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Utilising the RISE Framework to implement birthing services for First Nations families

In October 2022, First Nations community representatives, researchers, health service providers, policy advisors and clinicians will travel to Mparntwe, (pronounced mm-BARN-doo-uh), Alice Springs, for a national gathering on Central Arrernte land. The gathering provides an opportunity for delegates from across Australia to showcase exemplary models of care, to share new research and ideas, and to network and invest in a shared vision to address inequities in maternal and infant health services and outcomes for First Nations mothers and babies. Health services will showcase how they have redesigned and delivered their care to make a profound impact on Closing the Gap Target 2: First Nations children are born healthy and strong.

First Nations mothers and babies experience profound health inequities compared to other Australians. A disproportionate number experience adverse outcomes in pregnancy and birth [1,2] with mothers being 3–5 times more likely to die in childbirth [3], and their babies 2–3 times more likely to be born too preterm, low birth weight and to die in their first year (infant mortality) [4]. Inequity increases with remoteness with two thirds of First Nations birthing mothers live in rural and remote areas compared to 27% of other Australian women [4]. Many remote communities have inadequate access to services [5,6], do not have local midwives or birthing services [5,7] and this has worsened in recent decades [8] with a 41% reduction in rural maternity services over 20 years, and a 47% increase in babies born before arrival at hospital [5]. In the Northern Territory, where our gathering is being held, some communities are classified as 'very remote' and here we see the highest preterm rates in Australia: one in five babies born preterm (22%) [9]. We simply must prioritise the role of the midwife in these settings. Many risk factors for preterm birth [10], maternal mortality [11] and other poor outcomes are modifiable and/or treatable. We do not need midwives who are also nurses. Nurse midwives will always have to prioritise the sick, will need to take their share of the on-call roster and may then miss out on what was planned for the following day. Routine antenatal and postnatal can be cancelled and women can miss out. This becomes dangerous. For greatest impact and effectiveness, midwives must be available 24/7 to work holistically in the community (not necessarily the health centre) side-by-side with First Nations workers (e.g. Strong Women, Family Support workers, and home visiting teams such as the Australian Family Partnership Program or the Maternal Early Childhood Sustained Home-visiting teams). Our gathering will showcase how to redesign services for greater impact. We have evidence to show 'how' redesigned services, led by the Aboriginal community-controlled health services in partnership with mainstream, increase effectiveness. We now need to make it happen.

The Best start to life for First Nations families national gathering is an initiative of the Molly Wardaguga Research Centre (Birthing on Country Centre for Research Excellence) at Charles Darwin University and the Central Australian Aboriginal Congress, a large Aboriginal Community Controlled Health Service (ACCHS) based in Central Australia. Congress is one of the most experienced Aboriginal health organisations in the country, a national leader in primary health care, and home to Congress Alukura women's health service, established in 1987. The first national Birthing on Country Workshop was held in Mpartnwe, hosted by Congress and the Australian Maternity Services Inter-Jurisdictional Committee. We will explore the progress that has been made against the recommendations from a decade ago. A key outcome of the gathering will be a strategic roadmap for the redesign of maternity services that lead to direct health benefits for future generations. The roadmap will be underpinned by the RISE SAFELY translation framework (Fig. 1) [12]. This framework has been developed to guide research translation, adaptation and scale-up, focusing on the four **RISE** pillars: Redesigning the health service; Investing in the workforce; Strengthening First Nations families; and Embedding First Nations community engagement, governance and control in all aspects of the services [13]. Our framework was developed from a synthesis of the learnings from major maternity service redesigns: testing continuity of care for women of any risk in pregnancy [14,15] adapting this model in the First Nations remote setting to improve care for women travelling to Darwin for birth (2007–12) [16–18], and in the urban First Nations setting (2014–20) (Figure 2) [19,20]. Women and culture are at the centre of care and the framework is underpinned by Aboriginal relationality (interconnectedness) to 'Country', people (centre), dreaming (creation), law/lore (cultural practices, customs, laws and protocols), and ceremony [13].

This special issue reflects on current research aimed at understanding 'how' to improve First Nations maternity and birthing services. The articles have been categorised using the RISE Framework and have been published since the 2019 'Birthing on Country in Australia' special issue that was collated by leading First Nations academics Prof Cath Chamberlain and Prof Rhonda Marriot. They noted the 'critical socio-cultural and spiritual dimensions of Birthing on Country' and the slow government response to the Inter-jurisdictional report recommending these services be established in 2013 [21]. It is pleasing to see further progress has been made since then – though we still have a long way to go.

Redesign the health service

Current maternal and birthing data reflect systemic structural barries which result in First Nations health inequities. We need to interrogate the existing colonial structures and redesign a system that is clinically, and culturally safe centring mothers', babies and families. We need to a system that embeds the aspirations of First Nations people. In the first

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Fig. 1. RISE Framework.

paper First Nations author Pamela McCalm and team describe what women (n = >300) believe is important including: privacy and confidentiality (98%), feeling that staff were trustworthy (97%), unrestricted access to support people during pregnancy appointments, (87%) birth (66%) and postnatally (75%), midwife home visits (78%), female carers (66%), culturally appropriate artwork, brochures (68%) and access to Elders (65%).

Paper two describes the experiences of women from the Kimberley region of Western Australia.

Most women described positive experiences and highlighted the valuable role of family support and the Aboriginal workers during the antenatal period. Many women described travelling long distances for both antenatal care and birth, often spending many hours on bumpy roads and some flying to regional centres, including Perth without partners or escorts. These stories echo a continuing legacy of system failure that is unfair and unjust, far from women centred. Our challenge is to reopen services closer to home and family, where this isn't possible, every woman should have an escort of their choosing.

Invest in the workforce

This pillar focuses on a clinically and culturally exceptional workforce that provides continuity of care across the maternity journey from both the midwifery workforce and the First Nations wrap around services. Growing First Nations midwives in Australia is a national priority. Paper three helps us understand 'how' research works to drive service improvement. It describes the Participatory Action Research approach used to mentor two young First Nations women as research assistants on the Indigenous Birthing in an Urban Setting study. The women's narratives where reported to the Steering Committee for immediate action.

Paper four provides a integrative literature review exploring Aboriginal Bachelor of Midwifery student experiences in Australia, to provide an insight into their perceptions of enablers and barriers to success. Cultural safety, kinship and support, access to role models and mentors were all important factors. Barriers to successful completion of the BMID degree included racism, financial concerns, feelings of isolation, and lack of confidence and literacy.

Strengthening the capacity of First Nations families

The third pillar is about working with women and their families to strengthen their capacity across the first 1000 days (pregnancy to 2-years). Privileging the voices of women papers five and six highlight the work of Prof Chamberlain and her team as they explore how best to provide culturally appropriate support for parents experiencing complex trauma. Goals for trauma-aware culturally safe care include nurturing authentic partnerships; a skilled workforce educated in trauma awareness; empowering and compassionate care for building trust and safe and accessible environments to facilitate parent engagement.

Papers seven and eight describe the latest evidence regarding breastfeeding with a systematic review highlighting the limitations associated with current data, and that First Nations women do not meet the internationally recognised rates for breastfeeding. Paper nine provides an insight to why this may be the case with four factors influencing women's breastfeeding practice; sources of support including community knowledge and support, family and partner support and breastfeeding mentor programmes, culturally appropriate care, intention to breastfeed and social determinants (e.g. education).

Embed First Nations community engagement, governance and control

We need a system that embeds the aspirations of First Nations people. How to do this is clearly outlined in the paper nine in this issue by where collaborators Associate Professor Yolŋu knowledge holder Lawurrpa Mapilama, Dr Sarah Ireland and team describe the transferability of the RISE Framework from an urban setting to a culturally, linguistically and historically distinct area in East Arnhem Land. Importantly, women describe that being born on 'their country' is interpreted by Yolŋu as their ancestral lands [22]. In the context of Birthing on Country Services they need to incorporate Yolŋu sovereignty over their lands and bodies; and provide opportunities for women to be cared for and give birth in a safe and home-like environment physically connected to their 'home' ground i.e. place of usual residence – *wäŋa* and their *gurruṯu* – kinship networks. Through the process of transforming the RISE Framework they highlight the RISE pillars as foundational beliefs and values required for maternity services to adequately care for Yolŋu women and families. The team are working with stakeholders across the area to respond to community requests to return childbirth services to the island. They will be redesigning care to embed Djakamirrs (Yolŋu childbirth companions) into the workforce, ensuring the kinship networks can be present, even when women need to leave home for birth [23].

Current maternity and birthing services in Australia are hospital-centric and fail to reflect the aspirations of First Nations people as described in our last articles of this issue. A coalition of Indigenous and non-Indigenous researchers from Australia, Aotearoa New Zealand, United States and Canada argue for the urgent need for adequately funded Indigenous-led solutions to perinatal health inequities for Indigenous families in well-resourced settler-colonial countries. Authors describe examples of successful community-driven programmes making a difference and call on all peoples to support and resource Indigenous-led perinatal health services by providing practical actions for individuals and different groups [24].

In summary, the Indigenous Birthing in an Urban Setting study [19, 20] highlighted what can be gained when services work in partnership with RISE principles providing a framework forward. The leadership from the Institute for Urban Indigenous Health, the Mater Hospital, and the Aboriginal and Torres Straight Islander Community Controlled Health Service, Brisbane found unprecedented success with the ACCHSs now planning scale out across South-East Queensland.

Prof McLachlan and her team successfully translated this evidence into practice for First Nations women in three maternity services in Victoria, Australia [25]. Key enablers included co-design with First Nations people, staff cultural competency training, identification of First Nations women and regular engagement between caseload midwives and First Nations hospital and community teams. Translation into a rural setting was not successful. It is the rural and remote settings, and how to 'scale out' that now needs urgent further.

The first Birthing on Country National Conference in 2012 laid a solid foundation of capturing the aspirations and vision for First Nations women. The Best Start to Life gathering continues to build on this foundation to ensure that First Nations mothers and babies get the best start in life. The RISE Framework presents a phased approach for the implementation of Birthing on Country services aimed at improving

services and outcomes for First Nations families.

This special edition seeks to shine a light on the urgency of addressing maternal and birthing services for First Nations mothers and babies as well as showcasing the research and celebrating the success of what is occurring in this area.

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Ethics approval and consent to participate

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Author agreement

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Author contributions

This is a true statement that all authors meet the criteria for authorship and that all people entitled to authorship are listed as authors. All authors contributed equally to conceiving, writing, revising and proof reading this editorial.

Conflict of interest

None declared.

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