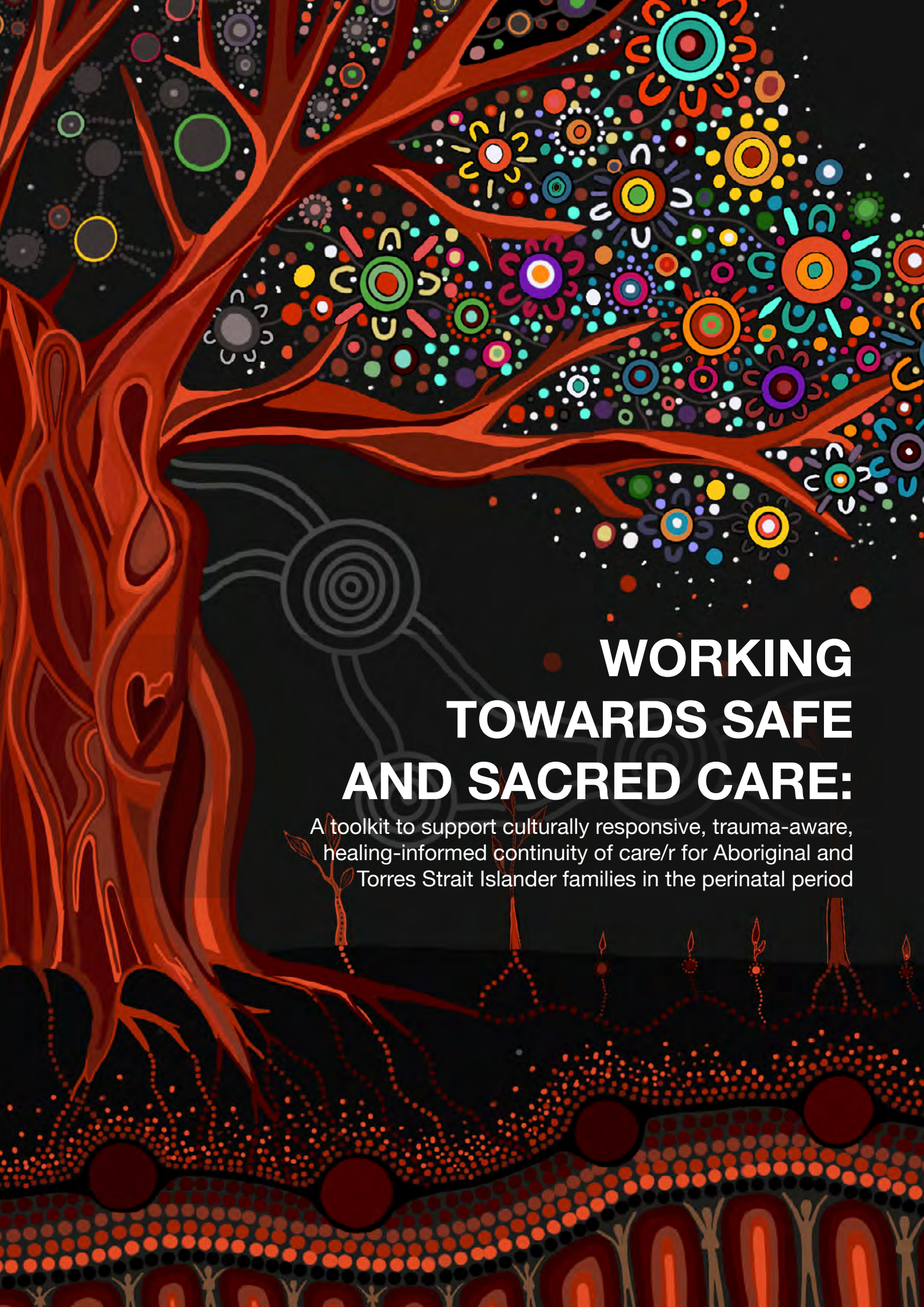

WORKING TOWARDS SAFE AND SACRED CARE:

A toolkit to support culturally responsive, trauma-aware, healing-informed continuity of care/r for Aboriginal and Torres Strait Islander families in the perinatal period

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Inquiries regarding this toolkit can be directed to:

Replanting the Birthing Trees

cacham@unimelb.edu.au

Replanting the Birthing Trees (cover artwork)

Valerie Ah Chee, 2022

This artwork represents the strength and resilience of Aboriginal and Torres Strait Islander people in respect to our birthing and parenting over the generations. The tree is strong and healthy and has strong roots that are embedded deeply in country, culture and family. The trunk is strong, sturdy and enduring and a family is represented here: pregnant mother, father and child supported by the roots and each person an integral part of community. In the top left corner, we start with communities, represented by circles that make up the foliage of the tree. This foliage starts out grey and muted with pops of colour representing our traditional knowledge, birth rites and practices emerging from trauma and hardship, knowledge that has always been there, but has been lying dormant until the time was right to emerge. As this foliage moves across to the right, it blooms with strength, health and colour and are connected to form a beautiful and vibrant canopy, supported by the sturdy trunk and ancient roots. This foliage drops seeds so that other trees, the saplings seen here, can grow and stand strong. The grey circles on the black background represent the birthing places all over this land, connecting us again to country. In the earth, the circles represent the continuing birthing women, from generation to generation, unbroken with the smaller circles above and below representing our knowledge and strength as energy, passed on from our grandmothers and is never ending. At the bottom of the picture are our ancestors, men and women, born from country and passing back into country, holding us up, protecting us and making us strong. In our lives we tap into this strength from our ancestors to keep us moving forward.

Storm Henry, Sophie Cullen, Jillian Donnelly, Jacqui Sundbery, Trish Ratajczak, Helen McLachlan, Della Forster, Paola Vasquez, Kate Reynolds, Philippa Reppington, Res McCalman, Susan Walker, Shakira Onwuka, Ellen McEvoy, Kimberley Jones, Claire Gallagher, Rhonda Marriott, Gina Bundle, Catherine Chamberlain

Design by Jordan Lovegrove, Karko Creations

Yalbilinya Miya photographs by Alicia Frail from OchreUp

Working towards safe and sacred care

CONTENTS

ACKNOWLEDGEMENT OF COUNTRY

The Replanting the Birthing Trees team and project partners acknowledge the Traditional Custodians of the unceded lands on which this toolkit was prepared and will be read. We pay our respects to Elders past and present. We pay our respects to Aboriginal and Torres Strait Islander peoples, Countries and knowledges.

We recognise that connection to Country, kin and community have been important to the health and wellbeing of Aboriginal and Torres Strait Islander families since time immemorial. Sacred birthing business and nurturing strong, healthy families are embedded in Aboriginal and Torres Strait Islander culture.

We acknowledge the right of Aboriginal and Torres Strait Islander families to equitable, accessible healthcare that respects Aboriginal ways of knowing, being and doing and enables communities to thrive.

We pay our respects and gratitude to the Aboriginal and Torres Strait Islander people who guided the development of this toolkit and who dedicate their work to delivering culturally responsive, trauma-aware and healing-informed continuity of care.

We recognise that improving care for Aboriginal and Torres Strait Islander families is the responsibility and work of everyone in the health system.

ACKNOWLEDGEMENTS

We thank the many contributors who shared their insights and enriched this toolkit.

With gratitude, we acknowledge Suzanne O'Shannessy, Tania Day, Zoe Bradfield, Barb Vernon, Melina Connors, Jennifer Fielding, Luke Hutchins, Jodi Knight, Amie Furlong, Terina Hegarty, Bridgette Kelly, Rebecca Radford, Kerryn Eccleston, Cristina Lochert and all those who offered feedback on toolkit content.

We also acknowledge the teams behind the featured case studies and materials, including Queensland Health, the Queensland Aboriginal and Islander Health Council and the International Association for Public Participation.

Particular thanks to the members of the Toolkit Workstream group for their contributions and oversight. Thanks to Alicia Frail, Ammie Howell and Valerie Ah Chee for their permission to reproduce their beautiful art. Thanks to Jordan Lovegrove for the design of this toolkit.

OVERVIEW OF THE TOOLKIT

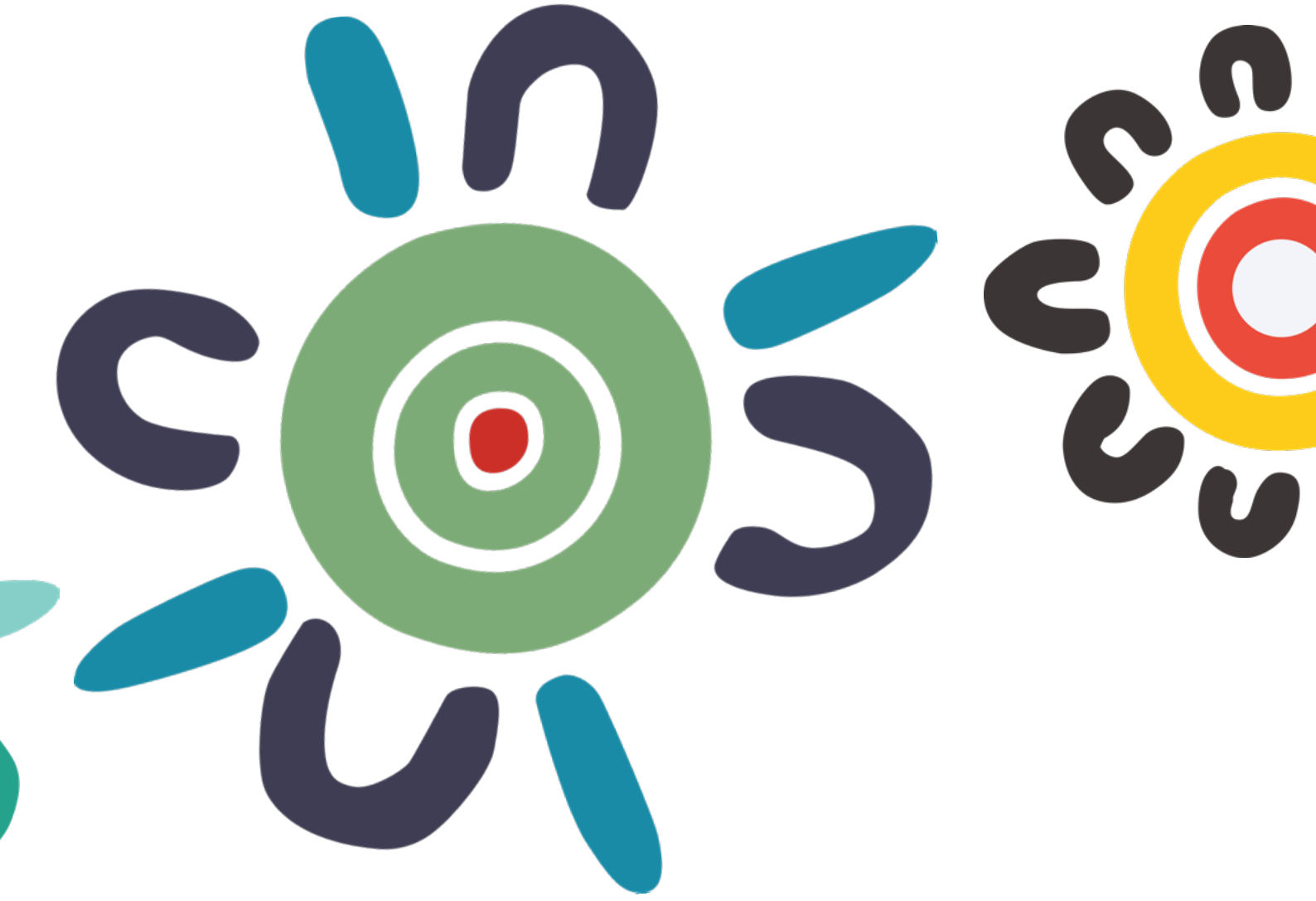
This toolkit is for clinicians, managers or project officers from maternity services that provide care for Aboriginal and Torres Strait Islander families. It is designed to help services to implement and improve **culturally responsive, trauma-aware, healing-informed continuity of care/r**, an approach that helps families offer children the best start in life, promote healing from trauma and reduce health inequities.[1-3]

The toolkit is part of the Replanting the Birthing Trees (RBT) project. Toolkit development was guided by a working group, pilot tests at maternity sites and findings from an RBT scoping review[4] of resources currently available to support culturally responsive, trauma-aware, healing-informed continuity of care/r. The toolkit describes the key pillars and processes that support positive perinatal health outcomes and experiences for Aboriginal and Torres Strait Islander families.

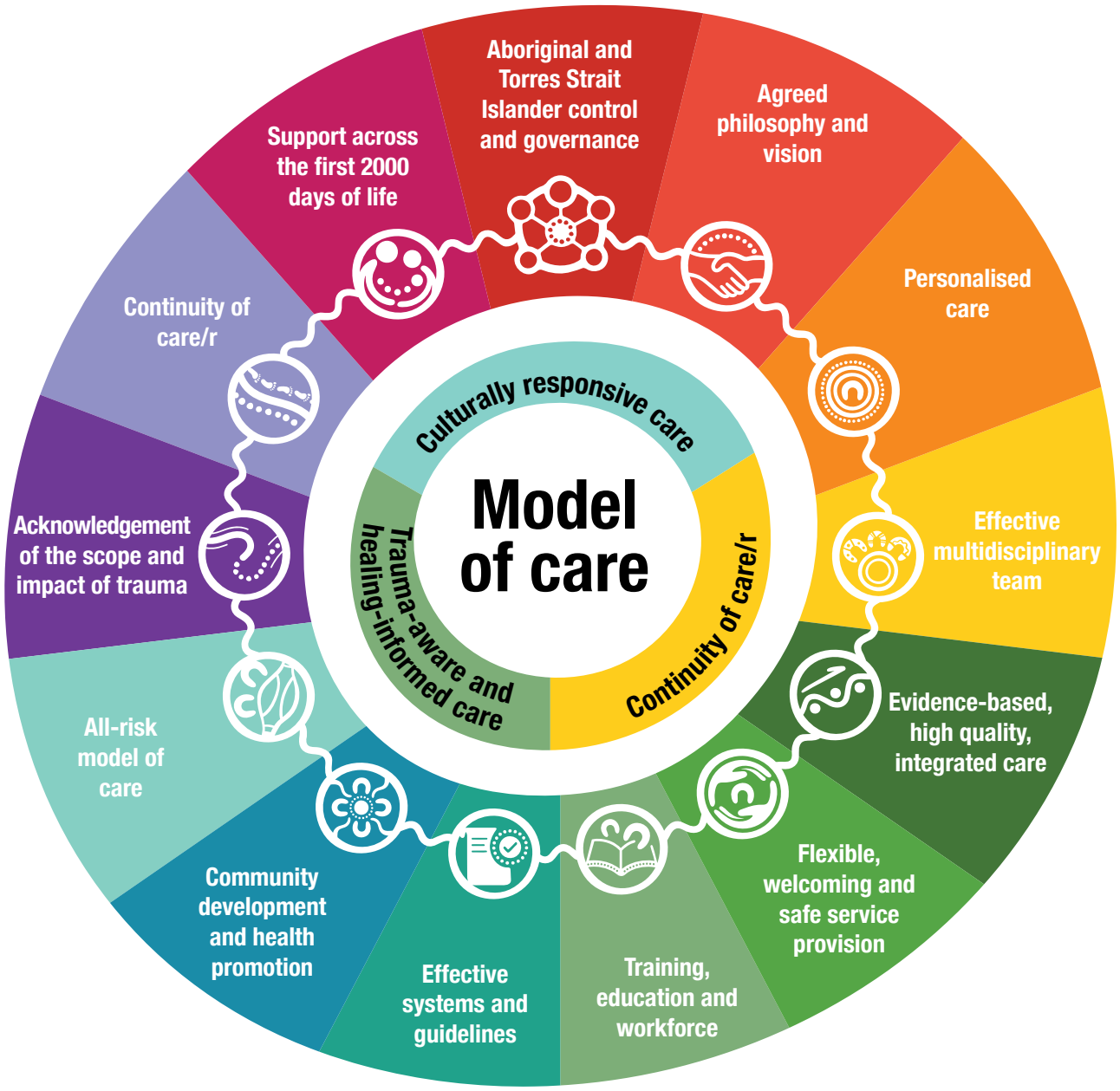
NSQHS Standards

Strengthening culturally responsive, trauma-aware, healing-informed continuity of care/r will help your service meet the National Safety and Quality Health Service (NSQHS) standards. We recommend exploring the NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health[5] alongside this toolkit.

Look out for the icons throughout this toolkit that represent the 'core components' identified in the RBT scoping review.[4] These core components of care support culturally responsive, trauma-aware, healing informed continuity of care/r and contribute to a program's effectiveness, so are important to keep in mind.



THE MODEL OF CARE




Aboriginal and Torres Strait Islander control and governance


Agreed philosophy and vision


Personalised care


Effective multidisciplinary team


Evidence-based, high quality, integrated care


Flexible, welcoming and safe service provision


Training, education and workforce


Effective systems and guidelines


Community development and health promotion


All-risk model of care


Acknowledgement of the scope and impact of trauma


Continuity of care/r


Support across the first 2000 days of life

HOW TO USE THIS TOOLKIT

This toolkit consists of three parts that explore the key concepts and processes underpinning culturally responsive, trauma-aware, healing-informed continuity of care/r.

This toolkit is not a prescriptive instruction manual. You can use it flexibly based on the context and needs of your service. You can use it alongside other toolkits or guidelines for continuity of care, Aboriginal and Torres Strait Islander health, maternity health or child health.

Key tip: Use the **Contents page to select** the sections, tools and case studies most relevant to your setting. Keep in mind that a holistic program requires equal attention to cultural responsiveness, trauma-aware, healing-informed care and continuity of care/r[4] and that these concepts are intertwined.

1. **Part 1** on page 9 sets the scene and covers important groundwork that will enable your service to strengthen care provision. Don't miss the **self-assessment tool** on page 9. It can help you identify some of strengths and gaps in your service's current programs and direct you to the sections of the toolkit you might like to read first. Don't miss the tips on **co-design** and Aboriginal and Torres Strait Islander **governance** on page 14.

2. **Part 2** on page 23 covers **three critical pillars** of care for Aboriginal and Torres Strait Islander families: culturally responsive care, trauma-aware and healing-informed care and continuity of care/r. Explore the case studies and the practice points for examples of actions your service can take.

3. **Part 3** on page 43 covers the **processes** for implementing or improving care. It includes tips on planning, implementation, monitoring and evaluation, sustainability and supporting staff.

4. The **Tools and Resources** section on page 57 features checklists and templates, as well as an index of all resources linked throughout the toolkit.

Look out for the icons throughout the toolkit representing the core components of care for Aboriginal and Torres Strait Islander families identified in the RBT scoping review.

If you see a box like this, it contains a **case study.** These are examples of existing care programs and partnerships from different settings.

If you see a box like this, it contains **practice points.** These are some possible practical steps that can be made at an individual, program and organisational level to strengthen culturally responsive, trauma-aware, healing-informed continuity of care/r.

If you see a box like this, it contains a **key action.** Like the practice points, these are also practical actions and strategies, but covered in more depth.

If you see a box like this, it links the topic to the National Safety and Quality Health Service Standards. This helps show the relevance of the concept or practice point at hand when it comes to delivering NSQHS actions and requirements.

If you see a box like this, it contains **tools and resources** specific to that section, including links to websites, training programs, reports and more.

A note on language

We use the terminology ‘Aboriginal and Torres Strait Islander.’
We acknowledge the vast array of Countries, cultures, communities, knowledges and histories that this encompasses.

For consistency, we use the terms ‘mother’ and ‘woman’ to refer to those giving birth. We recognise the diverse lived experiences and identities of birthing people, some of whom may not identify as women or mothers. We acknowledge that every family is unique and that there is diversity among caregivers, some of whom may not identify as biological parents.

For consistency, we refer to Aboriginal and Torres Strait Islander community controlled organisations as ACCOs and Aboriginal and Torres Strait Islander community controlled health organisations as ACCHOs. Different states and territories will have different names for these organisations (e.g. ATSICHSs).

We define the perinatal period as pregnancy, birth and up to one year after birth.

PART 1:
SETTING THE SCENE

PART 1: SETTING THE SCENE

This section provides background context for the toolkit, a practical checklist to help you start to think about areas you might want to address in your service and fundamental governance considerations.

1.1 BACKGROUND

Aboriginal and Torres Strait Islander families have nurtured the wellbeing of children and community for many thousands of years, supported by kinship networks, lore, cultural practice and connection to Country.[4-6] Aboriginal and Torres Strait Islander birthing and parenting knowledges have long contributed to good health across the whole lifespan.[7] This includes a holistic approach to spiritual, social and emotional wellbeing alongside physical health.[8]

Colonisation disrupted these sophisticated support systems with genocide, discrimination, policies of exclusion and the forced removal of Aboriginal and Torres Strait Islander children from their families and Country, known as the Stolen Generations.[8] Most Aboriginal and Torres Strait Islander women and babies experience healthy pregnancies and births. Being non-Indigenous, however, is linked with advantageous health outcomes. Non-Indigenous women and newborns are more likely to survive the perinatal period and are less likely to experience low birthweight or preterm birth.[9] Non-Indigenous children are less likely to be in out-of-home care.[10] Pregnancy, birth and the first 2000 days is a critical time for Closing the Gap in these health outcomes between Aboriginal and/or Torres Strait Islander and non-Indigenous Australians.

Aboriginal and Torres Strait Islander birthing and parenting knowledges and practices are alive and ongoing. These knowledges need to be incorporated into maternity services to improve cultural, spiritual, social and emotional care during pregnancy and birth, which will also improve health outcomes.

Perinatal care for Aboriginal and Torres Strait Islander families

Culturally responsive, trauma-aware and healing-informed continuity of care/r represents critical components of perinatal care for Aboriginal and Torres Strait Islander families. It supports families with offering the best possible start to life for their babies and can improve health outcomes.[11-13] This approach is conceptual and multi-thematic, meaning it can apply in different contexts, from tertiary metropolitan hospitals to rural clinics.

Why this care is important

Culturally responsive, trauma-aware, healing-informed continuity of care/r is important because it:

- Prioritises Aboriginal and Torres Strait Islander governance and ways of knowing, being and doing. It supports self-determination and reconciliation.
- Improves health outcomes for mothers and babies[11] and reduces rates of contact with Child Protection.[14]
- Can improve experiences of perinatal services, including a sense of cultural safety.[11,15-17]
- Is more cost effective for health services than standard care, in part due to reduced preterm births and complications.[13]
- Supports progress towards targets of Closing the Gap,[18] such as increasing the proportion of Aboriginal and Torres Strait Islander babies with a healthy birthweight (Target 2) and reducing the overrepresentation of Aboriginal and Torres Strait Islander children in out of home care (Target 12).
- Aligns with the National Safety and Quality Health Service Standards (NSQHS Standards),[19] including those outlined in the NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health.[3]
- Aligns with national and state-based health strategies and policies, which advocate for Aboriginal governance, person-centred care and continuity of care/r.[20-22]
- Recognises the importance of the perinatal period, which provides a unique opportunity to interrupt intergenerational trauma cycles and promote healing.[1,23]
- Supports optimal health across the first 2000 days of life, which bolsters cognitive development and lifelong wellbeing.[23-25] It supports a seamless transition from perinatal services to child and family services.

1.2 SELF-ASSESSMENT TOOL

This self-assessment tool can guide how you read the toolkit and apply suggested strategies in your service. The tool is designed to prompt reflection and discussion. It is not a comprehensive evaluation. It might help you find key areas that could be strengthened in your service. Once you have identified these areas, you can turn to the relevant section in the toolkit for further information.

1. Answer 'Yes,' 'No' or 'Partially' to the prompts.
2. Give an example of actions your service is taking in each area to see if more can be done.
3. Complete the questionnaire collaboratively with your colleagues, with input from Aboriginal and Torres Strait Islander community representatives and staff. Check the Cultural Responsiveness section in Section 2.1, page 23 for guidance on how to conduct collaboration responsibly.

What does cultural responsiveness look like in your service?

While services can aim to be responsive to cultural needs and respectful of culture difference, only Aboriginal and Torres Strait Islander families and staff can decide if a service feels culturally safe.

1. Does your service have an Aboriginal and Torres Strait Islander steering or advisory committee?

Yes, No, Partially	Example of Action

2. Does your service have formal partnerships (such as Memoranda of Understanding) with local Aboriginal health services or community controlled organisations (e.g. to facilitate shared care)?

Yes, No, Partially	Example of Action

3. Does your service have a Reconciliation Action Plan?

Yes, No, Partially	Example of Action

4. Does your service have an accessible feedback mechanism for Aboriginal and Torres Strait Islander families to use?

Yes, No, Partially	Example of Action

5. Does your service have clear processes for identifying and recording when mothers and children (including unborn babies) identify as Aboriginal and/or Torres Strait Islander?

Yes, No, Partially	Example of Action

6. Does your service have an Aboriginal and Torres Strait Islander employment strategy?

- Does it include student, recent graduate and/or early career pathways for an Aboriginal and Torres Strait Islander workforce?

Yes, No, Partially	Example of Action

7. Are all Aboriginal and Torres Strait Islander families offered engagement with an Aboriginal and/or Torres Strait Islander staff member, such as an Aboriginal Hospital Liaison Officer (AHLO)?

Yes, No, Partially	Example of Action

8. Does your service have specific education and training for all staff that provides skills and knowledge about cultural safety and anti-racism?

- Is this mandatory for all staff?
- Is this training ongoing/repeated?
- Is this training co-designed, delivered or evaluated by Aboriginal and Torres Strait Islander community representatives?
- Do you track and report rates of training completion?
- Do you evaluate the effectiveness of the training?

Yes, No, Partially	Example of Action

9. Do staff (Aboriginal and Torres Strait Islander staff and non-Indigenous staff) working with Aboriginal and Torres Strait Islander families receive regular cultural supervision*?

Yes, No, Partially	Example of Action

10. Have your physical spaces been designed in collaboration with Aboriginal and Torres Strait Islander community members and practitioners to ensure they are welcoming for Aboriginal and Torres Strait Islander families?

Yes, No, Partially	Example of Action

11. Does your service welcome and encourage extended family and community members to attend and support families? (For example, you have flexible visitor policies allowing multiple family members in a birthing room for labour support).

Yes, No, Partially	Example of Action

12. Does your service have strong referral pathways to Aboriginal and Torres Strait Islander social and emotional wellbeing services, such as those led by community controlled organisations?

Yes, No, Partially	Example of Action

To learn more about how to strengthen your service, see the section on Culturally Responsive Care on Section 2.1, page 23

*See page 52 to read about cultural supervision and its value for Aboriginal and Torres Strait Islander and non-Indigenous practitioners.

What does trauma-aware, healing-informed care look like in your service?

1.Does your service have specific education and training for all staff that provides skills and knowledge about trauma-aware, healing-informed care for Aboriginal and Torres Strait Islander families?

- Is this mandatory for all staff?
- Is this training ongoing/repeated?
- Is this training co-designed, delivered or evaluated by Aboriginal and Torres Strait Islander community representatives?
- Do you track and report rates of training completion?
- Do you evaluate the effectiveness of the training?

Yes, No, Partially	Example of Action

2. Does your service use culturally responsive tools to guide sensitive enquiry (e.g. tools validated for use with Aboriginal and Torres Strait Islander populations)?

Yes, No, Partially	Example of Action

3. Where there are child protection concerns, does your service provide preventative care in line with the Aboriginal and Torres Strait Islander Child Placement Principle?[26]

Yes, No, Partially	Example of Action

To learn more about how to strengthen your service, see the section on Trauma-aware, Healing-informed Care on section 2.2, page 29

What does continuity of care/r look like for Aboriginal and Torres Strait Islander families in your service?

1. Does your service offer a dedicated continuity of care/r program (e.g. Midwifery Group Practice (MGP)) for Aboriginal and Torres Strait Islander families? If this is not possible, does your service offer a continuity of care/r program that prioritise Aboriginal and Torres Strait Islander families?

Yes, No, Partially	Example of Action

2. Does your service offer Aboriginal and Torres Strait Islander families a choice of their preferred program or care provider from a range of options? For example:

- Aboriginal-specific MGP
- Standard MGP
- Shared/combined care with GP or private obstetrician
- Shared/combined care with Aboriginal Community Controlled Health Organisation (ACCHO)
- Other

Yes, No, Partially	Example of Action

3. Does your service offer Aboriginal and Torres Strait Islander families antenatal and postnatal visits in the home, in the community or through other outreach options?

Yes, No, Partially	Example of Action

4. Do your service's funding and recruitment plans support a sustainable continuity of care/r model?

Yes, No, Partially	Example of Action

5. Does your continuity of care/r program have dedicated practitioners from diverse disciplines?

This might include midwife, Obstetrics Consultant and/or Senior Registrar, Neonatology Consultant and/or Senior Registrar, social worker, mental health practitioner and an Aboriginal Health Worker/Practitioner, Aboriginal Hospital Liaison Officer or care navigator. It may include clinicians from other specialist areas, such as diabetes educator, physiotherapist or dietician.

Yes, No, Partially	Example of Action

6. Does your service have clear guidelines for staff about referring families to external services? These may include housing, mental health, domestic and family violence, legal support and other health and psychosocial services.

Yes, No, Partially	Example of Action

7. Does your service partner with local Aboriginal community controlled health organisations to offer shared maternity care and/or transition of care to maternity and child services beyond six weeks postpartum?

- Is this partnership supported by a mechanism for safely transferring patient information, such as shared information systems or a 'Care Navigator'?

Yes, No, Partially	Example of Action

8. Are all Aboriginal and Torres Strait Islander families able to access your continuity of care/r program, regardless of perceived risk status? This encompasses obstetric and psychosocial complexities.

Yes, No, Partially	Example of Action

To learn more about how to strengthen your service, see the section on Continuity of Care/r on section 2.3, p35.

In addition to the self-assessment tools provided here, you may choose to undertake a comprehensive audit of cultural safety in your service, such as the Cultural Safety Audit Tool for Organisations from the Lowitja Institute.

1.3 GOVERNANCE, COMMUNITY CONTROL AND CO-DESIGN

Before you begin planning any improvements in care for Aboriginal and Torres Strait Islander families, you must reflect on how your service embeds Aboriginal and Torres Strait Islander governance and control. Governance is the foundation beneath the pillars and processes that will be outlined in Parts 2 and 3. It is important to reinforce this foundation if you want to deliver culturally responsive, trauma-aware, healing-informed continuity of care/r for Aboriginal and Torres Strait Islander families.

Aboriginal and Torres Strait Islander governance places services for Aboriginal and Torres Strait Islander peoples in their community and within their control. This self-determination underpins the Closing the Gap agreement and the understanding that better health outcomes are achieved when Aboriginal and Torres Strait Islander people have a genuine say in the design and delivery of programs and services that affect them. A maternity service might co-design its perinatal care program with community members, set up partnerships with ACCOs, set up feedback mechanisms, or recruit for Aboriginal and Torres Strait Islander leadership roles.

- **Governance:** how a group of people or a system is organised in terms of decision-making, ethics, administration, accountability, achieving objectives and sharing power and responsibility.[27,28] Aboriginal and Torres Strait Islander groups have practised governance for thousands of years, driven by beliefs and relationships embedded in culture. Explore the Australian Indigenous Governance Institute for more information.
- **Co-design:** when health programs targeting a community are collaboratively developed, implemented and evaluated with that community.[29] Co-design is different from consultation, as it requires active community participation, decision-making and leadership at every step.[30]
- **Community:** An Aboriginal and Torres Strait Islander family may belong to or identify with more than one community. Connection to community, family, Elders and kinship networks underpins Aboriginal and Torres Strait Islander identity and greatly impacts health and wellbeing.[6,31] In this toolkit, 'community' is typically used to describe the local Aboriginal and Torres Strait Islander community who might interact with your service, including families, Elders, leaders and representatives.

NSQHS Standards

Co-design principles align closely with NSQHS standard for Partnering with Consumers, which calls for services to partner with users in health service design, evaluation and governance. Action 2.13 relates to partnering with Aboriginal and Torres Strait Islander communities in healthcare delivery.

You may refer to the NSQHS Standards: User Guide for Aboriginal and Torres Strait Islander Health.[3]

The IAP2 Participation Spectrum

This spectrum from the International Association for Public Participation shows a scale of increasing engagement with stakeholders. You could place community control in the 'Empower' category.

CO-DESIGN

COMMUNITY PARTICIPATION GOAL	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
	To provide the **community** with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.	To obtain **community** feedback on analysis, alternatives and/or decisions.	To work directly with the **community** throughout the process to ensure that **community** concerns, aspirations and **Aboriginal ways of knowing, being and doing** are consistently understood and	To partner with the **community** in each aspect of the decision including the development of alternatives and the identification of the preferred solution.	To place final decision making in the hands of the **community**.
PROMISE TO THE COMMUNITY	We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how community input influenced the decision.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how community input influenced the decision.	We will look to you for advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible	We will implement what you decide.

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This work was created with contributions from Lewis Michaelson, Martha Rozelle, and Doug Sarno.
www.iap2.org.

Types of partnering arrangements

There are different ways for a health service to form agreements with a community controlled organisation or external service. The type of agreement can guide how partners share resources, information, personnel and spaces. Read about Waminda's partnership with Illawarra Shoalhaven Health District on page 18.

Queensland's Aboriginal and Torres Strait Islander Health Equity Toolkit[32] outlines some possible partnering arrangements in this table:

	Letter of Intent	Memoranda of Understanding	Unincorporated joint venture	Incorporated venture (Partnership)
Coverage	Scope of the agreement is dependent on the parameters of the collaboration sought with the partnering organisation or service.	Scope of the agreement is dependent on the parameters of the collaboration sought with the partnering organisation or service.	Both parties are bound to fulfil whatever obligations are written in the joint venture contract.	The partnership creates a separate legal service made up of the two parties. Services have a responsibility to perform the duties and obligations as described in the partnership agreement, and are also expected to exercise their rights and powers in good faith to benefit the partnership.
Obligations	You have within reason attempted to engage all of the prescribed persons subcommittee, clearly explained your need and the expectations of the prescribed persons.	Your obligation is to set out what has been agreed upon with the partnering party.	Obligations are set out in terms of the partnership agreement and also arise through general (common law) obligations.	As an incorporated joint venture, parties are likely to be members of the joint venture company and have broader obligations as members than those outlined in the contract.
Legality	Not likely to be legally binding	Not likely to be legally binding	Legally binding document	Legally binding document
Intent	Where parties wish to show willingness and intent to collaborate.	Where the two parties are separate organisations, but have agreed to work collaboratively together.	Where the two parties are separate services, but now are also part of a joint venture together. Both parties commit resources and take on risk and a joint venture is agreed.	Where two parties are jointly and separately liable for expenses of the partnership.
Example	A maternity service might write a letter of intent to start engaging with their local ACCO.	A maternity service and ACCO might agree to work together to achieve certain outcomes.	A health service may provide workforce to a community organisation that offers an existing service.	Two health services may lease a property together and commit their separate resources to offer co-located service provision in-community.

Adapted from the Queensland Aboriginal and Torres Strait Islander Health Equity Toolkit. (October 2021, page 30), by Queensland Health and the Queensland Aboriginal and Islander Health Council (https://www.health.qld.gov.au/__data/assets/pdf_file/0018/1121382/health-equity-toolkit.pdf).

Practice points

- Involve Aboriginal and Torres Strait Islander staff and/or community representatives in quality improvement activities, including presenting de-identified data and developing a culturally responsive feedback mechanism specifically for Aboriginal and Torres Strait Islander families.[33] Review all feedback and enact it where appropriate.
- Establish an Aboriginal and Torres Strait Islander advisory committee that meets regularly to oversee programs for Aboriginal and Torres Strait Islander families. The committee should remain in place during service delivery (not just in planning phases) even as committee membership changes over time.
- Connect with community representatives such as Aboriginal Hospital Liaison Officer (AHLO) teams, ACCHOs, local community groups and Land Councils.[21] An individual does not necessarily speak for a whole community; engage with a variety of representatives and groups.[34]
- Develop a partnership arrangement with your local ACCOs to help with the sharing of spaces, resources and staff.[32] Consult legal advice to ensure the agreement is not legally binding unless this is what you decide. Set an end date to revise the agreement.
- Allocate resources, time and staff to the co-design process and to maintaining partnerships. Compensate community members for their expertise and for time spent travelling and attending meetings.

Tools and resources

- Building Respectful Partnerships, Victorian Aboriginal Child Care Agency
- Co-design toolkit, NSW Government Agency for Clinical Innovation
- Health Equity Toolkit, Queensland Health
- IAP2 Public Participation Spectrum, International Association for Public Participation
- Indigenous Governance Toolkit, Australian Indigenous Governance Institute
- Individual Self-Reflection and Organisational Readiness Assessment for co-design, NSW Health Agency

CASE STUDY: Waminda, NSW

Waminda South Coast Women's Health and Wellbeing Aboriginal Corporation is a culturally responsive, wraparound service led by local Aboriginal women for the Aboriginal and Torres Strait Islander families in the Illawarra/Shoalhaven region. Its model is the first in Australia to offer privately endorsed midwives who can support births of Aboriginal and Torres Strait Islander babies in a public hospital.

Waminda's Model of Care is embedded in Aboriginal ways of being, knowing and doing through the Cultural Framework which creates culturally safe programs and services to deliver to community on their healing journey. To support the Cultural Framework, the organisation developed the Balaang Healing Framework and Staff Wellbeing Framework. These frameworks create the foundation and structure to deliver a decolonising practice to push back on systemic racism.

The main areas in which Waminda provides programs are:

- Health, Wellbeing and Primary Health Care - clinics, allied health, Dead or Deadly, youth programs for young women and young men
- Family and Community Client Services - case management, counselling, DV/FDV/SHLV, Justice Health, Drug and Alcohol, Mental Health, Balaang Gunyah, Preservation and Restoration, Men's Behavioural Change
- Birthing On Country and Maternity Services - Midwifery Group Practice, Child Health from 0-3
- Cultural Programs - Ceremonies, Language, gatherings
- Education, Employments and Social Enterprises - Traditional garden, Blak Cede Cafe/Catering, Decolonisation Workshops

Waminda initially delivered antenatal and postnatal care to women who were having an Aboriginal baby, with two midwives employed in the maternity services program. Listening to community need for local women to birth their babies in a safe space free of racism started Waminda's journey of lobbying to build, own and operate its own Birthing Centre. After eight years of lobbying, Waminda secured funding to build and operate the Birth Centre and to establish the Birthing on Country Midwifery Group Practice (MGP). The Birthing on Country (BOC) program employs Endorsed Midwives who privately practice to deliver Aboriginal babies within the local public hospital. Waminda created a partnership with the Illawarra Shoalhaven Health District to collaborate and endorse the MGP to be credentialled within the hospital. BOC creates optimal continuity of care from antenatal and intrapartum care to postnatal care, wrapping around the baby and the mum. The Birthing Centre will be built and operational by mid-2026 so mothers can give birth away from mainstream hospitals surrounded by culture and ceremony.

Waminda also secured funding to build and operate a Refuge for Aboriginal Women and Children, which will be operational by end of 2025, and an Aboriginal women and families Rehabilitation Centre which will be operational by 2027.

Courtesy of Cleone Wellington and Waminda South Coast Women's Health and Wellbeing Aboriginal Corporation

Take note of how Waminda gradually scaled up their continuity of care/r approach from an antenatal/ postnatal only arrangement to an independent, community controlled birthing centre. If you are a hospital-based maternity service, take note of the partnership agreement between Waminda and Illawarra Shoalhaven Health District allowing credentialled Waminda midwives to provide hospital-based care.

PART 2:

PILLARS OF CARE

PART 2: PILLARS OF CARE

2.1 CULTURALLY RESPONSIVE CARE

What is culturally responsive care?

An approach to healthcare delivery that is respectful, equitable and empowers individuals to actively take part in their own care.[35]

It acknowledges that connection to culture promotes social, emotional and physical wellbeing and healing.[8] It is free from racism and discrimination. It considers diverse experiences, requirements and expressions of culture and is delivered in an environment that is welcoming and flexible. Culturally responsive care should be guided by Aboriginal and Torres Strait Islander leadership and governance.[36]

While services can aim to be *responsive* to cultural needs and respectful of culture difference, only Aboriginal and Torres Strait Islander families and staff can decide if a service feels *culturally safe* to them.[35]

Definitions

- **Equity:** recognises equal rights to good care by acknowledging that patients experience different barriers to access and participation, and by modifying the support provided according to need.

Features of culturally responsive care[2]:

- Aboriginal and Torres Strait Islander governance and leadership, including partnership with Aboriginal and Torres Strait Islander community controlled health organisations (ACCHOs). See section 1.3, p16.
- A dedicated program specifically for Aboriginal and Torres Strait Islander families.
- Welcoming and accessible design of physical spaces that considers factors such as privacy, lighting and freedom of movement. See tool on page 53.
- Provision of compassionate, personalised care that gives families choice based on their individual needs, strengths and preferences.
- Recognition of Aboriginal and Torres Strait Islander pregnancy, birthing and parenting practices, including respect for unique cultural practices.

Birthing on Country and RISE Framework

'Birthing on Country' is "*a metaphor for the best start in life for Aboriginal and Torres Strait Islander babies and their families, an appropriate transition to motherhood and parenting for women and an integrated, holistic and culturally appropriate model of care for all.*"[37]

Birthing on Country embodies culturally responsive birthing services by ensuring these services are designed with and for Aboriginal and Torres Strait Islander families.[38]

The RISE Framework[39] supports the implementation of a Birthing on Country approach. Recommendations are available on how to progress along a continuum towards this goal. There are four key pillars to drive reform:

- **R**edesign the health service
- **I**nvest in the workforce
- **S**trengthen families
- **E**mbed Aboriginal and Torres Strait Islander community governance and control

NSQHS Standards

Providing responsive care for Aboriginal and Torres Strait Islander families relates to Action 1.2, about addressing health needs of Aboriginal and Torres Strait Islander populations. Action 1.33 defines a welcoming environment as one that recognises the importance of culture for Aboriginal and Torres Strait Islander people.

You may refer to the NSQHS Standards: User Guide for Aboriginal and Torres Strait Islander Health.[5]

Practice points

Here are possible ways to approach culturally responsive care [6,21,34,40-42]:

Individual Practice Points

- Greet Aboriginal and Torres Strait Islander families warmly when they enter your service. Introduce yourself and share something about you. Demonstrate compassion and respect. See Clinical Yarning Tips on page 58.
- Be proactive in establishing positive professional relationships with Aboriginal and Torres Strait Islander colleagues. If you are in a hospital, for example, ensure that you know the AHLOs. See the Ahpra fact sheet on Working with Aboriginal and Torres Strait Islander Health Practitioners.[43] Listen to Aboriginal and Torres Strait Islander colleagues' assessments and worldviews in meetings.
- Follow local ACCOs on social media to stay up to date with events. Attend community events that celebrate the resilience of Aboriginal and Torres Strait Islander peoples (e.g. NAIDOC Week, Children's Day celebrations).
- Reflect on how you can help people in your care feel safe and respected. You might use a self-audit tool such as the Lowitja Institute Cultural Safety Audit Tool for individuals.
- Ask families if you can support them with any cultural practices, such as Welcome Baby to Country ceremonies. It may be inappropriate for you to participate in a specific cultural practice if you are non-Indigenous, but you could connect families to the right supports (e.g. AHLO or Aboriginal Health Worker/Practitioner) and liaise with health service staff. Cultural practice varies greatly from family to family. Not all families will necessarily want or need this support. Offering the option is important , but avoid making assumptions.
- Refer families to specific Aboriginal and Torres Strait Islander-developed resources (e.g. iSISTAQUIT for smoking cessation, SMS4DeadlyDads for support for fathers, 13YARN crisis support line, Replanting the Birthing Trees Resource Hub).
- Read through the SNAICC Working and Walking Together[6] resource. It has detailed information about culturally responsive communication and cultural protocols.

For more detail about cultural responsiveness and cultural safety, including the impact of cultural safety training and elements of good practice, review the Lowitja Institute's Cultural Safety in Australia discussion paper.

Program Practice Points

- Prioritise a dedicated continuity of care/r program tailored to Aboriginal and Torres Strait Islander families. Choice is incredibly important. Ensure families are offered a choice of program/model of care, including the option for shared care with community controlled maternity programs where possible.
- Dedicate the first months of a new program to building relationships and trust before launching.[2]
- Consider appointment flexibility by hosting drop-in clinics or offering telehealth and outreach appointments.
- Provide the workforce with access to cultural resources that support culturally responsive conversations, such as the Replanting the Birthing Trees Resource Hub.
- Display visual signs of respect for culture to create a welcoming environment.[44] For example, display the Aboriginal and Torres Strait Islander flags and engage local Aboriginal and/or Torres Strait Islander artists to create art for waiting rooms, brochures and posters. Ensure you adhere to Indigenous Cultural and Intellectual Property requirements and compensate artists for their work.
- Consider equipping your birth suite with a co-designed 'trolley' or 'kit' containing cultural items and supports to use during labour and birth,[45] such as Aboriginal-designed wraps.
- Collaborate with community groups and ACCOs to develop culturally responsive health promotion materials (e.g. brochures, posters etc.).

Organisation Practice Points

- Establish clinics in the community. These might be hosted in spaces connected to the local ACCO, to then allow for co-location and shared care during and beyond the postnatal period.
- Commit to the recruitment and wellbeing of an AHLO or AHW/AHP team of suitable size to manage the number of families engaging with your service. Ensure all staff are aware of how to connect families to AHLOs.
- Account for colonial/cultural load (page 24) in Aboriginal and Torres Strait Islander staff workload management.
- Facilitate regular supervision and professional development opportunities for staff.
- Consider flexible visitor policies to allow for extended family and community support.
- Design infrastructure to ensure all spaces are flexible, safe and welcoming[44] (page 53). Service-based clinical care should be located close to the entrance or outside of the main hospital building in a homely and culturally welcoming space.
- Implement or update your Reconciliation Action Plan (RAP). A RAP for non-Indigenous organisations can embed reconciliation in existing structures.[46] It can support systems to be more inclusive and accessible.
- Ensure staff regularly complete training in inclusivity, cultural safety and anti-racism.[47] Consider joint training for staff at your service and at local community controlled organisations to strengthen partnerships.
- Invite local community members, organisations and peak bodies to your health service events. Attend and help at community events (you could host a stall).

KEY ACTION: safe identification of Aboriginal and Torres Strait Islander families[3,48]

Correctly and safely identifying Aboriginal and Torres Strait Islander people is required of all health services. Everyone has the right to self-report their Indigenous status,[48] which should never be assumed. Consistently collecting this status will help connect families with proper supports (such as AHLOs) and support monitoring and evaluation.

Here are some quick tips:

- Give families the opportunity to identify their baby as Aboriginal and/or Torres Strait Islander.
- Aboriginal and Torres Strait Islander people will be more likely to identify if it feels safe to do so; ensure a welcoming environment and respectful interaction.
- Ensure all staff are trained to respectfully collect identification information.
- Ensure all staff are aware of next steps if a family identifies as Aboriginal and/or Torres Strait Islander (e.g. offering connection with an AHLO; correctly reporting in all required information platforms).
- Include space for Indigenous status on your referral forms or documentation.
- Develop documentation systems that minimise opportunity for errors in recording.[49]
- Families also have the right not to identify, which must be respected.

NSQHS Standards

The NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health emphasises safe identification of Aboriginal and Torres Strait Islander families (Action 5.8) as one of six key actions that support the health rights and needs of Aboriginal and Torres Strait people. It suggests developing policies and procedures to ensure consistent and increased identification, such as a review of patient intake protocol and workforce training. The User Guide has strategies for Action 5.8.

KEY ACTION for non-Indigenous practitioners: consider colonial load and consultation fatigue

Be conscious of the colonial load that Aboriginal and Torres Strait Islander colleagues might bear. This load can come from added, unpaid responsibilities or expectations placed on community representatives, such as the responsibility to educate non-Indigenous colleagues or offer cultural supervision. You might have heard this referred to before as 'cultural load.' Weenthunga Health Network instead uses 'colonial load' as a reminder that this burden is placed on Aboriginal and Torres Strait Islander practitioners by mainstream or colonial institutions. Weenthunga differentiates 'colonial load' from 'cultural responsibility' to family and community.

This load also applies to organisations. Aboriginal community controlled organisations like ACCHOs often provide wide-ranging, holistic services to a large population and may receive numerous requests to provide unpaid cultural input. It is important to respect the position and influence of these organisations in their communities, while also respecting 'consultation fatigue.'[16] Australia's colonial history of exploiting Aboriginal and Torres Strait Islander knowledge and data can understandably contribute to hesitation to form new partnerships or provide input. This reluctance might be stronger when it comes to institutions such as hospitals[50] that have historically been complicit in violence, racism and child removal.

Tools and resources

Featured tools:

- Checklist for creating flexible, safe and welcoming clinical spaces on page 53
- Checklist for facilitating culturally responsive events on page 58

Additional tools:

- Aboriginal Cultural Inclusion Checklist for Maternity Services, NSW Health
- Aboriginal and Torres Strait Islander Cultural Protocols in Victoria. MCRI Guide for Researchers, Murdoch Children's Research Institute
- Cultural responsiveness checking tool for services and programs, Yulang Indigenous Evaluation and University of Technology Sydney
- Cultural Safety Audit Tool for individuals, Lowitja Institute
- Cultural Safety in Australia Discussion Paper, Lowitja Institute
- Replanting the Birthing Trees Resource Hub, RBT Project
- RISE Framework, Kildea et al.
- Tips for establishing a culturally safe environment for Aboriginal children and young people, Commission for Children and Young People
- Working and Walking Together, SNAICC
- Working with Aboriginal and Torres Strait Islander Health Practitioners, Australian Health Practitioner Regulation Agency
- iSISTAQUIT
- SMS4DeadlyDads
- 13YARN

CASE STUDY: Baby One, QLD

The Baby One Indigenous Health Worker-led program provides care for families in Cape York.

'Baby One' is a term used by families in the Cape York region to refer to a new baby or youngest child. A family visiting program of the same name was developed and is led by the community controlled Apunipima Cape York Health Council for Aboriginal and Torres Strait Islander families in remote Cape York communities.

Through Baby One, Aboriginal Health Workers are supported by midwives and maternal and child health nurses to provide health education to families throughout pregnancy and the first 1000 days of life. The AHWs offer families fifteen visits in a time and place of their choice,[51] which is typically at home or outside of the hospital setting. Visits align with the clinical schedule and child health milestones to facilitate a strong partnership between health workers and midwives or maternal and child health nurses.

Across the visits, families are provided with seven 'baby baskets' with clothing, Pēpi Pod Program portable sleep spaces, recipe books, information sheets and more. Yarning activities led by the health worker during visits cover many topics, including sexual health, gestational diabetes, breastfeeding, immunisations, domestic and family violence, father's health, sun protection and normal child development.

The program seeks to involve the whole family. When Baby One launched in July 2014, every single family who was invited participated in the program.[51] The Indigenous-led program continues to provide care for families in Cape York.

If you are a mainstream maternity service, you might partner with a program like Baby One to ensure seamless transition to community-based child and family health services after discharge, for example.

CASE STUDY: Birthing in our Community, QLD

Birthing in Our Community (BiOC) is a continuity of care model that applies Birthing on Country principles. See page 23 for more information on Birthing on Country.

One example of BiOC is operating as a partnership between the Institute for Urban Indigenous Health (IUIH) and the Mater Hospital in Brisbane.

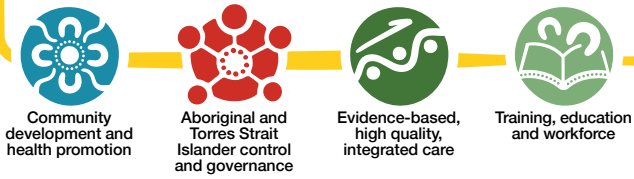
The BiOC model reflects many aspects of culturally responsive, trauma aware and healing informed continuity of care introduced in this toolkit, including Midwifery Group Practice. A named midwife follows Aboriginal and Torres Strait Islander families through pregnancy until six weeks post-birth, in partnership with Indigenous family support workers. Care is available 24-hours per day and can be delivered at home, at the hospital or at a community-based hub. It can incorporate transport, childcare, social work and mental health support.

Each BiOC model is governed by a Steering Committee with Aboriginal and Torres Strait Islander leadership.[52] The Mater model is a joint initiative between the Mater, the Institute for Urban Indigenous Health and the Aboriginal and Torres Strait Islander Community Health Service Brisbane. It features cadetships, placements and career support for Aboriginal and/or Torres Strait Islander midwives. These strong partnerships and governance structures ensure the program's sustainability.

Extensive evaluation was conducted to assess and improve the model through the Indigenous Birthing in an Urban Setting study from 2014 to 2019. The study found that BiOC successfully reduced preterm birth[53] and engagement with Child Protection services[14] among Aboriginal families, when compared with standard care.

The BiOC program at the Mater combines federal and hospital funding. Other BiOC programs exist as partnerships with public hospitals and the IUIH or private midwives and the IUIH.

You might consider how BiOC used caseload midwifery, community leadership and succession planning to deliver their outcomes, as well as partnership between private, community controlled and hospital sectors to fund and sustain the model of care.



2.2 TRAUMA-AWARE, HEALING-INFORMED CARE

What is trauma-aware, healing-informed care?

Strengths-based care that acknowledges the impact of trauma among Aboriginal and Torres Strait Islander communities.[54,55]

It recognises that trauma is context- and culture-dependent. You might be more familiar with the term 'trauma-informed'. Guided by the Healing Foundation[56] and the National Aboriginal and Torres Strait Islander Health Plan,[20] 'trauma-aware and healing-informed' has been used in this toolkit to emphasise a strengths-based, person-centred approach. For Aboriginal and Torres Strait Islander families, social and emotional wellbeing and healing are underpinned by connection to culture, family, community and Country, and by safe, respectful frameworks that allow autonomy and choice.[57]
A trauma-aware, healing-informed service will also acknowledge the impact of vicarious trauma on the staff providing care. See page 51.

Definitions

- **Safe care:** personalised care that meets physical, social, emotional and cultural needs without causing harm or re-traumatisation.
- **Strengths-based:** focuses on the positive, protective factors and existing assets available to a family to promote healing, rather than on deficits. Culture and community, including family networks or kinship structures, are sources of strength for Aboriginal and Torres Strait Islander families.[6] Comparison with non-Indigenous populations can highlight deficits and ignore the impacts of racism and other social determinants of health on outcomes.[58]
- **Social and emotional wellbeing (SEWB):** a holistic approach to health and wellbeing. It encompasses what non-Indigenous patients and practitioners might understand as mental health, but is broader than this. For Aboriginal and Torres Strait Islander families, SEWB can be understood as:

  The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing[59] defines the guiding principles of providing SEWB-based healthcare as:

  - health as holistic,
  - self-determination,
  - cultural responsiveness,
  - the impact of history on trauma,
  - human rights,
  - impacts of racism,
  - centrality of family and kinship,
  - diversity of Aboriginal and Torres Strait Islander identities and experiences and
  - strengths-based approach.
- **Trauma and intergenerational trauma:** Trauma refers to an emotional response to a distressing experience that overwhelms a person's ability to cope. Intergenerational trauma is the transmission of effects of trauma experienced by previous generations. Aboriginal and Torres Strait Islander people experience higher rates of trauma than non-Indigenous Australians, which is a result of dispossession, racism, institutionalised violence and the forced removal of children (known as the Stolen Generations).

Features of trauma-aware, healing-informed care:

- Staff training in understanding trauma, sensitive screening and assessment, compassionate response and appropriate supports.[60-63]
- Person-centred support that is tailored to the individual's or family's unique needs, preferences and strengths.[21,61-68]
- Involvement of the whole family (as appropriate), including father-inclusive practice, attention to social and kinship networks and attention to the perspective and needs of the child.
- Holistic approach that considers SEWB[10] and the impact of cultural, social and environmental factors on health.
- Protection of staff wellbeing and management of potential vicarious trauma.[61,62] See page 51.

NSQHS Standards

The NSQHS standard for Comprehensive Care specifically calls for partnership with patients, carers and families and systems to support caregiving based on individual need.

You may refer to the NSQHS Standards: User Guide for Aboriginal and Torres Strait Islander Health.

Trauma-awareness and Child Protection

A key target (target 12) of the national Closing the Gap agreement[18] is to reduce the over-representation of Aboriginal and Torres Strait Islander children in out-of-home care.

A maternity service can support families to stay together by providing culturally responsive, trauma-aware, accessible, community-led and family-centred care. The Birthing on Country approach of the Birthing in Our Community (BiOC) program in Brisbane,[14] for example, reduced rates of child removal from Aboriginal and Torres Strait Islander families compared to standard care.

The antenatal period offers a unique opportunity to support families with complex social and emotional needs. Culturally responsive assessment and referral to services that address risk factors appropriately can reduce child protection notifications and strengthen families. Partnerships and robust referral pathways with the ACCO sector can also help.

Approaches to Child Protection can be guided by the Aboriginal and Torres Strait Islander Child Placement Principle.[26] This framework supports the right to self-determination in child welfare and aims to keep children connected to family. It acknowledges the intergenerational trauma caused by removal of children from families and culture. The principle[26] and Implementation Guide[69] are designed for services and government agencies working in Child Protection. However, they explain relevant factors contributing to child and family wellbeing and highlight the need for all sectors to prioritise a preventative approach to involving Child Protection.

Practice points

Here are possible ways to approach trauma-aware, healing-informed care:

Individual Practice Points

- Complete the self-paced online courses "Replanting the Birthing Trees" and "Healing the Past by Nurturing the Future" on the Emerging Minds website.
- Use the clinician and practitioner section of the Replanting the Birthing Trees Resource Hub to access more resources about trauma-aware, healing-informed care.
- Make a self-referral pathway available to families to recognise autonomy in decision-making. Ask Izzy is a hub of available support services to offer families.
- Practice deep listening and establish trust. Take time to explain processes, offer choices and invite questions. See the clinical yarning tips (page 58) for more communication tips.
- Address children, fathers, Elders and support people who are present as well as mothers.
- Use professional development and supervision sessions to explore conflicts between personal beliefs and family choices. See page 52 for more about Supervision.
- Take strengths-based, detailed and factual notes.

Program Practice Points

- Use culturally appropriate, strengths-based screening and assessment tools, such as the Kimberley Mums Mood Scale and Baby Coming You Ready? tool.
- Visit the website of your state or territory's Office or Commissioner for Children and Young People. South Australia, for example, has a dedicated Commissioner for Aboriginal Children and Young People.
- ACCOs and Aboriginal and Torres Strait Islander practitioners should be involved in decisions about reports to Child Protection to increase understanding of complex issues involved.

Organisation Practice Points

- Review organisational competency matrices and embed trauma-aware, healing-informed professional development (including staff wellbeing) into training for staff. Support staff to attend face-to-face training to supplement virtual learning.
- Develop an understanding of ACCO and community involvement in formal child protection decision-making and advocacy. Co-design a process for understanding, measuring and reporting your service's intersection with Child Protection systems.
- Develop an understanding of your service's policies and protocols for reporting to Child Protection and how they relate to the system in your jurisdiction. Determine how improvements can be made when working with Child Protection staff to ensure the process is culturally responsive, prioritises therapeutic perinatal intervention and involves existing community structures.
- Make a formal apology to Aboriginal and Torres Strait Islander communities for your profession or organisation's role in historical forced child removals. Ensure ongoing actions reinforce your commitment to change. The Royal Women's Hospital in Melbourne has, for example, shared its hospital apology online.

Tools and resources

Featured tools:

- Tips for Clinical Yarning in Practice on page 58

Additional tools:

- Aboriginal and Torres Strait Islander Child Placement Principle and Implementation Guide, SNAICC
- Clinical Yarning eLearning Program, Western Australian Centre for Rural Health
- Closing the Gap
- Cultural Safety in Trauma-Informed Practice from a First Nations Perspective, Nicole Tujague & Kelleigh Ryan
- A Good Practice Guide to support implementation of trauma-informed care in the perinatal period, Blackpool Better Start Centre for Early Child Development
- Family Matters Report 2024, SNAICC
- Healing Foundation
- National Aboriginal and Torres Strait Islander Health Plan 2021-2031, Commonwealth of Australia, Department of Health and Aged Care
- National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing, Commonwealth of Australia, Department of the Prime Minister and Cabinet
- "Replanting the Birthing Trees" and "Healing the Past by Nurturing the Future" online courses, Emerging Minds
- Replanting the Birthing Trees Resource Hub
- Supporting Aboriginal and Torres Strait Islander Families to Stay Together from the Start (SAFeST Start): Urgent call to action to address crisis in infant removals. Chamberlain et al.
- Toolkit for Doulas: Understanding the Impact of Gender-Based Violence, Wellness Within
- Trauma-Informed Care and Practice Organisational Toolkit, Mental Health Coordinating Council
- Trauma-Informed Healthcare Approaches, Megan R. Gerber (Ed.)
- Trauma-informed services and trauma-specific care for Indigenous Australian children, Judy Atkinson
- Working and Walking Together, SNAICC
- Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice, Pat Dudgeon, Helen Milroy, Roz Walker (Eds.)
- Ask Izzy
- Kimberley Mums Mood Scale
- Baby Coming You Ready? tool

CASE STUDY: Baby Coming You Ready?, Australia-wide

Baby Coming You Ready? (BCYR) is a digital platform that supports a new generation's mental health and wellbeing assessment and screening process (incorporating patient/clinician jointly shared decision-making and reflection) and is used by/with Aboriginal women in the perinatal period.

It was co-designed on Noongar Boodjar (Perth, Western Australia) with and by Aboriginal communities from 17 differing Clans/Nations, Elders and Senior Aboriginal women and men, Aboriginal and non-Aboriginal practitioners and Aboriginal and non-Aboriginal researchers.

BCYR is based on a parent-led model of care that uses touchscreen images, voice-overs and skip logic to provide safe and effective screening and assessments for wraparound care. It is a therapeutic intervention that supports clients in achieving their goals and directs care providers/practitioners to follow up with the women at subsequent appointments.

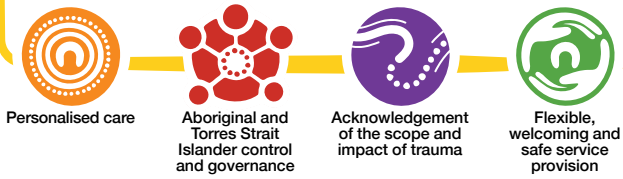
A parent chooses images of their strengths and worries to create a personalised care plan, which may include brief interventions such as information on contraception or managing post-birth bleeding. These care and safety plans can generate Clinical Event summaries that practitioners can use for referrals.

BCYR is designed to develop trust and engagement, identify and enhance strengths, and understand contextual factors in the mothers' lives and how these might impact risk assessment. It encourages open reflection and self-evaluation.

No Child Protection notifications were made by participating services during the BCYR pilot, and there was an increase in reporting of family violence by parents, indicating an increased sense of safety through using the platform.

Ratajczak, T. (2024). Exploring Cultural and Clinical Factors Contributing to Aboriginal and Torres Strait Islander Women's Resilience: A Study Utilising the Baby Coming You Ready Program.

Tools like BCYR can be adopted in your service to improve trauma-informed practice and the efficiency of referrals and information sharing. Take note of how BCYR is patient-led, strengths-based and, most importantly, designed by community.



CASE STUDY: Yalbilinya Miya, NSW

Yalbilinya Miya means "learn together" in Wiradjuri language and is a celebration of 65,000 years of Aboriginal and Torres Strait Islander breastfeeding practices. The program is led by Riverina Medical and Dental Aboriginal Corporation (RivMed) on Wiradjuri Country in Wagga Wagga, NSW and is designed by Aboriginal women for Aboriginal women.[70] The project is led by lead researcher Simone Sherriff (Wotjobaluk) and project lead Kristy Williams (Wiradjuri). It was developed from a community need for a program to ensure culturally responsive breastfeeding supports are available to Aboriginal mothers and their babies. The first stage of the program involved research to better understand breastfeeding barriers, enablers and preferences as experienced by local Aboriginal women. A team of Aboriginal women used the Indigenous research approach of Yarning to gather information from local female Elders, Aboriginal mothers and members of their support networks. This information was used to inform the design of the holistic breastfeeding program which also emphasises social support and wellbeing.

Yalbilinya Miya's program provides Aboriginal mothers with community-designed education materials, a breastfeeding pack with an electric breast pump, feeding cover and milk storage bags. Mothers can attend a weekly group, attend specific breastfeeding support appointments with a GP trained in lactation care at RivMed, engage funding to see a lactation consultant if needed, and can engage with a support phone line and private Facebook community group.[70] Mentorship and connection with Elders and other Aboriginal women are key aspects of the program. Cultural breastfeeding photoshoots on Country were held with the women and their babies to celebrate this special time and to empower other local women to breastfeed. The program also hosted a community art exhibition showcasing pieces submitted by local Aboriginal artists that represented breastfeeding and also the photographs of the mums and their babies from the cultural breastfeeding photoshoots. More information about the program and this event can be found online.

If you come from a mainstream hospital, consider how you might partner with a program like Yalbilinya Miya. If you know of a program like this in your area, you might recommend it to families or set up a referral pathway.

Images from the breastfeeding photoshoots can be seen throughout this toolkit thanks to the generosity of the mothers featured. Photos by Alicia Frail (Wiradjuri) from OchreUp.

Aboriginal and Torres Strait Islander control and governance

Community development and health promotion

Personalised care

Support across the first 2000 days of life

2.3 CONTINUITY OF CARE/R

What is continuity of care/r?

Coordinated care provided by one primary clinician (continuity of carer) or a small team of clinicians (continuity of care) known to the family.

By building a trusting relationship between a family and clinician, continuity of care/r aims to foster comfort, safety, familiarity and autonomy for families in healthcare settings.

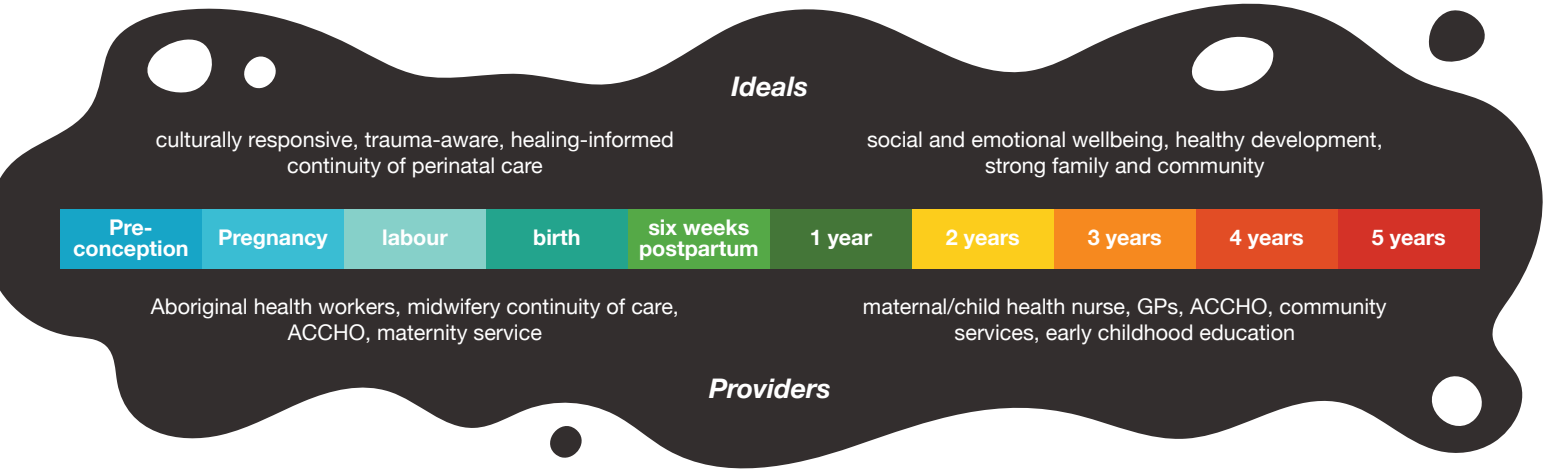
Midwifery continuity of care/r is a common approach to continuity of care/r in public maternity services that care for families during pregnancy, labour, birth and/or the early postnatal period. Midwifery continuity of care/r has been shown to improve maternal and neonatal outcomes including reducing preterm births[11-14] and improving how women feel about their care.[13,15-17,71] This includes regional and rural settings.[72] Some midwifery continuity of care/r programs have seen a decrease in burnout and increase in job satisfaction among midwives compared to standard care.[73-76] Cost savings for health services have also been seen in midwifery continuity of care/r models.[13,77]

Other care providers can also offer continuity, such as GPs, family support workers or obstetricians and nurses. The ideal program for your service will depend on feasibility and the needs of the local community.

Features of strong continuity of care/r[4]:

- Effective multi-disciplinary teams (this might include midwife, dedicated obstetrician, AHW/AHP, AHLO, GP, social worker, psychologist, neonatologist and other allied health professionals as needed[78]).
- Agreed philosophy and vision to guide a cohesive daily way of working.
- Clear consultation guidelines, service maps and referral pathways (including to external services after six weeks postpartum).
- Acceptance of all Aboriginal and Torres Strait Islander families, regardless of perceived or actual needs and levels of clinical or social risk.[4] Women with obstetric and psychosocial complexities are known to benefit from continuity of care/r models; including families of any risk status will maximise the benefit of your service.[15,79-81]
- Shared information, communication and technology systems to ensure direct transfer of patient information and electronic medical records. This might include transfer of a family's information between a hospital and a local ACCHO, for example, so that community-based care can be resumed after discharge. This might also include clear clinical handover protocols (such as a modified, culturally adapted ISBAR - Introduction, Situation, Background, Assessment, Recommendation - tool[82,83]) that relays a patient's kinship/support networks, cultural considerations and their community, with their approval.
- Executive/managerial champions to endorse and advocate for the model.[4]

Continuity in the perinatal period up until one year postpartum and beyond into the first 2000 days can set up foundations for a healthy life.



Continuity of care/r models and strategies

- **Caseload midwifery or Midwifery Group Practice (MGP):** An allocated primary midwife provides most of a woman's antenatal, intrapartum and postnatal care up until six weeks, with one or two back-up midwives. The primary midwife (or their back-up) is on call for 24 hours a day and attends the labour and birth. They collaborate with doctors as needed. This is also known as one-to-one midwifery care or relational care.
- **Team midwifery care:** A small team of midwives (maximum eight) provides care for a group of women throughout antenatal, intrapartum and postnatal periods so that continuity of philosophy and some continuity of care exists, but midwives are not required to be on call. They collaborate with doctors as needed.[22]
- **Dedicated, tailored continuity of care/r program for Aboriginal and Torres Strait Islander families:** A specific MGP or other continuity of care/r program with Aboriginal and Torres Strait Islander midwives or with non-Indigenous midwives trained in cultural responsiveness. See the BiOC (page 28) or Baggarrook (page 39) case studies.

Visit the Australian Institute of Health and Welfare[84] or COAG Health Council[22] lists of possible maternity models of care for more options.

If a continuity of care/r maternity model such as MGP is not currently feasible for your service, consider other strategies to strengthen continuity. These might include:

- **Antenatal and Postnatal** (such as MAPS: Maternity Antenatal and Postnatal Service): The same midwife (or small midwifery team) cares for a family in the antenatal and postnatal periods (outpatient care), but not necessarily during birth. This might help you scale up to an MGP.
- **Care navigation:** A practitioner (clinical or non-clinical) accompanies a family and bridges the gaps between GPs, surgeons, community health and so on. This role can take different forms. It might involve navigating social services and administration (e.g. arranging referrals, appointments and transport), advocacy (communicating on behalf of a patient or acting as a liaison), outreach, or emotional and cultural support.[85] It is recommended that the navigator identify as Aboriginal and Torres Strait Islander and focus on handovers and linking services of different sectors.[86]

KEY ACTION: recruiting and training Endorsed Midwives

An Endorsed Midwife has additional postgraduate qualifications authorising them to prescribe certain medications, request certain diagnostic tests and directly refer to some specialists. Endorsed midwives are eligible for a range of Medicare items including antenatal visits, labour and birth care and postnatal care.[87] Recent changes to legislation have made it more straightforward for midwives to become endorsed.[88] Support Aboriginal and/or Torres Strait Islander midwives to become endorsed so as to establish practices that are community based and allow for births to occur at a location chosen by the mother. Weipa MGP in the Western Cape is an example of endorsed midwives working publicly with expanded scope of practice.

Enablers of continuity of care/r programs

Midwifery continuity of care/r programs have been shown to benefit midwives, who report greater job satisfaction, autonomy and skills.[73] While the majority of evidence reports positive experiences of midwives in continuity of care/r models, it is important to note that there are also some potential challenges.[89-92] Enablers of a strong midwifery continuity of care/r program[90,91,93] include approachable managers who champion the program, caseload sizes proportionate to the potential complexity of the population, protected time off, a collaborative community of practice with shared responsibility, a balance of skills in a team and good succession planning.

Practice points

Here are just some possible ways to approach continuity of care/r for Aboriginal and Torres Strait Islander families:

Individual Practice Points

- Schedule appointments to allow time to build relationships as well as offer clinical care. See page 64 about a clinical yarning approach.
- Consider whether your personal circumstances and support system will allow your sustained wellbeing in the program. For example, working in a caseload or MGP model requires being on call and does not suit everyone.[91]
- Stay up to date with your service's referral guidelines and pathways.[21,61-67,94-97]
- If you are a health service executive or manager, openly demonstrate your support for continuity of care/r models.[73]

Program Practice Points

- Where possible, provide the option of midwifery continuity of care/r for all women having an Aboriginal and/or Torres Strait Islander baby.
- Reduce the number of mothers allocated per FTE in an all-risk caseload program for Aboriginal and Torres Strait Islander families.
- Employ Aboriginal and/or Torres Strait Islander midwives or Aboriginal Maternal Infant Care (AMIC) workers in your continuity of care/r program where possible.
- Offer telehealth consults to make repeat attendance accessible, especially in regional or remote settings.
- Offer home visits when safe and practicable.
- Develop rostering processes around proposed schedules of care (for example, if a family sees an obstetrician every second Tuesday, aim for the midwife or family support worker to be available to the family on the same day so relationships can continue to develop).
- Provide staff with a directory of services for referral, prioritising partnerships with Aboriginal community controlled services and agencies.

Organisation Practice Points

- Prioritise an Aboriginal and Torres Strait Islander workforce (e.g. midwives, Aboriginal Maternal Infant Care workers, AHLOs, AHWs, AHPs etc.) across your organisation. Include Aboriginal and Torres Strait Islander members on recruitment panels and create training opportunities.
- Create a dedicated funding plan for your continuity of care/r program (e.g. for your dedicated Aboriginal and Torres Strait Islander MGP). This may involve internal funding opportunities from within your health service, as well as state, federal or non-government funding sources.
- Support home visits, outreach services and community-based clinics.
- Consider training and employment of Endorsed Midwives if applicable, which may expand scope of practice and allow flexible care provision outside mainstream hospital settings.
- Work closely with partner services such as housing assistance, domestic and family violence services, income support and education to extend continuity of care/r beyond the early postnatal period. See the co-design and partnership section 1.3, p16 for ways to collaborate. See the 'Guidance for nurses and midwives working with Aboriginal and Torres Strait Islander Health Practitioners'[43] factsheet from Ahpra.
- Ensure recruitment plans accommodate appropriate team size, caseload size and leave cover to support continuity of care/r sustainability.[78]
- Facilitate handovers and information transfer between programs so that all care team members have a complete understanding of a family without duplicating processes. Consider using tools like a culturally tailored ISBAR (Introduction, Situation, Background, Assessment and Recommendation) and sharing information about hospital presentations and follow-up plans with partner ACCOs.

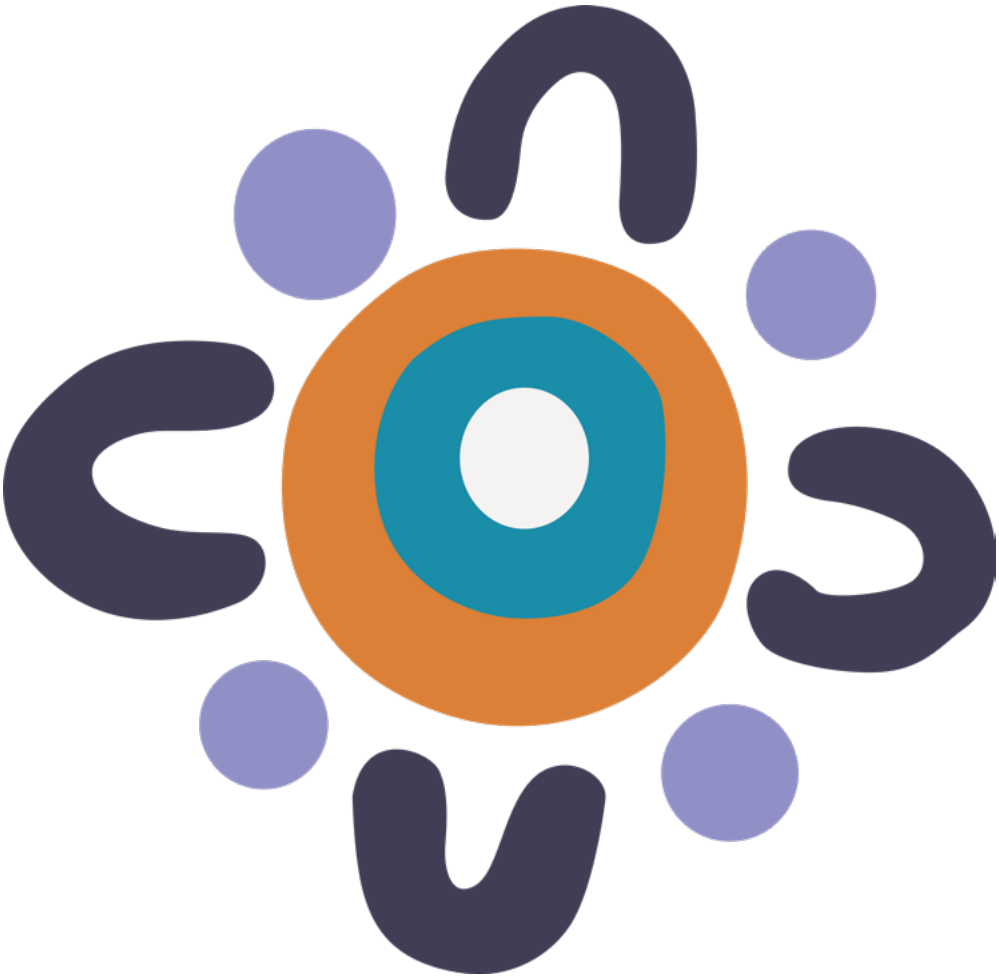
Tools and resources

Featured tools:

- Journey Map exercise on page 61
- Network Map template on page 62

Additional tools:

- Continuity of Care Handbook, Australian College of Midwives
- Continuity of Carer Models: A Midwifery Toolkit, NSW Health
- Figure 5 in The Daalbirrwirr Gamambigu (Safe Children) Model: Embedding Cultural Safety in Child Protection Responses for Australian Aboriginal Children in Hospital Settings, Flemington et al.
- Guidance for nurses and midwives working with Aboriginal and Torres Strait Islander Health Practitioners, Nursing and Midwifery Board, Ahpra
- Implementing Birthing on Country services for Aboriginal and Torres Strait Islander families: RISE Framework, Kildea et al.
- An interactive decision-making framework (i-DMF) to scale up maternity continuity of care models, Toohill, Chadha and Nowlan.
- Midwifery Continuity of Carer Model Toolkit, Western Australia Department of Health
- Systems change to improve Aboriginal and Torres Strait Islander Maternal and Child Health Continuity of Care in South Australia, Glover et al.
- Woman-centred care: strategic directions for Australian maternity services, COAG Health Council



CASE STUDY: Baggarrook Yurrongi, VIC

Baggarrook Yurrongi means 'Woman's Journey' in the Woiwurrung language of the Wurundjeri people. It is also the overarching name of a new culturally tailored caseload midwifery care program for Aboriginal and Torres Strait Islander families that was implemented at three tertiary hospitals in Naarm/Melbourne: the Royal Women's Hospital (where the program is called Baggarrook), Joan Kirner Women's and Children's (called Galinjera, which in Wemba Wemba language means 'to come together and connect and love') and Mercy Hospital for Women (called Nangnak caseload or Nangnak Babun Murrup, which in Woiwurrung language means 'nurturing Mother's spirit').

Baggarrook Yurrongi was a partnership between these sites, La Trobe University and Victorian Aboriginal Community Controlled Health Organisation.

The new programs were successful in substantially increasing access to culturally tailored caseload midwifery for women having an Aboriginal and/or Torres Strait Islander baby.[15,98] Women are cared for by either an Aboriginal and/or Torres Strait Islander midwife or a non-Indigenous midwife who had received cultural training. The midwife works with one or two back-up midwives, hospital-based Aboriginal Health Workers, obstetricians and other practitioners as needed. This means that the program can welcome families with complex needs or risk. Care is coordinated with other supports available to Aboriginal and Torres Strait Islander families, such as the Victorian Koori Maternity Service. Families can choose to receive antenatal care entirely in the hospital or have some appointments with their community health provider, such as their GP or Aboriginal Health Service.

Overall, women who participated reported very high levels of satisfaction in caseload care compared with standard care.[15] They also expressed feeling emotionally and clinically safe, and valued flexibility, choice, personalised care and building a closer relationship with their midwife.[16,17] Clinical outcomes were also substantially improved with many more babies born healthy.

Take note of the partnerships behind Baggarrook, between university, hospital and ACCO partners. Note that caseload-based care allows for an all-risk approach and is supported by connection with Aboriginal maternity services and by additional cultural responsiveness training for non-Indigenous staff.

PART 3:

FROM CONCEPT TO PRACTICE

PART 3: FROM CONCEPT TO PRACTICE

Part 3 provides an overview for implementing culturally responsive, trauma-aware, healing-informed continuity of care/r programs in a maternity service. Implementation is the process of turning ideas, strategies or plans into everyday practice. It is about ensuring that the changes you want to make in your service happen in a way that works for your staff, patients and community, which requires a structured approach. The key processes highlighted in this section were identified in the scoping review.[2]

The Process Checklist for Implementation (see page 63) provides an overview of these factors 'at a glance.'

3.1 PLANNING

Appoint key personnel, committees and leadership

- Personnel may include a project officer, key stakeholders, community members, executive sponsor.
- Committees may include a steering committee, Aboriginal and Torres Strait Islander advisory committee. Local governance is crucial to ensuring the model is relevant, acceptable and represents the perspectives of Elders and knowledge keepers. It also supports the continuation of Aboriginal and Torres Strait Islander birthing and midwifery knowledges.[64,65]
- Having a dedicated implementation facilitator is shown to improve the likelihood of successful implementation.[99]
- Seek executive approval by presenting the business case and program plans once they have been accepted by a governance committee.[21]

Embed co-design

- This requires engagement with Aboriginal and Torres Strait Islander families and collaboration with local services and community controlled organisations.
- Culturally responsive models of care must be produced in partnership with the community they are serving, and trauma-aware models of care in partnership with service users with lived experience or understanding of the vulnerabilities and triggers of survivors.[63]
- See page 56 for information on co-design, including types of partnership arrangements and definitions of community governance.

Identifying funding sources

Existing programs designed to improve culturally responsive, trauma-aware and healing-informed continuity of care are funded by a wide variety of sources and different combinations of sources. Depending on your type of model and where you are operating, you may have a range of funding available. For example, you might consider grant-based funding, Medicare-based funding and state-based funding. Alternatively, you might look within your health service or hospital to see how your internal funding could be budgeted to support a new program based on savings from improved health outcomes or accessing targeted funding to improve health equity. It might be helpful to talk to people who have successfully obtained funding to brainstorm some possible options to explore.

Understand local context and collect baseline data

- Understand your starting point by identifying what is working well in your service and where there are gaps in data and processes. You might use this toolkit's self-assessment tool (see section 1.2 page 9), another audit tool (PAGE 67) or a journey mapping exercise (page 61).
- Gather pre-implementation data about maternal health, neonatal health or child health outcomes.
- Understand staffing profiles, current vacancies, number of beds, staff per shift, caseload requirements, number of students and number of new graduates.[21] Consider telehealth usage and rates of transfer to and from hospitals (especially in regional/remote settings).
- Gather feedback from Aboriginal and Torres Strait Islander families and your workforce to determine perceptions of existing care provision and the acceptability of your proposed program.[21]
- Know what Country you work on and who the Traditional Owners are, as well as other Aboriginal and Torres Strait Islander groups living there.[8] Become familiar with the local community's birth history.[64-67]
- Understand existing local service networks including agencies and medical providers. Use the Network Mapping tool on page 62.
- Understand the profile of your local area including birth rate and regional-rural status, for example by using the Australian Rural Birth Index (ARBI).[100] The ARBI will score a service based on its isolation, number of births and the social vulnerability of its catchment population. It then guides services through actions when planning a rural maternity service related to population trends, risk, transport logistics, workforce, infrastructure and more.[100]
- Conduct a risk assessment with a range of staff and community representatives. Prepare for challenges by thinking about what might get in the way and how to overcome it.

KEY ACTION: Understanding your policy context

Aligning your program with national, state and local policy will ensure it is relevant, well-supported and sustainable. This may help with applications for funding and with securing support from executive champions. Each state or territory has different policies. In general, we recommend investigating whether your region has specific plans for the following areas:

- Aboriginal and Torres Strait Islander health
- Women's health or maternal health
- Health workforce
- Aboriginal and Torres Strait Islander employment
- Child health
- Gender justice
- Closing the Gap

Key strategies are sometimes accompanied by implementation or action plans.

For example, Queensland Health has its Growing Deadly Families[101] strategy for maternity services and the National Aboriginal and Torres Strait Islander Health Plan[20] is designed for the whole of Australia.

Develop program plans

All plans should be co-designed with community. See page 16.

- Develop a project plan which may contain the project purpose, a Logic Model, timeline, implementation plan and stakeholder engagement plan. This will shape the type of continuity of care/r model your service selects. See Table 4 (page 17) of Guiding Principles for Developing a Birthing on Country Service Model and Evaluation Framework[38] for an example Logic Model.
- Develop a business plan to explain the goals and design of your program (including establishment resourcing).
- Develop a sustainable funding plan, taking into consideration the wide variety of options to fund the program (e.g. internal, state, federal, non-government).
- Develop an operational plan to explain day-to-day operations of your program (including activities, staffing, organisation).
- Develop a workforce plan for recruitment, training, professional development and retention. Ensure you specifically account for Aboriginal and Torres Strait Islander workforce. See page 50 for more information on staffing.

Tools and resources

Featured tools:

- Journey Mapping exercise, page 61
- Network Mapping template, page 62

Additional tools:

- Australian Rural Birth Index, Longman et al.
- Emerging Minds Focus (to guide structured planning processes), Emerging Minds
- Guiding Principles for Developing a Birthing on Country Service Model and Evaluation Framework, Kildea et al.
- National Aboriginal and Torres Strait Islander Health Plan 2021-2031, Commonwealth of Australia, Department of Health and Aged Care
- RISE Framework, Kildea et al.

CASE STUDY: Connected Beginnings Lutruwita, TAS

The Connected Beginnings Lutruwita program is a comprehensive initiative designed to support Aboriginal and Torres Strait Islander families in accessing essential early childhood education and health services. By engaging directly with the community, this place-based program ensures that families receive the health information and services specific for their needs. Recent funding transitions to Aboriginal Community Controlled Organisations have strengthened this initiative, enabling effective collaboration between health and education backbone teams. This new coordinated and collective approach has strategically enabled Aboriginal families to access culturally safe services and supports that allows every Aboriginal child to thrive in their early years within their community.

Prioritising the wellbeing of Aboriginal children and their families, Connected Beginnings Lutruwita promotes integrated, comprehensive and culturally safe healthcare and educational services. The program encourages data sharing among maternal and child health services, allowing communities to co-design system changes that enhance health outcomes for our families.

Raylene Foster, Chief Operations Officer for the Tasmanian Aboriginal Centre, emphasises:

"Our deep commitment to place-based health and educational initiatives, and prioritising collective action within our communities has enabled us to transform our systems to ensure every child is born healthy and strong. The evidence is clear. When we integrate services and unite around a common vision and foster trust, we can create meaningful and lasting systemic changes that improve culturally safe maternal, postnatal and child health services that improve outcomes for Aboriginal and Torres Strait Islander families."

Courtesy of Connected Beginnings Lutruwita

Take note of how Connected Beginnings' clear vision and purpose guided their planning. Your maternity service might partner and share information with a program like Connected Beginnings to ensure care flows from the perinatal period into early childhood.

3.2 IMPLEMENTATION

Launch the model/program

- Plan the transition process, including a staged or gradual introduction period with no bookings or reduced bookings. Testing a strategy on a small scale first (e.g. in one team or location) can help you gather feedback and adjust before rolling out more widely.
- Launch the new program or model.
- Establish the program in everyday routines. Write it into policies, provide ongoing training and ensure resources are available.

Establish clear protocols, processes and pathways

- These might include referral processes, multi-disciplinary working guidelines, communication pathways, clinical governance processes and Standard Operating Procedures.
- Establish a team way of working. Provide training and resources to help staff feel confident with the change or new program and hold regular check-ins to address concerns.
- Ensure access to appropriate equipment and resources.

This is an overview only. For more details on implementation processes for maternity programs, consider these toolkits:

- Continuity of Care Handbook, Australian College of Midwives
- Continuity of Carer Models: A Midwifery Toolkit, NSW Health
- Midwifery Continuity of Carer Model Toolkit, Western Australia Department of Health

3.3 MONITORING AND EVALUATION

Establish agreed frameworks

- Develop internal frameworks for monitoring and evaluating your program as soon as possible, such as risk management and clinical governance frameworks.

KEY ACTION: choose an evaluation framework

Deciding on an approach to evaluation is important to ensure it is well embedded. You may already have Continuous Quality Improvement approaches or Plan, Do, Study, Act (PDSA) cycles in place. You may also like to refer to existing frameworks that support evaluation. These are just two examples, but there are many possibilities if using a framework would be useful to your service:

- **RE-AIM Framework for Evaluation[102]:** the RE-AIM Framework might help you develop evaluation questions to assess your program or model. It evaluates Reach, Effectiveness, Adoption (uptake), Implementation and Maintenance. There are resources online on the RE-AIM website with examples.
- **Consolidated Framework for Implementation Research (CFIR 2.0)[103]:** the CFIR 2.0 is a tool to help services understand what helps or hinders the implementation of innovative ideas. It has five domains of contextual factors[103] that might affect the delivery of a new program (outer setting, inner setting, individual, implementation process and innovation). CFIR 2.0 might be useful because it emphasises the importance of understanding community, staff and organisational needs. It also helps find barriers and enablers and offers a structured way to plan, test and embed changes in practice.

Engage in research

- Contribute to the evidence base by engaging in research regarding your program.
- Uphold Indigenous Data Sovereignty principles when working with data belonging to Aboriginal and Torres Strait Islander people.

KEY ACTION: uphold Indigenous Data Governance and Sovereignty

- Indigenous Data: "*information or knowledge, in any format or medium, which is about and may affect Indigenous peoples both collectively and individually.*"[104]
- Indigenous Data Sovereignty: "*the right of Indigenous peoples to exercise ownership over Indigenous Data... through the creation, collection, access, analysis, interpretation, management, dissemination and reuse.*"[104]
- Indigenous Data Governance: "*the right of Indigenous peoples to autonomously decide what, how and why Indigenous Data are collected, accessed and used. It ensures that data on or about Indigenous peoples reflects [their] priorities, values, cultures, worldviews and diversity.*"[104]

Strategies to support data sovereignty include partnering with Aboriginal and Torres Strait Islander people at all stages of data work, providing capacity-building opportunities, sharing information about what data is being used and how, reporting findings back to community and involving Aboriginal and Torres Strait Islander leadership in data governance.[105]

Conduct ongoing monitoring and evaluation

You may:

- Prepare a Monitoring and Evaluation plan.
- Carve out dedicated time, budget, staffing and resources to make sure your evaluation is executed properly with minimal added burden to staff.[68]
- Ensure information technology and communications systems enable staff to complete accurate and comprehensive reporting. This might include effective appointment scheduling programs that support data production (such as occasions of service per individual midwife and travel time for community visits) and capturing data input by midwives (e.g. gathering of clinical results from external health providers).
- Compare data against baseline pre-implementation data to help track change over time.
- Use data that is already collected by clinicians to avoid adding more administration to clinical load.[68]

KEY ACTION: Select outcomes to monitor

These are some examples of outcomes you might track to assess the impact of your program and identify areas to develop further.

Perinatal clinical outcomes

- Pre-conception care
- Antenatal visits before 13 weeks
- Antenatal attendances
- Gestational diabetes mellitus rate
- Alcohol or other drugs
- Depression /anxiety scores
- Smoking/vaping status
- Preterm birth rate
- Induction of labour rates
- Mode of birth
- Continuity of carer
- Location of birth (homebirth, birth centre, hospital, born before arrival)
- Rates of transfer to other facility for birth
- Birth weight
- Length of stay in hospital
- Number of postnatal visits conducted in the home
- Breastfeeding rate and duration
- Maternal admissions to HDU or ICU
- Neonatal admissions to NICU
- Neonatal transfers out of hospital
- Stillbirth rate
- Neonatal death rate

Social and emotional wellbeing

- Families' perceptions of a service or program's acceptability, accessibility and quality, including perceptions of quality of relationship with medical staff
- Completion of scheduled care visits
- Referrals to mental health services

Child Safety and Child Protection

- Child protection notifications
- Out of home care admissions
- Support provided for vulnerable families at risk of child protection involvement

Cultural responsiveness

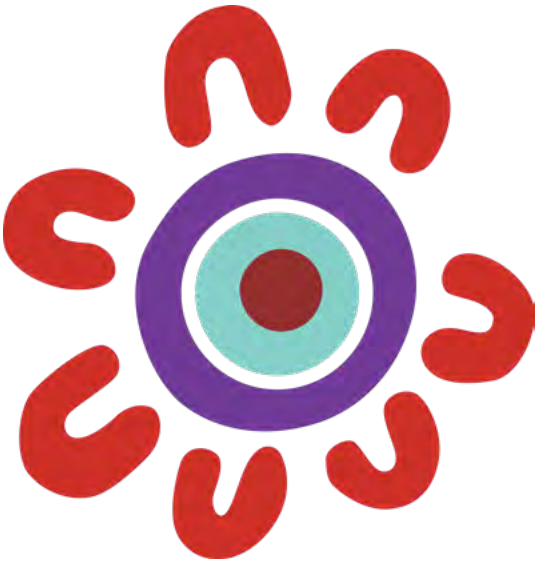
- Proportion of Aboriginal and Torres Strait Islander workforce
- Provision of interpreter services
- Access to traditional medicine or cultural practices
- Rates of completion of cultural safety training for staff
- Rates of engagement with AHLO, Aboriginal Maternal Infant Care or other dedicated Aboriginal and Torres Strait Islander staff
- Existence of community feedback mechanisms
- Families' feedback on cultural safety
- Existence of formal cultural responsiveness policy/procedure
- Aboriginal and Torres Strait Islander leadership at executive level

Examples of tools to assess these outcomes:

- Aboriginal Cultural Inclusion Checklist for Maternity Services
- ASQ-TRAK, Strong Kids, Strong Future
- Baby Coming You Ready?
- Cultural Safety Audit tool (individual and organisational), Lowitja Institute
- Genuine Partnerships Audit Tool, SNAICC
- Kimberley Mums Mood Scale
- Yanha Yalinya Cultural Responsiveness Checking Tool, Yulang Indigenous Evaluation
- Social and Emotional Wellbeing assessment instruments for use with Indigenous Australians: a critical review, Le Grande et al.

Tools and resources

- Aboriginal and Torres Strait Islander Child and Family Services Evaluation Readiness Toolkit, SNAICC
- AITSIS Code of Ethics for Aboriginal and Torres Strait Islander Research, Australian Institute of Aboriginal and Torres Strait Islander Studies
- Consolidated Framework for Implementation Research (CFIR 2.0), Center for Implementation
- Cultural safety in health care for Indigenous Australians: monitoring framework, Commonwealth of Australia, Australian Institute of Health and Welfare
- Ethical conduct in research with Aboriginal and Torres Strait Islander peoples and communities: guidelines for researchers and stakeholders, National Health and Medical Research Council (NHMRC)
- An Evaluation Framework to Improve Aboriginal and Torres Strait Islander Health, Lowitja Institute
- First Nations Cultural Safety Framework, Australian Evaluation Society
- Framework for Governance of Indigenous Data, Commonwealth of Australia
- A Guide to Evaluation under the Indigenous Evaluation Strategy, Productivity Commission, Commonwealth of Australia
- Indigenous Data Sovereignty Readiness Assessment and Evaluation Toolkit, Lowitja Institute
- Indigenous Data Sovereignty: Toward an agenda, Tahu Kukutai and John Taylor (book)
- Maiam nayri Wingara Indigenous Data Sovereignty Collective
- RE-AIM Framework



3.4 SUSTAINABILITY AND SUPPORTING STAFF

Sustainable funding, succession planning, strong and visible managerial commitment, care for the wellbeing and retention of staff, supervision and peer support mechanisms are essential to the longevity of an effective program or model.[2]

Supporting an Aboriginal and Torres Strait Islander workforce

An Aboriginal and Torres Strait Islander workforce is an essential element of culturally responsive, trauma-aware, healing-informed continuity of care/r. [39,64]

- Build Aboriginal and Torres Strait Islander student, graduate and early career clinician pathways into the program.
- Include Aboriginal and Torres Strait Islander representatives (such as Elders) in the recruitment process, including on interview and selection panels.
- Offer flexible cultural leave allowances for Aboriginal and Torres Strait Islander staff for Sorry Business (loss and bereavement), cultural events or cultural responsibilities.
- Offer a mentoring program, or facilitate events where Aboriginal and Torres Strait Islander staff can connect and set up supports.[106] Organisations such as CATSINaM (Congress of Aboriginal and Torres Strait Islander Nurses and Midwives) host mentorship pathways for Aboriginal and Torres Strait Islander midwives.
- Recognise that lived experience and cultural expertise are valuable.
- Ensure all staff complete regular cultural safety and anti-racism training, such as CATSINaM's Murra Mullangari program[107] on cultural safety and humility.

KEY ACTION for non-Indigenous practitioners: be an 'imperfect ally'

Being an 'imperfect ally'[108] means making an active, practical commitment to ongoing learning about cultural and personal bias. It means acting in solidarity with and support of Aboriginal and Torres Strait Islander colleagues. It requires humility and openness. Developing critical self-reflection will help you understand your own privileges and unconscious biases (assumptions you may not know you hold) and how these influence your actions and decisions as a practitioner, particularly when engaging with people from different cultural backgrounds.[109]

Self-reflection example actions:

- Keep a journal.
- Debrief with colleagues.
- Engage with content from Aboriginal and Torres Strait Islander thought leaders (such as books and podcasts). Refer to the Reconciliation NSW Ally Reading List[110] and the TACSI First Nations ally resources, books and films.[111]
- Engage in cultural supervision. See page 52.
- Join or start a discussion group or a reading group exploring equity, social justice, decolonising practice and more.[112]

Caseload allocations

For caseload-based models of care:

- Review caseloads and allocations (complexity, acuity and total bookings) at least every quarter to ensure the wellbeing of practitioners and the sustainability of continuity of care/r.
- Where possible, health workers should avoid booking families that are 'due' during and either side of planned leave periods. Consider leave cover, including a leave cover position to account for planned and unplanned leave in the team.
- Reduce caseloads for all-risk models (depending on the complexity of care required by each family), regional and rural contexts (accounting for practitioner travel requirements), outreach and community-based care, learning or graduate positions, 24-hour or after hours support requirements, duration of contact with family and how established the program is (e.g. commencing with smaller caseload in a brand new program or model).

MINI CASE STUDY: BiOC Brisbane caseloads

Guidance generally suggests an annual caseload of low-risk women to be 40 per midwife per year in low-risk mainstream MGP models.[21,68] BiOC in Brisbane required a reduction in caseload to 25 per midwife per year for their all-risk metropolitan model (or two to three families per month excluding holidays) to meet families' needs. The BiOC team found that additional travel considerably impacted the midwives time while still providing the same amount of clinical care.[113] This reduction in caseload contributed to the model's successful outcomes.

KEY ACTION: Establishing team ways of working

Cultivate a supportive team culture as well as efficient team processes.

- Hold regular team meetings to support links between staff, especially where there is individual or isolated work.[114]
- Integrate clinical supervision and cultural supervision into your program or model.[21,114]
- Rotate staff across all clinical areas to ensure confidence and ability across their full scope of practice. For example, ensure midwives gain ample experience in antenatal clinics as well as birthing suites.
- Consider gender diversity in your team. In some communities, there will be designated Men's Business that is only appropriate for men, or designated Women's Business that is exclusive to women. Aspects of childbirth, sexual health education, fatherhood support and so on may require staff of a certain gender.[6]

Create a healthy workplace – staff wellbeing

A healthy workplace promotes mental health, has a positive workplace culture and is equipped to facilitate care for employees with social and emotional wellbeing issues. The Midwifery Futures project[73] found that job satisfaction and workforce retention were affected by a sense of professional autonomy, respect and support in the workplace, appropriate staffing and skill levels and no workplace bullying.

- **Vicarious trauma:** the impact of indirect exposure to trauma, by being exposed to information about traumatic events and experiences. Staff who work with people with trauma may experience this. Common signs of vicarious trauma include frustration, distress, anxiety, disturbed sleep, difficulty managing personal boundaries or taking on too great a sense of responsibility, difficulty leaving work on time, loss of connection with others, loss of sense of identity and increased need to control events. Vicarious trauma is associated with 'compassion fatigue' and burnout.[61]
- **Psychological first aid:** a supportive response for people who have witnessed or experienced a distressing or traumatising event. It is often an early intervention that involves respectful social and psychological support.[115] Training in psychological first aid prepares people to support others who are distressed. It gives information on what to do and say and how to avoid causing harm. Psychological first aid is preferred by international organisations such as the Inter-Agency Standing Committee and World Health Organisation over psychological debriefing.[115]

Professional development and supervision

Professional development

Encourage staff uptake of further training opportunities beyond mandatory professional development. Some examples might be more breastfeeding training/lactation consultant certification, Endorsed Midwife qualification, or dental and oral health training. Supporting professional development might mean releasing staff for face-to-face training or subsidising costs of training.

Clinical Supervision

Clinical supervision is important for high-quality healthcare delivery, professional growth and staff wellbeing.[73] Clinical supervision is a formal, professional engagement between a supervisor and a supervisee or group of supervisees. It occurs during dedicated, regular, structured meetings (during work hours) and typically involves guided critical reflection on professional challenges or issues raised by the supervisee. It is designed to improve the supervisee's professional practice, help with decision making and develop their reflective practice.[116,117] The scoping review[2] found that supervision and peer support were particularly important when providing trauma-informed care and managing vicarious trauma.

Cultural supervision

Cultural supervision is structured, regular guided reflection during which practitioners might consider their belief systems and how they relate to their professional practice. Cultural supervision might involve:

1. Supervision for an Aboriginal and/or Torres Strait Islander practitioner from an Aboriginal and/or Torres Strait Islander supervisor, grounded in Aboriginal ways of knowing, being and doing. This might provide opportunities for mentorship, healing, growing in confidence, learning cultural knowledge and receiving support navigating interactions with mainstream services.[118] It might provide a safe space of shared understanding, acknowledging that supervision from non-Indigenous facilitators may not be culturally responsive.[119] Enabling a choice of supervisor and access to support from community controlled organisations can be of benefit.
2. 'Cross-cultural' supervision for a non-Indigenous practitioner from an Aboriginal and/or Torres Strait Islander educator or a qualified and experienced facilitator. It might help the practitioner understand how they interact with people with different belief systems.[109] It might provide an opportunity to encounter Aboriginal and Torres Strait Islander knowledges and histories in a culturally appropriate way and to learn about decolonising healthcare. Aboriginal and Torres Strait Islander supervisors or facilitators should be appropriately compensated for their time and expertise if they provide cultural supervision.
3. Reflection among non-Indigenous practitioners, such as an Imperfect Allies group.
4. Two-way knowledge sharing between Aboriginal and Torres Strait Islander and non-Indigenous colleagues.

Practice Points

Continuity of care/r has benefits for staff involved. A midwifery continuity of care/r model, for example, can lead to higher job satisfaction.[74,75] Benefits to staff can be enhanced by ensuring:

- Strong supports that protect staff from vicarious trauma, including psychological first aid, critical incident response and access to Employee Assistance Programs.[73]
- Weekly team meetings and communication.
- Clear reporting lines and clear clinical care and conflict escalation pathways.[21]
- Appropriate feedback and performance management.
- Optimised size of team with adequate mix of capacity and skill (including mentorship for junior staff).[78,120]
- Monitored and flexible workload allocations.
- Protected annual leave and time off call.[89,120]
- Adequate resources for staff, such as private office space, equipment and reimbursement for expenses when providing outreach appointments.[92]
- Role clarity with clear professional boundaries, balanced by a culture of collaboration and shared responsibility.[93] For example, ward staff might cover other staff breaks.
- Individual and team wellbeing plans.
- Co-location with partner teams or shared practice,[121] for example joint home visits by caseload midwife, child health nurse and AHW.
- Robust cultural leave policy, including adequate allowances for Sorry Business or bereavement protocols.[6]
- Peer support structures.
- Mentoring opportunities. Access to clinical and cultural supervision (see below).
- Regular meal breaks.[73]
- Supportive senior leadership or executive champions.[73,122]

Tools and resources

- Developing employee-centred rostering principles, Safer Care Victoria
- Nurse Midwife Health Program Australia. Provides a nationwide, free and confidential peer support and counselling service for nurses, midwives and students. It is delivered by nurses and midwives with lived experience. A dedicated branch of the program for Aboriginal and Torres Strait Islander practitioners is currently in development.
- Midwifery Futures: Building the Australian midwifery workforce, Homer et al.
- Murra Mullangari program, CATSINaM
- Position Statement: Clinical Supervision for Nurses and Midwives, Australian College of Mental Health Nurses, Australian College of Midwives and Australian College of Nursing
- Psychological First Aid: Guide for field workers, World Health Organisation
- Recommended Reading List for Reonciliation Allies, Reconciliation NSW
- Resources, books and films to help you be a better First Nations ally, TACSI
- The Thrive at Work Toolkit, Thrive at Work
- The Victorian Mentally Healthy Workplaces Framework, Victorian Government
- Workplace Mental Health toolkit, The Black Dog Institute
- WorkWell Toolkit, WorkSafe Victoria

CASE STUDY: Djäkamirr

In Yolŋu Matha language, djäkamirr means 'caretaker.' Since 2023, the Djäkamirr program has offered every pregnant Yolŋu woman living in Galiwin'ku, Arnhem Land djäkamirr support (birth companion most similar to a doula).[123]

Djäkamirr offer skilled companionship, comfort, education, ceremony and a sense of belonging and connectedness in a family's primary language during pregnancy, childbirth and the first two years of life. Djäkamirr can support a woman in community, bush, clinic, at home or during aeromedical evacuation, accompanying her to Nhulunbuy, Darwin and beyond. This improves a woman's sense of safety and connection to culture and community even when she has to give birth away from her Country and family.

The role of a djäkamirr does not replace a medical professional. Djäkamirr complete 12 to 18 months of government-accredited vocational certificate training in Pregnancy, Birth and Postnatal Companionship, delivered in partnership with Yolŋu Knowledge Experts, Molly Wardaguga Research Institute for First Nations Birth Rights and the Womb to Tomb Foundation. This approach means djäkamirr expertise can be recognised and supported both by Yolŋu communities and by balanda systems (settler or mainstream biomedical institutions).[123] It also overcomes the English language prerequisite that often excludes Yolŋu people from employment. Training content and delivery was informed by 'developmental evaluation' or consistent feedback and improvement, as well as Yolŋu input about birthing and parenting knowledges, practices and experiences.[123]

NT Health supports the djäkamirr by covering travel and accommodation expenses during 'Sitdown' when djäkamirr leave community to support women in attending a regional town for birth in hospital. During their training, trainees are offered a vocational placement scholarship and upon completion, are paid for their services through the 100 per cent Yolŋu-owned Djäkamirr Co-op Ltd. Continuing professional development and mentorship is provided by the Molly Wardaguga Research Institute and Womb to Tomb Foundation.

The program is part of the *To Be Born Upon a Pandanus Mat: Yothuw gayatha dhäwal' guyaŋa' nharaw* research project, an example of a Birthing on Country model. You can learn more about the program by watching Djäkamirr: Caretaker of Pregnancy and Birth, a 2021 documentary from One20 Productions.

This is one example of how continuity can be maintained when midwifery continuity of carer (like an MGP) is not possible, or in settings where mothers need to transfer to a different site. It highlights the value of dedicated training programs with state or territory government endorsement. You could introduce a similar supportive companion or navigator role in your service.

Take note of the various government and non-government partners that support the program.

TOOLS AND RESOURCES

TOOLS AND RESOURCES

Checklist for creating flexible, safe and welcoming clinical spaces[6,95,124]

Consider the following questions to consider how to plan spaces that are flexible and welcoming for Aboriginal and Torres Strait Islander families. Some may not apply to your service but can prompt reflection.

FLEXIBILITY

- ❑ Are your spaces child-friendly, with child-safe play areas? Will you offer childcare?
- ❑ Is there room for extended family and support people to stay/visit onsite and to move freely?
- ❑ Have you thought about accommodation for families who need to travel to receive care?
- ❑ Will you offer mobile/outreach services?
- ❑ Will you provide transport support?
- ❑ Will you establish a community-based clinic?

SAFETY

- ❑ Have you considered optimal or flexible lighting? Is the space well-lit with warm lighting?
- ❑ Have you considered aromas?
- ❑ Are there low noise levels?
- ❑ Will families have access to nature/green spaces?
- ❑ Are exits marked? Are signs and directions clear?
- ❑ Have you met Work Health and Safety requirements?

A WARM WELCOME

- ❑ Will families have opportunities to engage with Aboriginal and Torres Strait Islander staff?
- ❑ Will your space feature visible representations of Aboriginal and Torres Strait Islander culture (such as art or language)? Have you sought permissions and provided due compensation for displaying art/language?
- ❑ Have you removed catchment area restrictions?
- ❑ Are patients greeted with positive, welcoming language?

RESOURCING OUTREACH MODELS

- ❑ Do involved staff have access to a vehicle and petrol card?
- ❑ Do involved staff have a mobile phone and SIM card and/or laptop with Internet capabilities?
- ❑ Have you provided staff with clinical equipment appropriate to their role? Consider sphygmomanometer, stethoscope, doppler, transcutaneous bilirubinometer, portable digital baby/child scale, wound care supplies, newborn feeding supplies, measuring tapes, alcohol swabs, hand sanitiser and wipes
- ❑ Have you provided staff with emergency equipment, such as emergency birth kit, first aid kit and resuscitation equipment?
- ❑ Do patient transport vehicles have car seats for newborns and children?

Flexible, welcoming and safe service provision

NGARDANG (MOTHER)

Ammie Howell

This piece represents the special and significant areas of the Wadawurrung Country.

The blue area on the bottom right represents the beaches and the running waterways and rivers in the area with the You Yangs and Corio Bay in the distance.

The meeting places represent the diversity of Aboriginal peoples living on Wathaurong Land.

The spirits represent our Ancestors - significant women who are often called upon during the pregnancy and birth journey for strength and guidance, they are our Mothers, Grandmothers, Great-Grandmothers, Aunties, Sisters and Cousins - strong and proud Aboriginal women.

At the centre of everything, the woman, surrounded by all of these symbols supporting her through her pregnancy.

Aboriginal women are often the backbone of families and communities, they consistently demonstrate incredible strength and resilience through difficult times.

Ammie Howell is a descendant of the Arrernte people of Alice Springs, born and raised on Wadawurrung (Wathaurong) Country in Geelong. Ammie lives here with her partner, a Bundjalung man, and their 6 young children.

Ammie began painting in her early 20s alongside her mother and mother in-law. Her works have been sold Australia wide. She has donated many pieces to raise money for cancer research and has worked within schools to teach children about Culture and Art.

Ammie is a contemporary Aboriginal Artist who uses patterns, colour, shape and design to create paintings that portray a sense of country, culture and self.

Beautiful designs drawn from Ngardang (Mother) feature in the maternity ward spaces at Barwon Health in Geelong, Victoria.

Flexible, welcoming and safe service provision

Checklist for culturally responsive events[6,34,125]

This checklist is designed to help you coordinate culturally responsive events with community. Aspects of this checklist might apply to meetings with Elders, co-design workshops with Aboriginal and Torres Strait Islander partners, feedback sessions with families, or celebration days, for example.

All actions and preparations should be taken in collaboration with Aboriginal and Torres Strait Islander community members.

WORKING GROUP

- ❑ Establish a dedicated event working group (for example, co-design workshop facilitation group) with Aboriginal and Torres Strait Islander and local representatives
- ❑ Non-Indigenous staff and working group members complete Cultural Safety and anti-racism training

PREPARATION

- ❑ Invite Elders, community leaders and/or agency partners to attend, as appropriate
- ❑ Be prepared to postpone in the event of Sorry Business (community loss or bereavement)
- ❑ Decide if a Traditional Custodian will present a Welcome to Country
- ❑ If a Traditional Custodian will not be presenting a Welcome to Country, prepare an Acknowledgement of Country including acknowledgement of any Elders present
- ❑ Obtain permission to enter Aboriginal and Torres Strait Islander land as needed
- ❑ Understand confidentiality requirements (this may need to be more structured for research conduct, or could refer to traditional knowledge that should not be distributed beyond the meeting setting)

EVENT ORGANISATION

- ❑ Prepare a plan to share findings/outcomes (e.g. distribute workshop materials or decisions to partners)
- ❑ Recruit the services of an interpreter as needed (this may be in an official capacity or may be a local community member). Allow additional time and flexibility if working with an interpreter
- ❑ Provide a fee for service where relevant – for example, for an Elder facilitating a Welcome to Country, or for dancers
- ❑ Plan for feedback and follow-up mechanisms after the event/session

EVENT/SESSION SET-UP

- ❑ Select a venue chosen by community
- ❑ Ensure adequate space and equipment for children to attend (including providing toys). Ensure quiet spaces to allow attendees to retreat as needed.

CULTURAL PROTOCOLS

- ❑ Determine any considerations to be made for gender (e.g. if the event/session applies to men only or to women only or if a staff or working group member of a certain gender should facilitate)
- ❑ Prioritise Aboriginal and Torres Strait Islander leadership/facilitation
- ❑ Ensure permission to take and use recordings, videos and photos; seek permission from family or community members to use materials made with an Aboriginal and/or Torres Strait Islander person who may be deceased and provide notice when images or voices of Aboriginal and Torres Strait Islander people might appear in media
- ❑ If there is Community Sorry Business, seek advice from Elders or senior community leaders about whether the event should go ahead as planned or be rescheduled

Flexible, welcoming and safe service provision

Aboriginal and Torres Strait Islander control and governance

Additional tools and resources

- Aboriginal and Torres Strait Islander Cultural Protocols in Victoria, Murdoch Children's Research Institute
- Welcome Baby to Country Partnership Guide, Kerry Arabena et al.
- Working and Walking Together, SNAICC

Journey Map exercise

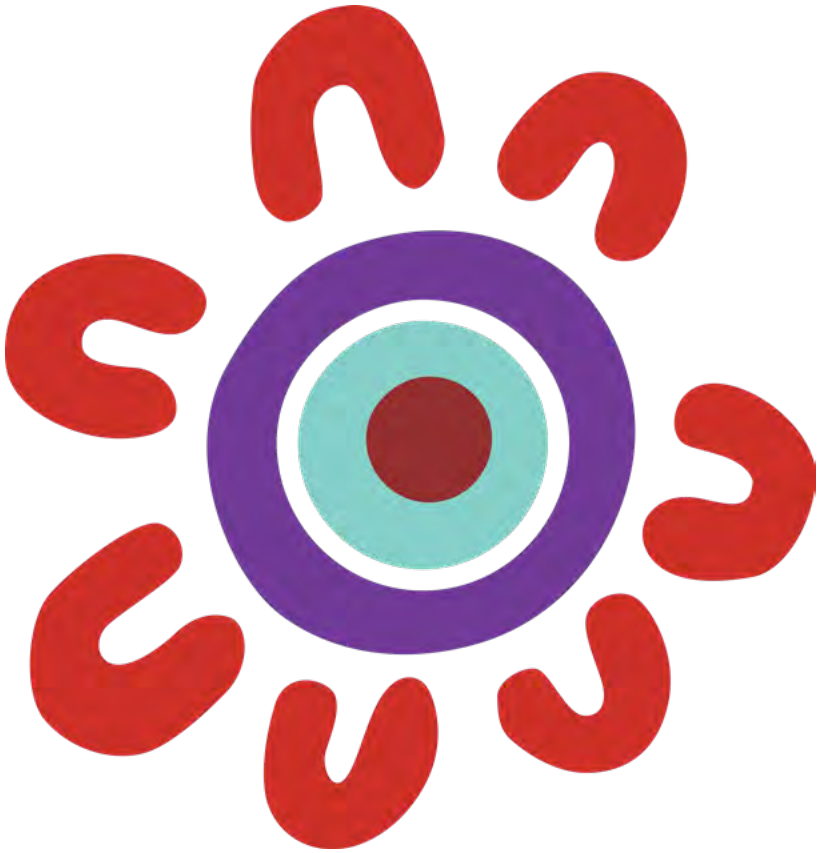
Track a family's journey through your service to better understand their needs and your service's gaps in continuity of care/r. Brainstorms, process maps and flowcharts are good examples of mapping formats. A successful patient journey map will[126]:

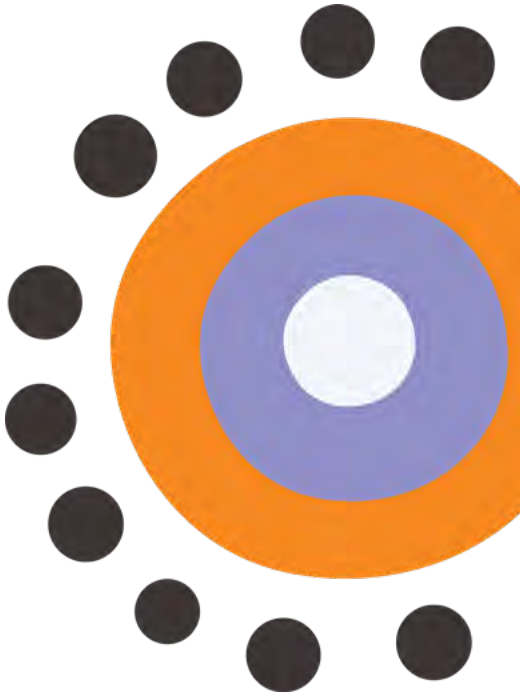
- Prioritise the perspective of the family engaging with your service, including what they need and hope to get out of the health encounter and how they feel at each stage.
- Draw from input and feedback from patient representatives.
- Involve perspectives from various 'stakeholder groups' such as Aboriginal and Torres Strait Islander staff, midwives, obstetricians, social workers, perinatal mental health, and executives.
- Be specific to your service.

You might like to brainstorm using a whiteboard, sticky notes and/or charting software. Consider key encounters during the perinatal period, what they involve for a family and what they require from your service.

See these resources for guidance on how to conduct a journey mapping exercise:

- Diagnostic and Process Mapping, NSW Health Agency for Clinical Innovation
- Health Journey Mapping Tool, Lowitja Institute
- Journey Map template, NSW Health Agency for Clinical Innovation
- Managing Two Worlds Together: Improving Aboriginal Patient Journeys – Maternity Case Studies, Lowitja Institute





Network Mapping template

Partner with the services in your network map to create pathways for referral and information sharing between inpatient and outpatient care, between hospitals and community-based care and between mainstream providers and ACCOs. This includes supporting shared/combined care and supporting transition to culturally responsive and trauma-aware, healing-informed services beyond the perinatal period. Providing strong continuity of care/r means considering what happens to families when they leave your service.

BUILDING NETWORKS FOR CONTINUITY BEYOND THE PERINATAL PERIOD

Key contacts for program Aboriginal Advisory/ Steering Committee

1.....

2.....

3.....

Nearest Aboriginal and Torres Strait Islander community controlled health organisations or services and key contacts:

.....

.....

Nearest community controlled maternal/child health clinics and key contacts:

.....

.....

Nearest community controlled maternal/child health clinics and key contacts:

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Other nearby maternal and child health clinics and key contacts:

.....

.....

Primary Health Network and key contact:

.....

.....

Primary Health Network and key contact:

.....

Local community support groups (e.g. Welcome Baby to Country sessions, Elder support networks, young parent groups, etc.):

1.....

2.....

3.....

Local mental health support services and contacts:

.....

.....

Local housing service and contacts:

.....

.....

Local legal service and contacts:

.....

.....

List of programs to recommend to families:

- SMS 4 Deadly Dads
- Deadly Tots app
- Ask Izzy
- Replanting the Birthing Tree Resource Hub
- 13Yarn

Process checklist for implementation

The RBT scoping review[4] found these key 'process factors' for establishing your care model. These were covered in more detail in Part 3 of the toolkit, but you can use this check list for an overview to work through.

Planning	
☐	Appoint key personnel and committees • Personnel may include project officer, key stakeholders, community members, executive sponsor • Committees may include: steering committee, Aboriginal and Torres Strait Islander advisory committee.
☐	Establish project leadership
☐	Consider the local context (see page 44)
☐	Co-design the model (see page 16)
☐	Develop a project plan • This may contain: model purpose, Project Logic Model, timeline, implementation plan, stakeholder engagement plan
☐	Develop a business plan to explain the goals and design of your model (including resourcing). See Section 3.13 on writing a business case in the NSW Continuity of Care toolkit
☐	Develop an operational plan to explain day-to-day operations of your model (including activities, staffing, organisation)
☐	Conduct a risk assessment with a range of staff and community representatives
☐	Establish a sustainable funding plan, taking into consideration the wide variety of funding possibilities available e.g. internal, state, federal, non-government
☐	Seek executive approval
☐	Develop a workforce plan for recruitment, training, professional development and retention • Ensure you specifically account for Aboriginal and Torres Strait Islander workforce
☐	Plan the transition process, including a staged or gradual introduction period with no bookings/ reduced bookings.
Implementation	
☐	Launch model, including promotion to local Aboriginal and Torres Strait Islander families
☐	Ensure access to appropriate equipment and resources
☐	Establish clear protocols, processes and pathways: referral processes, multi-disciplinary working guidelines, communication pathways, clinical governance processes, Standard Operating Procedures
☐	Establish a team way of working: Supervision, team meetings
Monitoring and Evaluation	
☐	Establish agreed frameworks
☐	Engage in research
☐	Ongoing monitoring and evaluation
Sustainability	
☐	Develop a succession plan
☐	Engage strong and visible managerial support
☐	Care for the wellbeing and retention of staff
☐	Establish supervision and peer support mechanisms

Tips for using yarning in clinical practice

Yarning to improve personalised care

Yarning is a form of relaxed, organic conversation and storytelling that can build trusting relationships and facilitate knowledge exchange.[127] Like all conversation, yarning can take different forms depending on its purpose and who is involved.

Tips for use in practice[6,128-130]

- Take time at the start of your meeting or consultation for casual conversation (share something about yourself)
- Start with a cup of tea or refreshments
- Ask open-ended questions
- Respond to body language and non-verbal cues. Note that in some communities, eye contact will be indirect only
- Avoid using medical jargon
- Allow for silence
- Avoid leading questions, allow the conversation to go 'off track,' and avoid interrupting
- Be authentic
- Take notes after the interaction so that you can focus on listening in the moment
- Ask someone what they would prefer to be called; do not assume and do not use titles such as Aunty or Uncle unless invited. Remember people's names.
- Consider gender and topics of conversation; it may only be appropriate to discuss certain aspects of perinatal health with someone of the same gender, for example.
- Shift from viewing clinical outcomes as your only goal, to prioritising the relationship and trust you have with patients

Additional tools and resources

- Applying clinical yarning to improve clinician-patient communication in Aboriginal health care, Lin et al.
- Clinical Yarning eLearning Program, the Western Australian Centre for Rural Health. Shares resources and an online training program for healthcare providers. The idea is to learn strategies to improve person-centred care and communication between care providers and Aboriginal and Torres Strait Islander communities.
- Figures 3, 4 and 5 in The Daalbirrwirr Gamambigu (Safe Children) Model: Embedding Cultural Safety in Child Protection Responses for Australian Aboriginal Children in Hospital Settings, Flemington et al.
- Working and Walking Together, SNAICC

Replanting the Birthing Trees Resource Repository

Our RBT team has created an online hub of courses, studies, podcasts, apps and videos about cultural responsiveness, trauma-awareness, ethical research, community partnership and more. It has sections designed for clinicians and practitioners, researchers and Aboriginal and Torres Strait Islander families and communities.

Flexible, welcoming and safe service provision

Personalised care

Acknowledgement of the scope and impact of trauma

Continuity of care/r

Index of tools and resources

Part 1

Governance, community control and co-design

- Building Respectful Partnerships, Victorian Aboriginal Child Care Agency
- Co-design toolkit, NSW Government Agency for Clinical Innovation
- Health Equity Toolkit, Queensland Health
- IAP2 Public Participation Spectrum, International Association for Public Participation
- Indigenous Governance Toolkit, Australian Indigenous Governance Institute
- Individual Self-Reflection and Organisational Readiness Assessment for co-design, NSW Health Agency
- National Safety and Quality Health Service Standards User Guide for Aboriginal and Torres Strait Islander Health, Australian Commission on Safety and Quality in Health Care

Part 2

Culturally responsive care

- Aboriginal Cultural Inclusion Checklist for Maternity Services, NSW Health
- Aboriginal and Torres Strait Islander Cultural Protocols in Victoria. MCRI Guide for Researchers, Murdoch Children's Research Institute
- Cultural responsiveness checking tool for services and programs, Yulang Indigenous Evaluation and University of Technology Sydney
- Cultural Safety Audit Tool for individuals, Lowitja Institute
- National Safety and Quality Health Service Standards User Guide for Aboriginal and Torres Strait Islander Health, Australian Commission on Safety and Quality in Health Care
- Replanting the Birthing Trees Resource Hub, RBT Project
- RISE Framework, Kildea et al.
- Working and Walking Together, SNAICC
- Working with Aboriginal and Torres Strait Islander Health Practitioners, Australian Health Practitioner Regulation Agency
- iSISTAQUIT
- SMS4DeadlyDads
- 13YARN

Trauma-aware, healing-informed care

- Aboriginal and Torres Strait Islander Child Placement Principle and Implementation Guide, SNAICC
- Clinical Yarning eLearning Program, Western Australian Centre for Rural Health
- Closing the Gap
- Cultural Safety in Trauma-Informed Practice from a First Nations Perspective, Nicole Tujague & Kelleigh Ryan
- The Daalbirrwirr Gamambigu (Safe Children) Model: Embedding Cultural Safety in Child Protection Responses for Australian Aboriginal Children in Hospital Settings, Flemington et al.
- A Good Practice Guide to support implementation of trauma-informed care in the perinatal period, Blackpool Better Start Centre for Early Child Development
- Family Matters Report 2024, SNAICC
- Healing Foundation
- National Aboriginal and Torres Strait Islander Health Plan 2021-2031, Commonwealth of Australia, Department of Health and Aged Care
- National Safety and Quality Health Service Standards User Guide for Aboriginal and Torres Strait Islander Health, Australian Commission on Safety and Quality in Health Care
- National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing, Commonwealth of Australia, Department of the Prime Minister and Cabinet
- "Replanting the Birthing Trees" and "Healing the Past by Nurturing the Future" online courses, Emerging Minds

- Replanting the Birthing Trees Resource Hub
- Supporting Aboriginal and Torres Strait Islander Families to Stay Together from the Start (SAFeST Start): Urgent call to action to address crisis in infant removals. Chamberlain et al.
- Toolkit for Doulas: Understanding the Impact of Gender-Based Violence, Wellness Within
- Trauma-Informed Care and Practice Organisational Toolkit, Mental Health Coordinating Council
- Trauma-Informed Healthcare Approaches, Megan R. Gerber (Ed.)
- Trauma-informed services and trauma-specific care for Indigenous Australian children, Judy Atkinson
- Working and Walking Together, SNAICC
- Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice, Pat Dudgeon, Helen Milroy, Roz Walker (Eds.)
- Ask Izzy
- Kimberley Mums Mood Scale
- Baby Coming You Ready? tool

Continuity of care/r

- Continuity of Care Handbook, Australian College of Midwives
- Continuity of Carer Models: A Midwifery Toolkit, NSW Health
- Guidance for nurses and midwives working with Aboriginal and Torres Strait Islander Health Practitioners, Nursing and Midwifery Board, Ahpra
- Implementing Birthing on Country services for Aboriginal and Torres Strait Islander families: RISE Framework, Kildea et al.
- An interactive decision-making framework (i-DMF) to scale up maternity continuity of care models, Toohill, Chadha and Nowlan.
- Midwifery Continuity of Carer Model Toolkit, Western Australia Department of Health
- National Safety and Quality Health Service Standards User Guide for Aboriginal and Torres Strait Islander Health, Australian Commission on Safety and Quality in Health Care
- Systems change to improve Aboriginal and Torres Strait Islander Maternal and Child Health Continuity of Care in South Australia, Glover et al.
- Woman-centred care: strategic directions for Australian maternity services, COAG Health Council

Part 3

Planning

- Australian Rural Birth Index, Longman et al.
- Emerging Minds Focus tool to guide structured planning processes, Emerging Minds
- Guiding Principles for Developing a Birthing on Country Service Model and Evaluation Framework, Kildea et al.
- National Aboriginal and Torres Strait Islander Health Plan 2021-2031, Commonwealth of Australia, Department of Health and Aged Care
- National Safety and Quality Health Service Standards User Guide for Aboriginal and Torres Strait Islander Health, Australian Commission on Safety and Quality in Health Care
- RISE Framework, Kildea et al.

Implementation

- Continuity of Care Handbook, Australian College of Midwives
- Continuity of Carer Models: A Midwifery Toolkit, NSW Health
- Midwifery Continuity of Carer Model Toolkit, Western Australia Department of Health

Monitoring and Evaluation

Screening and audit tools

- Aboriginal Cultural Inclusion Checklist for Maternity Services
- ASQ-TRAK, Strong Kids, Strong Future
- Baby Coming You Ready?
- Cultural Safety Audit tool (individual and organisational), Lowitja Institute
- Genuine Partnerships Audit Tool, SNAICC
- Kimberley Mums Mood Scale
- Yanha Yalinya Cultural Responsiveness Checking Tool, Yulang Indigenous Evaluation
- Social and Emotional Wellbeing assessment instruments for use with Indigenous Australians: a critical review, Le Grande et al.

Additional tools

- Aboriginal and Torres Strait Islander Child and Family Services Evaluation Readiness Toolkit, SNAICC
- AITSIS Code of Ethics for Aboriginal and Torres Strait Islander Research, Australian Institute of Aboriginal and Torres Strait Islander Studies
- Consolidated Framework for Implementation Research (CFIR 2.0), Center for Implementation
- Cultural safety in health care for Indigenous Australians: monitoring framework, Commonwealth of Australia, Australian Institute of Health and Welfare
- Ethical conduct in research with Aboriginal and Torres Strait Islander peoples and communities: guidelines for researchers and stakeholders, National Health and Medical Research Council (NHMRC)
- An Evaluation Framework to Improve Aboriginal and Torres Strait Islander Health, Lowitja Institute
- First Nations Cultural Safety Framework, Australian Evaluation Society
- Framework for Governance of Indigenous Data, Commonwealth of Australia
- Indigenous Data Sovereignty Readiness Assessment and Evaluation Toolkit, Lowitja Institute
- *Indigenous Data Sovereignty: Toward an agenda*, Tahu Kukutai and John Taylor (book)
- Maiam nayri Wingara Indigenous Data Sovereignty Collective
- National Safety and Quality Health Service Standards User Guide for Aboriginal and Torres Strait Islander Health, Australian Commission on Safety and Quality in Health Care
- RE-AIM Framework

Sustainability and supporting staff

- Developing employee-centred rostering principles, Safer Care Victoria
- Nurse Midwife Health Program Australia. Provides a nationwide, free and confidential peer support and counselling service for nurses, midwives and students. It is delivered by nurses and midwives with lived experience. A dedicated branch of the program for Aboriginal and Torres Strait Islander practitioners is currently in development.
- Midwifery Futures: Building the Australian midwifery workforce, Homer et al.
- Murra Mullangari program, CATSINaM
- National Safety and Quality Health Service Standards User Guide for Aboriginal and Torres Strait Islander Health, Australian Commission on Safety and Quality in Health Care
- Position Statement: Clinical Supervision for Nurses and Midwives, Australian College of Mental Health Nurses, Australian College of Midwives and Australian College of Nursing
- Psychological First Aid: Guide for field workers, World Health Organisation
- Recommended Reading List for Reonciliation Allies, Reconciliation NSW
- Resources, books and films to help you be a better First Nations ally, TACSI
- The Thrive at Work Toolkit, Thrive at Work
- The Victorian Mentally Healthy Workplaces Framework, Victorian Government
- Workplace Mental Health toolkit, The Black Dog Institute
- WorkWell Toolkit, WorkSafe Victoria

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ABBREVIATIONS

ACCO:	Aboriginal Community Controlled Organisation
ACCHO:	Aboriginal Community Controlled Health Organisation. For consistency, we use this to refer to all community controlled health organisations and services even though they are known by different names in different states and jurisdictions.
AHLO:	Aboriginal Hospital Liaison Officer
Ahpra:	Australian Health Practitioner Regulation Agency
AHW/AHP:	Aboriginal Health Worker/Aboriginal Health Practitioner. These roles are delineated by the training required and by professional roles and responsibilities. In NSW, for example, an AHW is a non-clinical role while an AHP has a Certificate IV in primary health care practice. Read more about scopes of practice from the National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners.
BCYR:	Baby Coming You Ready?
BiOC:	Birthing in Our Community
CATSINaM:	Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
CFIR**:**	Consolidated Framework for Implementation Research
GP:	General Practitioner
MGP:	Midwifery Group Practice. Also known as caseload midwifery. Care is provided through pregnancy, labour, birth and up to six weeks postpartum by a primary midwife, who is supported by a second midwife or a small 'back-up' team of midwives.
NSQHS:	National Safety and Quality Health Service
RAP:	Reconciliation Action Plan
RISE:	Referring to the RISE Framework,[39] which stands for Redesigning health services, Investing in workforces, Strengthening families, and Embedding community governance and control.
RBT:	Replanting the Birthing Trees, which is an Aboriginal and Torres Strait Islander-led, evidence-based project at the University of Melbourne implementing culturally responsive, trauma-aware, healing-informed continuity of care during the first 2000 days of life.
SEWB	Social and Emotional Wellbeing