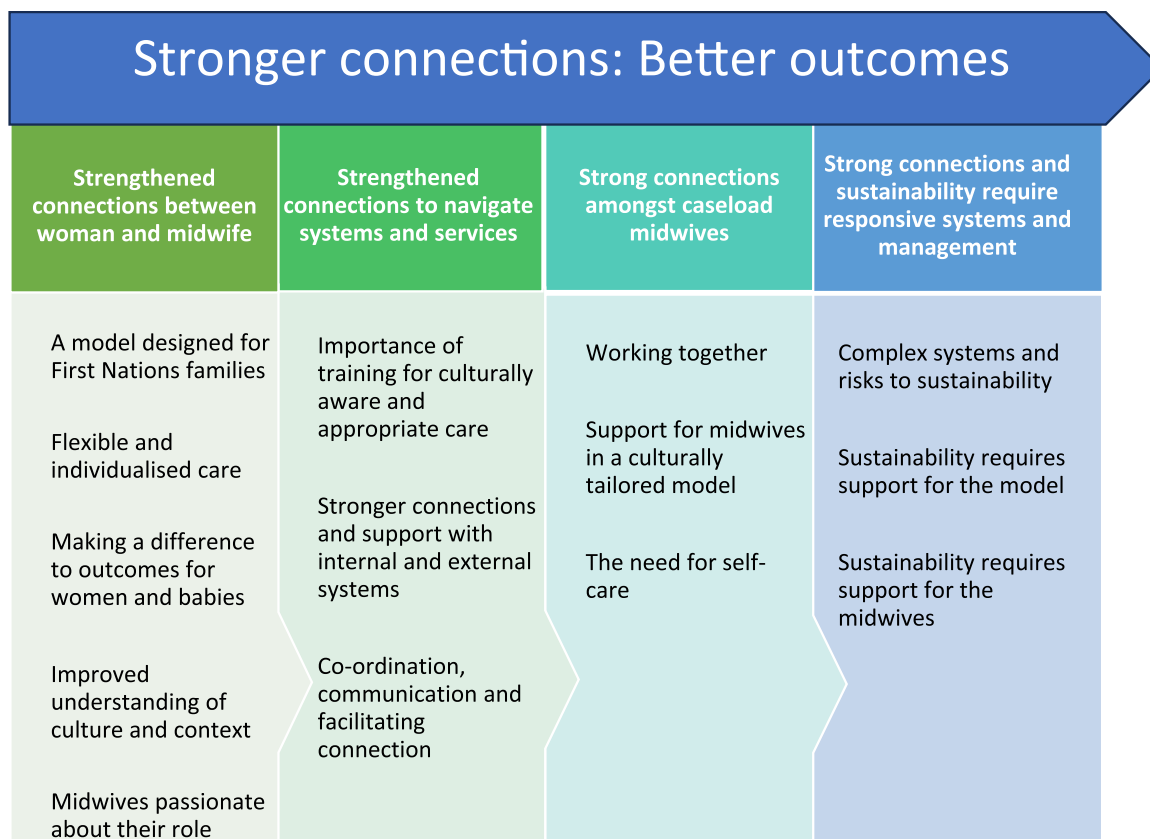


Fig. 2. Global theme, themes and sub-themes.

Table 2
Themes, sub themes and illustrative quotes.

Theme	Sub theme	Illustrative quotes
<p>Strengthened connections between the woman and midwife</p> <p>...I've always wanted to take a lot of time with women...I think doing a lot of, you know, the cultural education that we've done as well –especially in those initial booking visits, you know, my focus is – rather than just getting history and all sorts, just really a lot about, you know, their mob and where they're from, just really trying to build more of a rapport in that way...., we just always want to make sure that, you know, that these women are, getting the best care, which I think you do in any role. I don't think it's necessarily changed, but maybe just going a bit more of an extra mile maybe. (6009, Site 3, 2 years)</p>	<p>A model designed for First Nations families</p>	<p><i>it feels like maybe Baggarrook is a caseload ...it's used the same way the other three low risk caseloads are but probably needs to be viewed a lot more as a specialty clinic...it's not as straight forward ...when it's just a lot of education, but that knew enough to ask for caseloads and that are benefitting from a great program and they should, but it should be available to everyone. These are the women who really, really need it and there's less perception of that from the up high (6019, Site 1, 6-month)</i></p>
	<p>Providing flexible and individualised care</p>	<p><i>I've become a lot more aware of where women may fall through the gaps... in a big hospital sort of system... and that the hospital has made that effort to do something like that, like this model creates a level of safety for the women in that they know that this hospital is making an effort to be culturally safe and respectful which I think is an important first step...but I think it's important for the women... to get the time and space to communicate with a consistent person or... a couple of people about the planning and coordinating of their care, particularly – but not only the ones that are very medically complicated, particularly the ones that are also quite vulnerable for social reasons, and it means that their care is quite tailored to them (6019, site 1, 6-month)</i></p>
	<p>Making a difference to outcomes for women and babies</p>	<p><i>The hospital is known to have a very strong history with the Stolen Generation and I think having the women come to the hospital with an own caseload midwife who they can trust and have good care with helps repair that reputation a little bit, but also my hope is that – like they're engaging with the hospital services a lot more, that they have improved satisfaction of care.... I've seen all of these things happen over the past year, um, that as long as women are walking away just saying that they had really good care and that they feel happy and empowered and that they felt respected then that's great. (6003, site 1, 6-month)</i></p>
	<p>Improved understanding of culture and context</p>	<p><i>Yeah, well I think there is increased community demand because I think word has spread just about the care that we're giving.....we've had women who have returned but then other women who have said their cousin or their sister were with us and they really want to do that with us. So, there is that increased knowledge going out into the community about the service and the service being about the care (6001, site 1, End of project)</i></p> <p><i>...and it's like increased my empathy which has definitely increased my understanding and not only of like the women but of their families and understanding how that complex family dynamic, can just like really have an effect. So as much as you're like caring for the woman you're caring for her and her whole extended community (6012, site 1, Exit)</i></p> <p><i>... the racism that women are exposed to and the comments that are made towards us as their midwives ... which has been really frustrating and a massive eye opener... it's such a disappointment, which is hard because they're the women that we're working with and when we're not there they're [other staff] there ... caring for Aboriginal women – it's terrifying... knowing these women and their stories and – it just makes you even more – angrier, you know, that they're looked at and treated this way. (6013, site 1, 6-month)</i></p>
<p>Strengthened connections to navigate systems and services</p> <p>Working with Aboriginal women is a really relationship-based – I don't want to say process about working with women, but it's just a really relationship-based kind of thing. And I think working in the team that supports them is a really relationship-based thing as well. Like, “Who do you know? What can they can offer you? How kind are they to the women? Is this person culturally safe? Is this person not culturally safe?” Trying to do a lot of that kind of gatekeeping for the women. And we figure I guess that gatekeeping through the relationships with other members of the broader team. (6018, site 1, end of project)</p>	<p>Midwives passionate about their role</p>	<p><i>Yeah. I've really loved it. Enjoyed it. Yeah. I think I said earlier no regrets at all. It's been the change that I wanted. The extra stimulation. The extra – extra something. (6004 site 2, 6 month)</i></p> <p><i>I got as many benefits as I provided in that model. It was enormously satisfying (6007, site 2, Exit).</i></p>
	<p>Importance of training for culturally appropriate care</p>	<p><i>... we got sent to the VACCHO training day which was amazing and I was sitting there the whole time thinking, I wish every person in our hospital had to do this as mandatory [training]. Oh it was really good. Really good. And I think you know, when I first started I thought how am I ever going to know what I wanted to know everything. And I think most of it's come from working with the women and learning from the women rather than that one day. That was great to start off with. But just being with these women is what's taught me the most. (6013, site 1, 6 months)</i></p>
	<p>Stronger connections and support with internal and external systems</p>	<p><i>I think that having the AHLOs around mean that where, like my understanding of culture comes from a place of being kind and respectful to women and trying to incorporate their culture but I can't pretend that I understand exactly what their culture needs or wants all those things, so having, the Aboriginal Health Workers, they're a sort of safety net for me and a go-to for me when I have questions ... making the referrals to the AHLOs means that she's [the woman] getting the right advice and not just me making something up... it's just a really nice support. (6019, site 1, 6-month)</i></p> <p><i>So, our AHLO's, well they're always – their doors always open. Like, you know, they're always up for a yarn... we have a really good relationship with them...so, we've got two antenatal AHLO's and then our postnatal worker as well. Um, so we have a fortnightly meeting where we discuss, you know, women with particularly complex needs...so, they'll always be there when our clinics running, the women will usually be waiting with them and we'll drop in and have a bit of a chat and for updates at other times. (6009,</i></p>

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Table 2 (continued)

Theme	Sub theme	Illustrative quotes
		<p>site 3, 2 years)</p> <p><i>I was always referring to the same two obstetricians because I liked them and they're experienced and they know what to worry about and not to – what not to sweat about and they were always consistent ... we just thought wouldn't it be great just to have a couple of doctors that were [the model] doctors so all these women were always going to see these same two doctors... they all know the women. We know the women... yeah, worked perfectly with us and for the women and the women really liked them. (6004, site 2, 6-month)</i></p> <p><i>... right from the start we went over there [to the community First Nations service], we met them all, we had that face-to-face chat, and so right from the start I think we got off on a good foot in terms of our relationship and because we – yeah, we were all very enthusiastic about the model... there have been times where we've – it's been a challenge – I'm not going to lie. It's definitely been a challenge because we're both working with the same women so communication can often be a challenge, but, you know, I think when – when we feel like there are little things that are not working – just recently we've got together again to just talk about, okay, what's not working and how can we do this? (6002, site 1, 6-month)</i></p>
	Co-ordination, communication and facilitating connection	<p><i>We're just offering it to any risk. But also some people have already some, um, things already that make them high risk, um, medically so we have to – I guess we're like, you know, talking to doctors more and involving like social work or, um – and we're – that's another thing as well, we're still figuring out the communication with that ...I guess we're trying to set up more regular communication with the multidisciplinary team, like with the ALO's, with the social work, like ways we can have regular communication rather than just like as it like when you need it because it seems to work better. Like having regular meetings or sending like a regular email say with like [midwife name] y at [named ACCHO] we've set up like sending an email every Monday for like the women that are doing shared care \ (6010, site 3, 6-months)</i></p> <p><i>... and they would meet and create their own networks because that's so much bigger and so much more important than what we do is, you know, that fabric that they weave between them that holds them together long after we're done. You know, we're like a snapshot in time in their lives. Those relationships that they form with each can be, you know forever... (6004, site 2, 6-month)</i></p> <p><i>... you know what's wonderful is they all know each other and even if they haven't met that woman before, if we introduce them as "oh, this lady's in my caseload group to", and they work out the connections, "oh where are you from sister?" you know, and "who's the father of this baby?"; and they [the women] are so inclusive. (6001, site 1, 2 year)</i></p>
Strong connections amongst caseload midwives	Working together	<p><i>...we couldn't have done this past year in the caseload without each other....we're just a strong unit. Our communication's flawless. Our teamwork's flawless. Like we just gel so well. It's like the perfect team. I love working in that small team like without it I just don't know what this caseload would be like. (6003, site 1, 6-month)</i></p> <p><i>So, we just wanted to make sure that there was a – a fair load, um, throughout the midwives, so it's not like, you know, one person had, um, I don't know, lots of people with competing mental health and comorbidities that was going to kind of, yeah, you know, impact on them for that month in particular. (6009, site 3, 2 year)</i></p> <p><i>We kind of cover each other's leave so, you know, so [midwives' name] and I would not take leave at the same time. So that when I'm away she's covering my caseload but when I'm away I don't recruit for two weeks either side of the leave that I'm away.... but at least that way, you know, with [midwives' name] she knows them, they know her. (6004, site 2, 6 month)</i></p>
	Support for midwives in a culturally tailored model	<p><i>...When you're the midwife you can't just think, oh someone else will follow it up because you're that person that will follow it up and – and because you have such more of an emotional connection to your women you don't want to disappoint them and you want to be giving them the best care. It just puts a whole new level of pressure – like – I just put on myself ... (6003, site 1, 6-month)</i></p> <p><i>... the role for me was starting to get intense about six months in, I kind of realised I didn't really know how to process and let go of the - like the trauma and leave it at work which is such a difficult thing when you work on-call 'cause you never really leave work. Like you leave the building and you try to disengage but it's still like 'on'. (6013, site 1, 6 month)</i></p> <p><i>We need support so – and, you know, so – they - those meetings are fantastic because we can tell them this is – we are doing this and this is how it feels and – and they were able to listen and take that away and you know, obviously for the research and for the continuing of the model they need that feedback, so I think that's why the meetings are so important. (6002, site 1, 6-month)</i></p> <p><i>... it's like when we first started having sessions with her it was like somebody listening to us and hearing us... she just listened and she fed back and was helping us to find ways of sustaining ourselves... dealing with some of the very vulnerable women and she absolutely understood that and how we were feeling and how that would get us down... that understanding about generational trauma and then the vicarious</i></p>

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Table 2 (continued)

Theme	Sub theme	Illustrative quotes
	The need for self-care	<p>trauma for us for hearing women's stories and then trying to support them. Some of them, how they suffered or had suffered in the past. So, that made a huge difference. That feeling that you were being understood and she knew what we were feeling. It's super important. (6001, site 1, End of project)</p> <p>... for me, you know, trying to take my mind away from it when I am at home and exercising and you know, doing a bit of mindful - mindfulness practice which when you've worked long hours, you know, some weeks you're a little bit like a robot. You come - you get up, go to work, work, go home, you've got nothing else to give to yourself let alone anybody at home.... one week can be really, really tough and then the next will be lovely. (6013, site 1, 6-months)</p> <p>I think it helped us to bring us closer together...you are a close-knit team but to appreciate how each person felt. Because it is a safe space to talk about how you felt and how helpless you felt maybe in a particular situation. And then being able to check in on each other and we've also had - it has helped us to keep renewing and trying to have some social time together. (6001, site 1, End of project)</p>
Strong connections and sustainability require responsive systems and management ... I guess it's, it's really important to make it clear that it's sort of the structures around the model and how we give care as best we can, not around how the acuity of the women is, like I have like wonderful experiences with the women in my list, I get a lot of career satisfaction and of working in this area and the interactions that I have with women in my caseload are great, even the challenging times, you know? It's, it all feels really important, it's the frustration around trying to move in systems and services that makes it feel like you're not getting anywhere which can make you feel overwhelmed. (6016 Site 2, 6-month)	Complex systems and risks to sustainability	<p>... there is a huge lack of understanding from staff around why the program has been put in place and what it hopes to achieve. And then I think because of that lack of understanding it's really hard like you know, you leave someone on the postnatal ward and you're like, "Oh, it's a real roll of the dice now how this experience is going to go." (6018, site 1, End of project)</p> <p>I think probably since winning that award more managers will know about us, that's a lot of the discussion around [the model's] sustainability came since that award win... I think there's an understanding that it's important and that, you know prioritising care is important in that program, but I'm not sure they understand what it's for and why we have it, they just know it's important... (6016, site 2, 6-month)</p> <p>And we get all the congratulations and well done but I wished they'd - instead of, you know, saying all of this and recognising the caseload program ... that they'd recognise that we are struggling a little bit. And, you know, help put more supports in place for it to really work and be forever. (6013, site 1, 6-month)</p>
	Sustainability requires support for the model	<p>There are bits of it that I absolutely love. There are bits I really struggle with particularly I sort of get to the point sometimes where I wonder what's even the point of sometimes feeling like I'm killing myself, like not sleeping, putting in all this effort to try and help women have a good relationship only for the system to just squash those hopes and dreams. (6018, Site 1, End of project)</p> <p>... we have mentioned these things [administrative support, leave cover] and once again it's just - every time you mention it, it's sort of just like - it's brushed off a little bit. Like, oh well - actually they just don't really even acknowledge it. They make a joke being like, oh wouldn't that be nice, and then it's never spoken of again. The main things are we just really need support for that administrative process and the annual leave coverage... I swear if we had those two things I reckon we would be the happiest midwives and - and like maybe a lower caseload. But then if we had the support maybe we wouldn't need a lower caseload. (6003, site 1, 6 month)</p>
	Sustainability requires support for the midwives	<p>... so we're like starting to talk to our manager about having supervision at that time and, I just think it should have become like something that was implemented very quickly after we asked for it. Especially knowing that all the other hospitals that run this programme have it already incorporated into the model itself for its staff. So, yeah, it just made me feel a bit like the other hospitals care more about their staff mental health than my hospital cares about me which has made me quite resentful to the organisation... (6012, site 1, Exit)</p> <p>.... a lot of the attention does need to be on how we are feeling to be honest to make it succeed because otherwise - and because I think if the hospital staff - they're - when they see us burnout they're not going to want to apply for the job. (6002, site 1, 6-month)</p> <p>when I applied for the job and got it I - I really saw myself as just somebody keeping the seat warm until somebody better came along, someone more appropriate than me, you know (6004, site 2, Exit)</p> <p>I know there are Aboriginal midwives who are interested in working in Baggarrook, but the opportunities are not available until someone leaves. They should really be supported to say that, "This is something I'm interested in. Could I have some - like a secondment or a supported time in the team?" ... the research is the Aboriginal women want Aboriginal midwives. So I don't think on some level it's really appropriate for the Aboriginal midwives to have to wait for the hospital to create an extra position or to wait for someone to leave because they're burnt out. (6018, site 1, end of trial)</p>

Improved understanding of culture and context

Midwives identified stronger connections with women through increased awareness and understanding of the impact of colonisation on First Nations peoples' experiences of mainstream healthcare. This increased their cultural awareness, understanding of First Nations peoples' mistrust of the health care system, and the trauma of Stolen Generations and child removals. They recognised these as factors contributing to why hospitals may not be seen as a 'safe space'. This was reinforced by over half of midwives reporting having witnessed or heard of racism against First Nations families perpetrated by other hospital staff.

Midwives passionate about their role

Midwives were highly passionate about their role. They wanted to "have more impact" and improve health outcomes for First Nations families. Midwives felt personal satisfaction for the rewarding work and felt they made a difference. They valued the opportunity to contribute to women's experiences, building relationships with women, developing skills in caring for women with varied needs and expanding their learning about First Nations culture.

Theme 2: Strengthened connections to navigate systems and services

A key component of the midwives' work was to facilitate women's navigation of complex health systems and services both inside and outside the hospital.

Importance of training for culturally appropriate care

Midwives acknowledged the importance and value of initial and ongoing cultural awareness training received in preparation for the role. Many suggested that cultural safety training be provided to all hospital staff, to combat racism and improve culturally aware care outside the model.

Stronger connections and support with internal systems

Midwives felt the model promoted stronger connections and support between women, midwives and internal hospital systems, particularly with other First Nations teams (e.g., Aboriginal Hospital Liaison Officers [AHLOs], Aboriginal Health Units (AHUs), Koori Maternity Service workers). Midwives identified how these relationships provided additional culturally sensitive support for women, were a resource and support for midwives, and fostered a shared understanding about cultural support as core business.

At some sites, the model had a primary obstetrician and/or a primary social worker, which enabled streamlined communication and consultation. These relationships worked well when clinicians were familiar and supportive of the model. When working with specialist teams to coordinate care for women, regular communication (e.g., meetings, telephone contact) enhanced care. However, developing connections with internal teams could be challenging, for example, at one site the AHU and the midwifery clinic were in separate buildings, which made access difficult for women and was a barrier to ease of communication between staff.

The model also promoted stronger connections and communication between midwives, women, and First Nations community services which were beneficial in providing seamless care for women who were also having community-based care with an ACCHO. These relationships strengthened when personal connections between midwives and community services were established.

Co-ordination, communication and facilitating connection

Midwives described their role coordinating care for women, collaborating across multidisciplinary teams and services to support and strengthen care, and frequently communicating with AHLOs, social workers and medical teams. At times midwives facilitated appointments and accompanied women to provide support, advocacy and continuity.

Midwives believed the model facilitated and strengthened connections within the First Nations community, particularly when the model provided opportunities for women to meet. At one site the AHLOs and midwives established a 'yarning circle' to foster connections amongst the women and a sense of community, which they believed would extend well beyond the maternity care episode.

Theme 3. Strong connections amongst caseload midwives

Theme 3 describes the close working relationships of the midwives within the model, and how these relationships supported both the function of the model and the wellbeing of the midwives. The theme also includes midwives' views of strategies used to sustain their work in the model.

Working together

Midwives identified numerous benefits to working in a small team. Midwives knew each other well, had mutual respect, trusted and relied on each other, valuing teamwork where colleagues had a shared philosophy of holistic care. Regular communication provided opportunities to support each other through sharing workload and discussions with others who understood the role.

Given the nature of the all-risk model, some women experienced clinical and/or psychosocial complexities, with midwives balancing the allocation of women with additional needs across the group to manage workload. Midwives also worked together to manage planned leave, ensuring cover so that a known midwife would be available to the women in their absence. At two sites the midwives reduced their monthly bookings to manage planned leave, while a leave relief position (adopted by one site) was a way of providing continuity without impacting the workload of others.

Support for midwives in a culturally tailored model

Midwives described aspects of working in this model that differed to other caseload work. Almost all commented on administrative tasks such as booking appointments, liaising with internal and external services and following up with women, considered to be necessary to ensure women did not "fall through the gaps". These tasks took considerable time and effort, but the midwives felt responsible for undertaking this work to achieve the best possible outcomes.

Having greater understanding of the context of some women's lives had an emotional impact on some midwives. Caring for women who had experienced trauma and challenging life situations could weigh heavily, be "highly emotional", with significant "ups and downs". A number of midwives spoke openly about their response to vicarious trauma, and in a few cases these experiences led midwives to question how long they could continue in the role.

Midwives identified a range of supports relating to operational aspects of the role, guidance in providing culturally safe care, and managing potential vicarious trauma. Sources of support included caseload colleagues, managers, the research team, midwives working outside of the model, and other First Nations services. The midwives met regularly with the project research team for discussions around model implementation, debriefing, and strategies to improve operational processes (e.g., to reduce administrative tasks). However, midwives' experiences of support from their managers varied. Midwives expressed the need to meet with managers on a regular basis and in "protected time" so that meetings were not cancelled or rescheduled. While some midwives reported receiving adequate support and felt listened to, others reported a lack of support from managers and no action taken to address concerns.

Counselling sessions were provided for midwives at one site by an external service, but these were ad hoc, and the midwives reported that they were not always helpful because of a perceived lack of understanding of the issues specific to their role and caring for First Nations families. Midwives who had been provided with formalised clinical supervision reported the experience was helpful. One site offered access to

regular 'reflective supervision' with a hospital social worker, which midwives reported to be immensely valuable and created "a safe space" for sharing their experiences.

The need for self-care

Midwives recognised the need to protect their health and wellbeing to reduce the risk of burnout. Some midwives acknowledged that working long hours and being on-call could impact negatively on their personal life and mental health. Self-care strategies included working part-time to enable "a more balanced lifestyle," setting boundaries (e.g. turning off phones when not at work), mindfulness meditation, exercise, and taking personal leave). Teamwork was also key to caring for themselves and their colleagues.

Theme 4: Strong connections and sustainability require responsive systems and management

Theme four identifies that the connections with women, with internal and external services, and amongst the caseload midwives themselves could be at risk if systems and management are not responsive to sustain the model and the midwives.

Complex systems and risks to sustainability

Some midwives described how they were providing care in a culturally tailored model within a system that was complex and inflexible. They felt the key to sustainability was an understanding within the hospitals about the purpose of the model and what it involved. While health professionals who worked closely with the caseload team had a good understanding of the model and how it needed to operate, there was often a lack of awareness and understanding outside of these services. This occasionally created tensions, when staff external to the model commented that the model was "not effective", "difficult" or created more work for core staff.

A few midwives were cynical about the organisational commitment to improving care for First Nations families, describing a lack of support for the model and slow progress towards introducing supports and changes needed for sustainability.

Sustainability requires support for the model

Midwives described how the model could be jeopardised by slow or non-responsive hospital systems and staff. The midwives repeatedly suggested key improvements for the model's optimal functioning, including increased staffing, dedicated obstetric and social work staff, leave coverage, additional administrative support, and supporting a lower annual caseload, but felt as if there was little support for change. At one site, an ongoing shortage of clinical space for the model was perceived as "reeking of disrespect" creating more work for midwives trying to find space to conduct appointments and making it difficult for women to know where to go.

Sustainability requires support for the midwives

The midwives reported their work to be satisfying and making a difference for women, yet some had ongoing struggles with workload pressures that had a personal impact. Regular support meetings between midwives and managers, and regular clinical or reflective supervision from someone who understood the role were requested as strategies that would support sustaining their work in the model.

The need to recruit and retain staff was viewed as paramount to sustainability of the model. Midwives reported that some core midwifery staff viewed the role in the First Nations caseload model as busy and demanding. A few midwives identified the need to prioritise midwife wellbeing to retain those already in the role, and to attract new midwives. Reasons for leaving the model or considering resigning were feeling burnt out, tired of long hours, being on call, lack of work-life balance and lack of support from the hospital. Suggestions such as part-time positions and leave coverage to support midwives to maintain

work-life balance, and reduce burnout, could ultimately reduce staff turnover.

One of the aims of the model was to build the First Nations midwifery workforce. Across the three sites, there was one First Nations midwife working in the model during the study period. Midwives identified the lack of First Nations midwives as "a huge gap", and a few midwives spoke of their role in "keeping the seat warm" until First Nations midwives were recruited into the model. Occasionally it was felt that systems and processes had not supported the employment of the few First Nations midwives (e.g., not offering part-time positions) and that cadetships or "supported pathways for Aboriginal midwives" would increase the First Nations midwifery workforce.

Discussion

This study explored the experiences of midwives working in a caseload model designed specifically for women having a First Nations baby at three tertiary maternity hospitals. The global theme of 'Stronger connections - better outcomes' reflects midwives' views on the potential for the model to improve the experiences and outcomes of First Nations families accessing maternity care. Three of the four themes describe strong connections: between midwives and women, between the midwives working in the model, and linking together internal and external services. The final theme identified factors that jeopardise these connections and pose risks to the sustainability of the model.

Midwives' experiences in caseload models are widely reported as fulfilling, allowing for autonomous practice, centred on relationship building with women and collaboration with multidisciplinary teams [18]. However, challenges in maintaining work-life balance, lack of support from colleagues and management, and conflicts with the system in which the model is operating have also been reported [18]. Very few studies have explored midwifery-led care for First Nations families [14]. Survey findings from this project (reported previously [32]) reflected a high level of professional satisfaction and no increased burnout for midwives working in the culturally tailored model, however, the additional work associated with providing care in an all-risk model necessitated additional supports and a reduction in caseload size [32]. The importance of organisational support to facilitate the wellbeing of midwives, particularly in caseload models targeting specific groups of women have been reported [20], and our findings build on the understanding of working in these contexts [32].

Addressing health inequities for First Nations families was a motivating factor for midwives to work in the model of care. The legacy of colonisation in the organisation of healthcare systems has been recognised as contributing to systemic barriers to First Nations women accessing maternity care [39]. Midwifery-led continuity can facilitate the development of trust between women and midwives [6,40,41] and was recognised by the midwives in this study as fundamental to improving outcomes and experience for First Nations families. Models providing opportunities for First Nations families to develop trusting and respectful relationships within healthcare systems are recommended to improve maternity care [42,43] and can provide a sense of safety that facilitates asking questions, speaking up about concerns and increasing engagement with care [40].

Working in the culturally tailored model was different to standard caseload work. Recognising the context of women's lives, and the need for culturally appropriate care impacted on midwives' workload. While over half of the women in this model were considered to be 'low obstetric risk', a significant proportion were experiencing multiple life stressors, psychological distress, and worries [43], adding to the workload of midwives but was more difficult to quantify compared to identifying medical/obstetric risk. Much of the work was 'unseen' – such as additional administrative tasks and liaison with internal and external services, and this complex workload impacted on midwives' wellbeing and capacity to sustain work in this model. Recognising the additional complexity of providing care in all-risk models and the organisational

supports required to support midwives [32] needs to be acknowledged and accounted for in model design and size of caseload allocation.

The strong connections between the midwives were viewed as essential in sustaining their role. Experiencing a community of practice featuring practical and professional support, and a shared philosophy enabling trust in their colleagues to provide care in their absence, has been identified as a strategy to sustain continuity work [18]. Midwives 'going above and beyond' to ensure women are empowered, nurtured and safe is a feature of other all-risk caseload models [44] and recognition of women's individual needs is essential in providing culturally safe care [45]. Understanding and acknowledging the workload required in culturally tailored models to provide individualised care needs to be part of service redesign [3], and could include strategies such as leave relief [46] or reducing caseload size [3]. Recognising these factors in planning for culturally tailored models of care can facilitate decisions about sustainable model design.

The midwives identified the hospital First Nations teams as key partners in the model which supported engagement of the women with the health service in a culturally safe manner. They also acknowledged the importance of these connections in their own professional development and drew on the cultural knowledge of First Nations staff in the absence of ongoing training opportunities. Midwives and First Nations staff working together in intercultural partnerships has been shown to be mutually satisfying, facilitating a sharing of both cultural and clinical knowledge [47], assists women in navigating complex maternity care systems [41] and underpins culturally safe care [45]. These partnerships are a key component of BoC services [6], and opportunities to establish and foster these partnerships should be a key feature of culturally tailored models [41]. It is important, however, that organisations are not reliant on First Nations staff to be the drivers of cultural education and support for non-Indigenous staff [41], and that formalised and ongoing support for midwives to maintain and grow their cultural awareness is provided.

Some midwives reflected on the establishment of the model triggering a degree of racism directed at First Nations women. Racism in health care has been identified as a significant barrier to equitable and responsive care, resulting in low levels of trust and satisfaction and inadequate care provision [48]. More specifically, First Nations women's experience of racism and discrimination is associated with poor perinatal outcomes and is a clear demonstration of the inverse care law (i.e., the women at most risk of poor outcomes are also most likely to experience insensitive, disrespectful or judgemental care [42]). Midwives' observations of racism led them to believe that the cultural awareness training they received needed to extend across the health service. Cultural awareness training has been demonstrated to reduce racism, increase empathy, challenge stereotyping [48], and has been identified as an organisational responsibility in providing a culturally safe service [41].

Connections between the midwives and other health care teams were key to facilitating seamless care for First Nations families. Internally, continuity with the multidisciplinary team strengthened these connections, facilitating trusting relationships, and when they were lacking, caused concern and additional workload for the midwives. Sandall [7] identified the role that continuity models play in navigating complex maternity systems, addressing deficits in coordination, communication and cooperation that can result in poor quality care. Collaborative models of care with known care providers can reduce barriers and enhance access, referral and consultation leading to more timely interventions [49]. Establishing and fostering relationships between key service providers will enhance the effectiveness of culturally tailored models.

A supportive 'reflective supervision' model, where midwives could debrief and be professionally supported specific to their role was viewed as important to sustain working in the model. While managers of caseload models would be expected to provide a level of supervision and professional development, they may not have the cultural insight

required to cater to the needs of midwives working in these models. Conversely, while First Nations staff may be able to provide cultural guidance, there needs to be recognition of the extensive demands on these staff to be the source of all related education and training which is often unrecognised in their workload [47]. Proactive planning for formalised, culturally specific clinical support and supervision has been recognised as a key feature of models supporting BoC principles [6].

Strengths and limitations

The findings of this study provide a detailed account of the views and experiences of midwives working in an all-risk culturally tailored caseload model, and insights into the factors that impact sustainability of the model from a workforce perspective. These data help us better understand the quantitative outcomes from our prior study [32] and explain the positive outcomes reported in the overall Baggarrook Yurrongi project [50]. Given that all sites included in the study were in metropolitan locations, the findings may not apply to regional and rural areas, nor to midwives' experiences of models established for different groups of women. Not all midwives working in the model participated in the interviews, so we do not know if these findings reflect the views and experiences of the midwives who did not participate.

Conclusion

Midwifery-led continuity of care for women having a First Nation's baby has been shown to improve health outcomes and women's experiences of care. Connections between midwives, women and across the health services have been identified as the key element to successful and sustainable culturally tailored models. There is a risk to the connections and to the model's sustainability when the unique nature of the model is not recognised and supported. Sustaining midwives in culturally tailored caseload models requires cultural training, clinical supervision, adjustment of workload that takes into account clinical and social risk, as well as organisational support and commitment.

CRediT authorship contribution statement

Newton: Conceptualization, Methodology, Investigation, Formal analysis, Writing – original draft, Funding acquisition. **Crawford:** Formal analysis, Writing – original draft, Writing – review & editing. **Holmund:** Formal analysis, Writing – original draft, Writing – review & editing. **McCalman:** Writing – review & editing. **McLardie-Hore:** Methodology, Investigation, Writing – review & editing, Project administration. **Forster:** Conceptualization, Methodology, Writing – review & editing, Funding acquisition. **McLachlan:** Conceptualization, Methodology, Writing – review & editing, Funding acquisition.

Ethical approval

Ethics approval was granted by St Vincent's Hospital (16 \SVHM \233) on 16.1.2017 and La Trobe University (HREC 195/16) on 30.1.2017.

Declaration of Generative AI and AI-assisted technologies in the writing process

AI was not used in the preparation of this work.

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Author declaration

The authors declare:

- that the article is the author(s) original work.
- the article has not received prior publication and is not under consideration for publication elsewhere.
- that all authors have seen and approved the manuscript being submitted.
- the author(s) abide by the copyright terms and conditions of Elsevier and the Australian College of Midwives.

Declaration of Competing Interest

Authors declare that there was no actual or potential conflict of interest that could bias this work.

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At the time of submission of this manuscript all three organisations continue to offer the culturally tailored caseload model to women having a First Nations baby, and a growing number of First Nations midwives are working in the model.

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