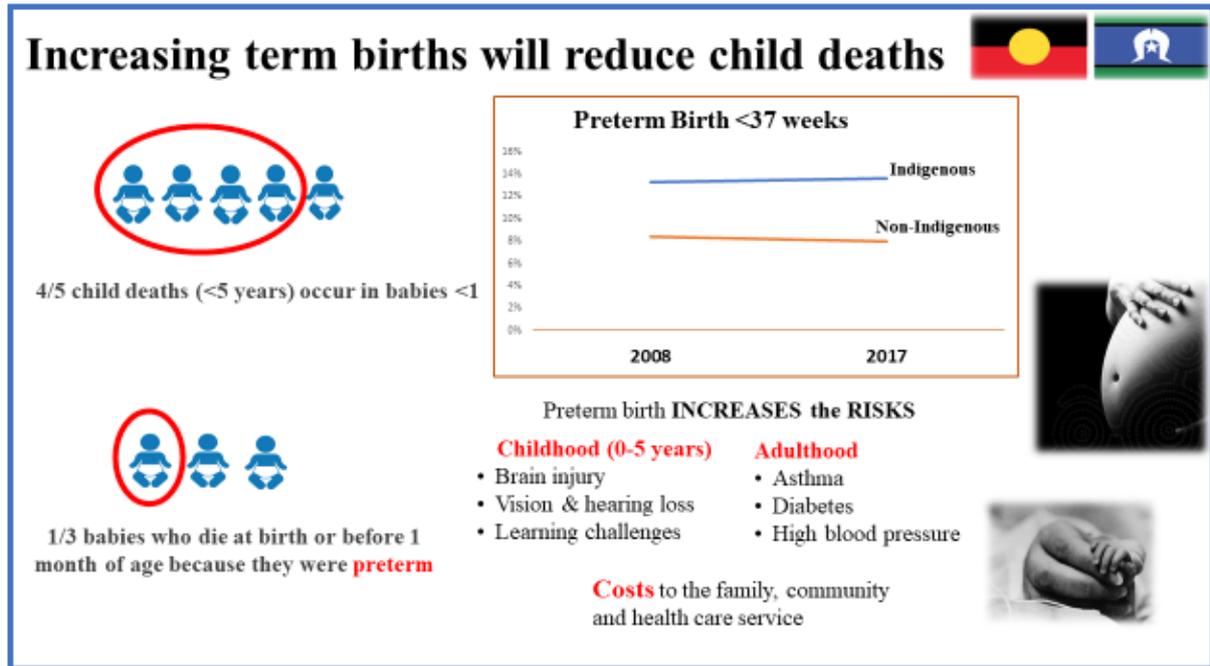
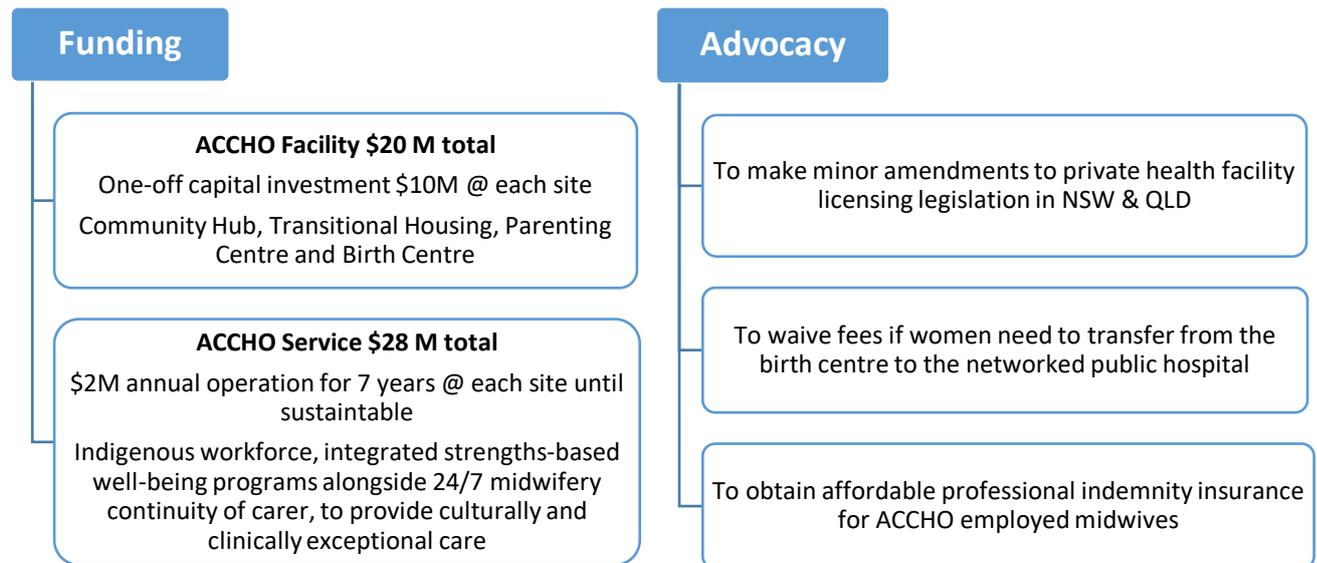


Birthing on Country services and facilities in Brisbane & Nowra: impact for Aboriginal and Torres Strait Islander families



Birthing on Country is community-driven innovative national solution to Closing the Gap.

It will increase life expectancy and quality of life through a reduction in preterm birth, low birth weight, child and maternal morbidity and mortality. Cost saving will result from improved health outcomes e.g. a single episode of neonatal nursery care for a preterm baby costs \$52,984 (range \$3,591 - \$297,567). Aboriginal Community Controlled Health Organisations (ACCHOs) will work in partnership with mainstream services to progress Birthing on Country. We need Government investment.



Background

Birthing on Country is an evidence-based, complex intervention designed to improve Aboriginal and Torres Strait Islander maternal and infant health outcomes within the first 1000 days.

Birthing on Country returns maternity services to Indigenous communities and Indigenous control with Indigenous governance a key part of the redesigned maternity service. Gold-standard midwifery continuity of care is **provided to all women**; those with *normal risk pregnancies* birth in the standalone Aboriginal and Torres Strait Islander Birth Centre that is networked into the closest maternity hospital, where women with *complex care needs* will birth with access to their known midwife providing their clinical care. Strategies to grow the Indigenous workforce and strengthen the capacities of families are integral to this program. All women will receive culturally safe care which will be mandated in staff training. Birthing on Country addresses the social determinants of health including income, employment, education, and access to culturally safe health care.¹ Birthing on Country² Services are:

“Maternity services designed and delivered for Indigenous women that encompass some or all of the following elements: are community based and governed; allow for incorporation of traditional practice; involve a connection with land and country; incorporate a holistic definition of health; value Indigenous and non-Indigenous ways of knowing and learning; risk assessment and service delivery; are culturally competent; and developed by, or with, Indigenous people.”³

Preterm birth has a number of risk factors which can be **modified through early and frequent access** to maternity care.⁴ Aboriginal and Torres Strait Islander women are more likely to delay booking for mainstream maternity care and to attend less frequently or not at all, because care is not accessible or culturally safe.⁵ To address this, **Birthing on Country** embeds key strategies, which are underpinned by national and international research:

- **Relationship-based care with a known midwife**, in collaboration with doctors, is cost-effective and safe.⁶ Research demonstrates that midwifery continuity of carer is a protective factor to reducing preterm birth.⁷
- **A free-standing birth centre** (Level 2 maternity service) for low-risk pregnant women planning a normal birth (no on-site epidural or caesarean section). Service and workforce requirements are governed by Clinical Service Capability Frameworks. Research shows these facilities provide safe perinatal care for babies and improved outcomes for mothers, including in rural and remote areas.⁸

Continuity of Midwifery Care:

A Cochrane systematic review (15 RCTs, n=17,674) of continuity of midwifery care found outcomes for women and babies are significantly improved when care is offered by a known and trusted midwife (relationships are vital to Aboriginal health and well-being), usually delivered through a midwifery group practice. These findings include:

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| <ul style="list-style-type: none"> • ↓ Fetal loss and neonatal death • ↓ Amniotomy • ↓ Augmentation (Syntocinon) • ↓ Epidural and spinal analgesia • ↓ Preterm birth • ↓ Episiotomy • ↓ Instrumental birth • ↓ Cost | <ul style="list-style-type: none"> • ↑ Women with no analgesia in labour • ↑ Spontaneous vaginal birth • ↑ Longer labour (< hour) • ↑ Known midwife at birth • ↑ Feelings of control • ↑ Satisfaction • ↑ Sustained breastfeeding |
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Proof of concept

The Birthing on Country urban service, called **Birthing in Our Community** in Brisbane, has seen a **significant reduction in preterm birth in 4-years**; it has National Health and Medical Research Council funds to conduct the evaluation. The **Birthing in Our Community** team credits the success of the program to:

- ✓ Partnership between two ACCHOs (**Institute for Urban Indigenous Health, Aboriginal and the Torres Strait Islander Community Health Service Brisbane Ltd**) and a Mainstream service (**Mater Health Service**) with the ACCHOs holding most of the funds and a Steering Committee overseeing governance
- ✓ Location of services in a ACCHO Community-Based Hub
- ✓ A Single Birthing in Our Community Service Manager
- ✓ Aboriginal and Torres Strait Islander Family Support Workers
- ✓ Continuity of midwifery carer
- ✓ Flexible service delivery model
- ✓ A comprehensive integrated primary health care platform
- ✓ Strength-based social and emotional well-being focus
- ✓ Investment in building and strengthening the Aboriginal and Torres Strait Islander maternity workforce
- ✓ A research framework.

Considerations

Policy	Birthing on Country aligns with the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 vision to ensure “ <i>Aboriginal and Torres Strait Islander people have access to health services that are effective, high quality, appropriate and affordable.</i> ” It is supported by the principles of the National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families - access, equity and equality, leadership and partnership, collaboration, evidence-based, strengths-based, culturally safe and competent services, workforce development and accountability.
Social and Cultural	Returning Aboriginal birthing to community control will ensure self-determination through sound Indigenous decision making processes that can mobilise resources to enact the aspirations of women and the community. Promoting a model of care that embeds cultural birthing practices that is mother and family-centred.
Economic	Increasing Aboriginal women’s early and sustained engagement with maternity care will increase rates of screening, treatment, referral and holistic care. Together this will impact maternal and infant outcomes which will deliver direct and indirect cost-savings to the health system and to the women.
Technological	Birth Centre midwives will utilise information systems that enable contemporaneous documentation of maternity care and continuity of care within networked services. Telehealth will be used to access health specialist (e.g case conferencing, pharmacists, psychologist) to provide timely access to key services.
Legal	There are private health facility licensing and professional indemnity insurance barriers which need to be addressed to enable the service and facility to operate in both New South Wales and Queensland demonstration sites.

Recommendations

Critical Areas	Without a solution to these barriers Birthing on Country is not viable	Options and recommendations
Funding	<p>We require Commonwealth government investment for capital works funding at both demonstration sites (QLD and NSW). Each site has architectural designs for the facility which has been co-designed with the community.</p> <p>We require Commonwealth government commitment to provide for annual operating costs for 7 years while both sites become self-sufficient and sustainable; and rigorous evaluation of the model occurs.</p>	<p>Capital works funding \$10M each site = \$20 M total</p> <p>Annual operating cost funding \$2M each site for 7 years = \$28 M total</p>
Legislation	<p>Minimum Patient Throughput Standard The Private Health Facilities Act 1999 (QLD) has subordinate legislation set-out in the Private Health Facilities (Standards) Notice 2016 (QLD) which includes the Minimum Patient Throughput Standard (version 5). This standard requires 240 births per obstetric facility per year. Although this standard references the Shearman Report (1989), examination of this document finds no recommendation for the number of births required per facility per year.</p> <p>Clinical Services Capability Framework (CSCF) – Neonatal The CSCF Neonatal module V3.2, Service Networks (page 2), states that high risk infants should be identified and transferred in utero to higher level service. However, if birth of an unwell neonate occurs in a facility without the necessary capabilities, it should be stabilised and transferred to higher level service in the network with appropriate capabilities. This is appropriate and the Level 2 service will be designed to enable timely transfer for the neonate. However the CSCF Neonatal module V3.2, Neonatal Level 2 Service Description (workforce requirements, page 5) states there must be <i>“access—24 hours—to registered medical practitioner able to attend within 30 minutes in normal circumstances.”</i></p> <p>The Private Health Facilities Regulation 2017 (NSW), Part 10, Section 38b requires a Level 2 private maternity facility (Birth Centre) to have a medical practitioner at the facility at all times. There is no current evidence base internationally that supports this statement. It is not a requirement in other jurisdictions (e.g. Queensland) or other countries (e.g. Canada, New Zealand, United Kingdom). A networked approach will enable staff 24/7 access to staff at the local hospital and facilitate timely transfer. The Operational Plan and Risk Management Plan provide guidance for escalation and support and the Australian College of Midwives Guidelines for Consultation, Referral and Transfer will underpin activities.</p>	<p>There is no current evidence base internationally that supports this throughput. Remove the requirement for a minimum number of births from the Minimum Patient Throughput Standard</p> <p>There is no current evidence base internationally that supports this statement. Remove the phrase <i>“able to attend within 30 minutes in normal circumstances”</i> from the CSCF – Neonatal</p> <ol style="list-style-type: none"> 1. Amend legislation to remove Section 38b 2. Offer a fixed term exemption whilst demonstration project is evaluated 3. Introduce new legislation for stand-alone Birth Centre

Critical Areas	Without a solution to these barriers Birthing on Country is not viable	Options and recommendations
Private admission fees	Women admitted to private health facilities (Birth Centre) or to hospitals as private patients (when transferring with midwife to referral hospital) attract significant fees i.e. reducing access to evidence based high quality integrated care.	<ol style="list-style-type: none"> 1. Birth Centre and the Hospital waiver fees 2. Fees are charged with funding sourced from government.
Professional indemnity insurance (PII)	To date we have been unable to secure an affordable PII product for an ACCHO to employ midwives to provide intrapartum care (during birth) in an ACCHO owned and operated Level 2 Birth Centre. The Medical Insurance Group of Australia (MIGA) has a product for healthcare companies and a quote has been received for \$55K per annum but exact terms are still being investigated to ensure this covers birth in a birth centre.	<ol style="list-style-type: none"> 1. Government assist in negotiations with MIGA to obtain a workable product 2. Government provide insurance whilst demonstration project is evaluated

Birthing on Country Logic Model

Inputs	Operational funding at each site		Capital works funding at each site		NHMRC research grant
Activities	Establish partnerships ACCHOs collaborate with key stakeholders	Develop services ACCHO employed and insured midwives provide continuity of carer with family well being workers	Develop facilities ACCHO owned, maternity hub + licensed Level 2 birth centres	Develop programs strengths-based social and emotional well-being programs	Develop career pathways Monitor cultural safety
Outputs	Indigenous-governed maternity service and facility Culturally and clinically safe, accessible and cost-effective		Strengths-based, holistic programs integrated into maternal infant health service		Pathways for midwifery and nursing higher education for Aboriginal students Cultural safety package for non-Indigenous staff Tools to measure cultural safety
Outcomes	<ul style="list-style-type: none"> ▲ Healthy mothers and babies ▲ Health engagement (early and sufficient maternity care) ▼ Risks (e.g. smoking, infections) ▼ Babies born too soon (preterm) ▼ Babies born too small (low birth weight) ▲ Normal births ▼ Cost to families and government 		<ul style="list-style-type: none"> ▲ Optimal nutrition mums and bubs (e.g. breastfeeding) ▲ Emotional resilience ▲ Family preservation and restoration ▲ Parental effectiveness ▼ Stress in pregnancy and homelessness ▼ Infant hospitalisations ▼ Child removals 		<ul style="list-style-type: none"> ▲ Indigenous health workforce ▲ Indigenous students ▲ Indigenous degree graduates ▲ Indigenous research workforce ▲ Cultural Safety ▼ Racism and discrimination
Impact	Birthing on Country sites which demonstrate how to Close the Gap for Aboriginal and Torres Strait Islander mothers and babies				
	ACCHO = Aboriginal Community Controlled Health Organisation				

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