Protocol

Systems change to improve Aboriginal and Torres Strait Islander Maternal and Child Health Continuity of Care in South Australia

SAHMRI
South Australian Health & Medical Research Institute

The Aboriginal Communities and Families Health Research Alliance

Systems change to improve Aboriginal and Torres Strait Islander Maternal and Child Health Continuity of Care in South Australia

2022-2032

This protocol has been produced for the South Australian Government Department of Health and Wellbeing, Aboriginal Health Strategy Branch (the Department) by the South Australian Health and Medical Research Institute (SAHMRI) Women and Kids Theme, in collaboration with the Aboriginal Health Council of South Australia (AHCSA), all SA Aboriginal Community Controlled Health Organisations (ACCHOs) and health and other systems leaders across South Australia.

The responsibility for implementation of this protocol rests with the Department.

Artwork story:
The artist is Dawn Likouresis, who is Adnymathanha, Antikirinya, Arabana, and her daughter Leilamarie Stuart -Likouresis
Artwork title: *Tjitji Umbunini*

- *Holding on to the baby* (Antikirinya).

The women in the circle represent a healthy pregnancy. The green circle represents the country with bush tucker and healthy foods. The feet around the outside of the large circle represent the stillborn babies that are still with us in spirit and the feet around the smaller circles represents the babies through miscarriage. The circle dots represent the healthy children born, from birth to 5 years of age. The larger horseshoe shape represents the fathers, and the smaller horseshoe shapes represent mothers, grandmothers, grandfathers and the community support. The different colours of the mothers represent Stolen Generation women and all Aboriginal women.

Acknowledgements

SAHMRI acknowledges Aboriginal and Torres Strait Islander people as the first peoples of Australia and the longest continuous living culture in the world. We recognise the injustices of the past and that Aboriginal and Torres Strait Islander people do not experience the same equality of rights and life expectancy as other Australians. We respect the resilience of Aboriginal and Torres Strait Islander people in the face of adversity.

SAHMRI acknowledges the support and contributions from the: AHCSA Chief Executive Officer (CEO) Forum, Consultation and Engagement Working Group, Pregnancy and Birthing Working Group, the Child Health Working Group, independent facilitators, Rapid Review Working Group and project champions for their commitment and expertise provided to ensure Aboriginal and Torres Strait Islander voices were privileged and that we stayed true to the purpose of the project throughout the development of this protocol.

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Aboriginal Affairs and Reconciliation	AAR
Aboriginal Community Controlled Health Organisation	ACCHO
Aboriginal Community Controlled Organisation	ACCO
Aboriginal Communities and Families Health Research Alliance	ACRA
Australian College of Rural and Remote Medicine	ACRRM
Aboriginal Family Birthing Program	AFBP
Aboriginal Health Council of South Australia	AHCSA
Australian Health Practitioner Regulation Agency	AHPRA
Aboriginal Health Strategy, SA Health	AHS
Aboriginal and Torres Strait Islander Health Worker	AHW
Australian Medical Association	AMA
Aboriginal and Torres Strait Islander Child Placement Principle	ATSICPP
Aboriginal Maternal and Infant Care Worker/Practitioner	AMIC
Australian Nursing and Midwifery Federation	ANMF
Australian and New Zealand School of Government	ANZSOG
Child and Family Assessment Referral Networks	CFARNS
Child and Family Health Service	CaFHS
Congress of Aboriginal and Torres Strait Islander Nurses and Midwives	CATSINAM
Chief Executive, Department for Health and Wellbeing	CE Health
Chief Executive Officer	CEO
Chief Operating Officer	COO
Commission on Excellence and Innovation in Health	CEIH
Close the Gap (funding agreements and implementation plans)	CTG
Community Health Centre	CHC
Commissioner for Aboriginal Children and Young People	CACYP
Department for Child Protection	DCP
Department for Education	DfE
Department for Health and Wellbeing	DHW
Department for Premier and Cabinet	DPC
Department of Human Services	DHS
Department of Treasury and Finance	DTF
National Disability Insurance Scheme	NDIS
Institute for Urban Indigenous Health	IUIH
Non-government Organisation	NGO
Infant family-centred developmental care	IFCDC
Limestone Coast Local Health Network	LCLHN
Local Health Network	LHN
National Safety and Quality Health Service	NSQHS
National Safety and Quality Primary and Community Healthcare Standards	NSQPCHS
Nursing and Midwifery Coalition	NM coalition
Office of the Early Years (SA Government)	OEY
Out of Home Care	OOHC
Primary Health Networks	PHN
Public Health Medical Officers	PHMO
Quality and Safety	Q&S

Royal Australian College of General Practitioners	RACGP
Rural Support Service (Eyre, Far North LHNs)	RRS
South Australia	SA
SA Health including LHN’s	SA Health
South Australian Aboriginal Community Controlled Organization Network	SAACCON
South Australian Aboriginal Health Partnership	SAAHP
Senior Officers Group Aboriginal Health	SOGAH
Wellbeing part of Department for Health and Wellbeing	Wellbeing SA
Women’s and Children’s Health Network	WCHN
World Health Organization	WHO

Executive Summary

The Australian health care system contributes explicitly and implicitly to health inequities experienced by Aboriginal and Torres Strait Islander people (1) by reflecting a legacy of western Eurocentric views (2). There is a lack of integration of historical and/or cultural perspectives of Aboriginal and Torres Strait Islander societies guiding current health care practice (2) which exacerbates and propagates a culturally unsafe health care system.

In South Australia (SA), Aboriginal and Torres Strait Islander women are less likely to attend antenatal care than non-Aboriginal women. In 2017, 17.2% of Aboriginal and Torres Strait Islander babies born in SA were of a low birthweight, 2.5 times higher than other babies (3). Data from the Aboriginal Families Study (AFS)—a population based birth cohort of 344 Aboriginal and Torres Strait Islander infants and their mothers (of which 225 were Aboriginal mothers and 26 non-Aboriginal mothers of Aboriginal children)/carers—found one in five Aboriginal and Torres Strait Islander women did not see a general practitioner (GP) in the first four to nine months after giving birth (4, 5). In addition, one in seven women in the AFS did not recall seeing a Child and Family Health Services (CaFHS) nurse during the postnatal period.

Many Aboriginal and Torres Strait Islander women and women of Aboriginal children in SA also experience social health issues during their pregnancy including housing instability, exposure to family and community problems including family violence, and grief resulting from loss of family members. The AFS found one in four Aboriginal and Torres Strait Islander women and women of Aboriginal children experienced five to 12 social issues during their pregnancy (6).

Aboriginal and Torres Strait Islander women, women of Aboriginal children, children and families have the right to receive the highest quality health and social care. This cannot be achieved with a 'business as usual' approach or with short-term uncoordinated efforts. Dedicated and augmented initiatives, supported with long term funding, are required to effectively close this health disparity gap.

Consultation process

In collaboration with Aboriginal Community Controlled Health Services across SA, we conducted extensive stakeholder consultations throughout 2021. Our process privileged

Aboriginal and Torres Strait Islander voices and experiences and incorporated the views of health care providers working in Aboriginal community controlled health services, mainstream acute and primary care settings, and representatives from Government and non-government organisations (NGOs) providing health and social care in the early years of life for Aboriginal and Torres Strait Islander communities.

Our consultations revealed it was critical to address health and wellbeing outcomes for women, children and families from these communities, now and for future generations. The issues identified were consistent with SA health system strengths (e.g., Aboriginal specific roles) and weaknesses (e.g., short term funding, siloed programs, lack of evaluation) identified in the past decade (7-9). Our consultations also provided an opportunity for stakeholders to determine where accountability and monitoring functions should sit for the recommendations and actions developed. Issues to address included:

- Eliminate institutional, systemic, and interpersonal racism experienced by Aboriginal and Torres Strait Islander health services and Aboriginal and Torres Strait Islander families.
- Reduce unnecessary notifications to the child protection system, including unborn child notifications, by increasing early interventions that support families experiencing challenges, and prevents or reduces the number of Aboriginal and Torres Strait Islander infants and children (of both Aboriginal and non-Aboriginal mothers) encountering the Department of Child Protection (DCP).
- Reduce fragmentation of care for women, children, and families, particularly in the postnatal, infancy and early childhood periods, as referrals to unknown specialist and other services can damage the relationship families have with known service providers.
- Increase access to culturally responsive health and social care in these important life stages of pregnancy, birthing, infancy, and early childhood.
- Remodel care and reform systems through trialling and improving models of care consistent with continuity of care.
- Improve identification and management of Aboriginal and Torres Strait Islander children, (born to Aboriginal and non-Aboriginal mothers) with developmental issues or physical or intellectual disabilities.
- Increase the number of skilled and trained Aboriginal and Torres Strait Islander workers in maternal, infant, child health development and care coordinator roles.

- Strengthen the role for Aboriginal Community Controlled Health Organisations (ACCHOs) to deploy Aboriginal and Torres Strait Islander maternal and child health continuity of care initiatives.

Protocol for Continuity of Care

Following consultation, and a comprehensive review of the academic literature, we developed 13 recommendations, with specific action items, for implementation in the *immediate*, *medium* (until June 2023), or *long term* (from 2023 onwards). Our protocol reflects actions to address continuity of care across three components (10):

1. Relational continuity – the ongoing relationship between the primary care provider and patient (interpersonal continuity), and the history of interactions with that provider (longitudinal continuity).
2. Informational continuity – the availability of patient information across encounters and health providers, accumulated knowledge on context, and the use of this information to inform treatment decisions.
3. Management continuity – the complementary care received from different providers and/or organisations that may extend beyond health care to include social services.

By addressing continuity of care across these components, major reform will be possible through enhancing existing SA Government health initiatives including implementing quality and safety standards, consumer engagement activities, service level agreements and current state-wide action plans and strategies.

Roadmap to systemic change

Change cannot be achieved by one single entity and requires improving collaboration between all parts of the health and social care systems. Our consultations with health care stakeholders identified that a system framework to support continuity of care should be based on recognition that all service systems are linked. Mutual understanding of how each health area operates, however, was often absent. This suggests services in many areas operate in a silo (including Local Health Networks [LHNs]).

There was also recognition that LHNs, and other services across the sector, focus on specific groups and have differing policies, procedures, legislative and funder requirements. Funding and/or reporting arrangements are often inflexible which do not support families that move within and across these systems. To reduce the isolated and siloed administrative and service delivery elements, we need to ensure system components unite in a culturally responsive manner.

This protocol reflects the cultural considerations from consultations, health and social health service feedback as well as the components of the 2014 WHO health systems framework: Health information, Workforce, Health service delivery, and these come through in the set of recommendations (see Figure 1).

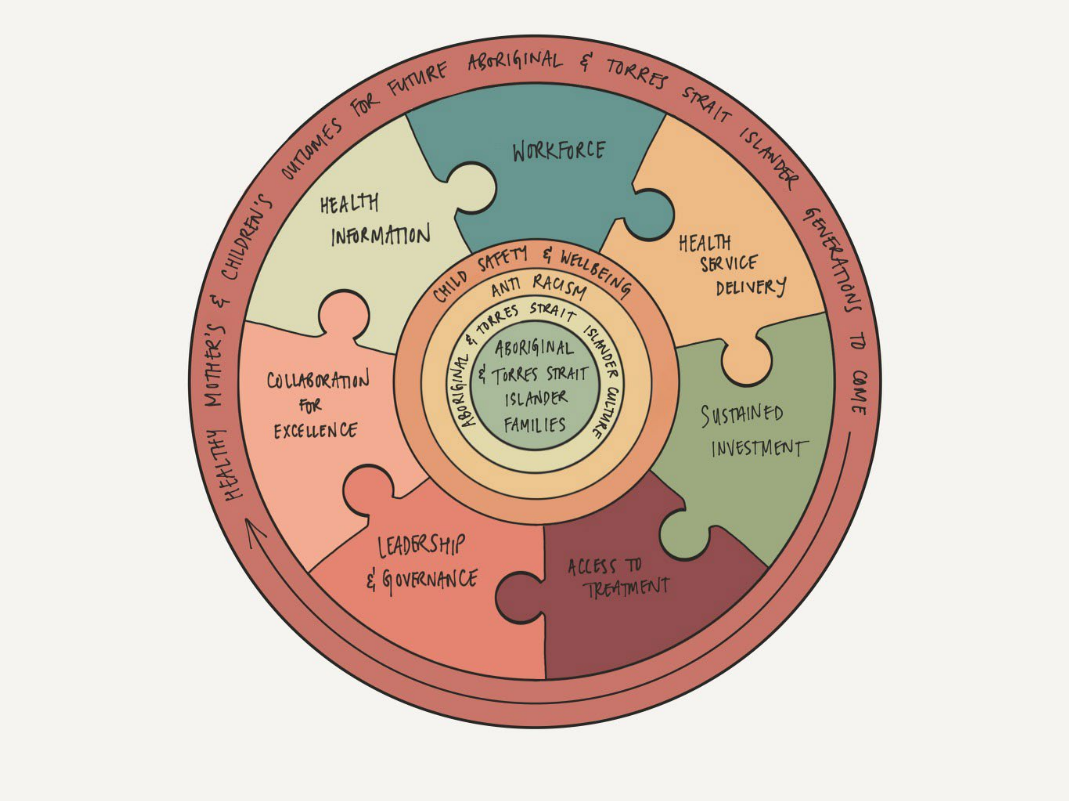

Figure 1. *Framework for system reform to support Aboriginal and Torres Strait Islander maternal and child health continuity of care initiative adapted from WHO Systems Framework 2014*

Our protocol supports the aspirations outlined in the SA Aboriginal Affairs Action Plan and its priorities to improve Child and Family Support services to Aboriginal and Torres Strait Islander families, children and young people. Our recommendations and action items will aid the South Australian Aboriginal Community Controlled Organisation Network (SAACCON), and the SA Government, to fulfil their commitments under the National Partnership Agreement on the refresh of Closing the Gap initiative at the Commonwealth Government level. Implementation of our protocol will also support hospitals in LHNs to meet regulatory requirements under the National Safety and Quality Health Care Standards (11). These standards are critical to improving long term outcomes for Aboriginal and Torres Strait Islander maternal and child health (11).

Our protocol also identifies opportunities to support primary health care services to meet the three Aboriginal and Torres Strait Islander specific standards within the National Safety and Quality Primary Health Care Standards (12). Building on existing quality and safety standards, we recommend implementation of a quality and safety framework to address discriminatory and racist practices and behaviours, with adequate resourcing and monitoring of outcomes. Doing so will contribute to empowering the SA health care system to deliver culturally safe services (13).

Finally, implementation of all 13 recommendations will contribute to meeting the strategic imperatives identified in the Women's, Child and Youth Health Plan 2021-2031 for SA, which identifies Aboriginal and Torres Strait Islander families as a priority population (14).

Equity is not the same as equality

To address disparities, health services should not aim to treat all people the same way, although this is not always understood by many non-Aboriginal health care providers (8). Western health systems focus primarily on identification of disease and disease risk. This is inconsistent with identifying and responding in culturally safe ways to issues that affect the health and wellbeing of Aboriginal and Torres Strait Islander children and families. These issues include no understanding or thought of Aboriginal and Torres Strait Islander cultural strengths such as language, kinship systems and connection to country and place. This manifests as deficit descriptions of Aboriginal and Torres Strait Islander cultural, health, social and emotional and wellbeing needs, including a lack of or no access to interpreters, extreme social disadvantage, housing insecurity, financial insecurity, legal problems, family and community violence, drug and alcohol problems and fear of the child protection system. An effective response to these social and historical determinants of health requires a holistic approach to health and wellbeing that centres on families and communities, rather than disease processes.

Cultural considerations

For many Aboriginal and Torres Strait Islander peoples and communities their culture and beliefs have survived through colonisation, dispossession, and assimilation and are considered protective for health and wellbeing (15-17). Aboriginal and Torres Strait Islander views on health see all aspects of life as interconnected including social, emotional, spiritual and culture, and physical health (16). Cultural considerations are, therefore, central to planning, designing, implementing and delivering culturally safe programs and services (2).

The concept of culturally responsive maternity services for Aboriginal and Torres Strait Islander women is not new. It was identified by the Australian Health Ministers' Advisory Council in 2012, and in a number of strategies recommended within the National Maternity Services Plan in 2010 (18). Disappointingly, many of the key characteristics of providing culturally competent care to Aboriginal and Torres Strait Islander women, women of Aboriginal children and families have remained unchanged.

Within SA, there are specific cultural considerations for the context of Aboriginal and Torres Strait Islander maternal and child health including:

- **Creating physical environments that are welcoming:** Designated areas where women and their families are accommodated in a culturally safe environment.

- **Family-centred care:** Services need to incorporate cultural and family obligations, by being flexible and inclusive of Aboriginal and Torres Strait Islander kinship structures.

- **Gender sensitivities:** Aboriginal and Torres Strait Islander women and women of Aboriginal children may not engage or feel culturally safe with male health providers.

- **Relationship based health care:** Consistency of care providers, where relationships are established to support on-going engagement, are essential.

- **Elders and grandmothers:** Elders are the knowledge holders and are treated with the utmost respect. Grandmothers also play an important role in raising grandchildren.

- **Appropriate communication styles:** Communication must reflect staff are listening to the needs of the women and their families. Self-reflection and being open to feedback will minimise discontinuity of care.

- **Significance of place/Country:** Some women and families may have been affected by the Stolen Generation policies directly and/or generationally. Displacement needs to be handled with cultural and emotional sensitivity. Some Aboriginal and Torres Strait Islander women and women of Aboriginal children believe that to give birth on country facilitates the rebirth of their ancestral line.

- **Service models:** Multiple caregivers (i.e., Aunts/Uncles/Grandmothers/Older siblings) play an important role in parenting which is often viewed as suboptimal and neglectful. This contributes to child protection notifications rather than being considered in a framework of providing culturally responsive care.

- **Birthing practices:** Birthing protocols to improve and incorporate Aboriginal and Torres Strait Islander birthing practices are needed. A system wide adaption of a 'cultural care plan' should be developed through the Aboriginal Family Birthing Program (AFBP), other similar services, and CaFHS. Implementation of the plan must be in partnership with Aboriginal and Torres Strait Islander health professionals, and Aboriginal and Torres Strait Islander cultural support persons.

- **Appropriate terminology:** Terms considered offensive and unacceptable in any context include, but are not limited to: Abo, Aborigine, Aborigines, ATSI, coon, native, blacks, mixed blood, half-caste, quarter-caste, full-blood, part-Aboriginal e.g., 25% (blood quantum) (19).

Guiding Principles

The following principles were adopted to guide the development of our protocol:

- Privilege Aboriginal and Torres Strait Islander voices, be family-centred and consider Aboriginal and Torres Strait Islander kinship systems and families.
- Recognise this is an opportunity to influence significant system reform, challenge poor practices and institutional racism.

- Deliver responsive services through all parts of the health system including primary and hospital services, that encompass prevention and early intervention to keep people healthy.

RECOMMENDATIONS

Ongoing long-term investment and implementation of the 13 recommendations in our protocol will achieve improved health and social health outcomes for Aboriginal and Torres Strait Islander people. After Recommendation 1 as the first priority, our recommendations are not priority ordered; rather they synergistically will lead to optimal continuity of care pathways in three key areas: (i) pregnancy and birthing; (ii) children aged 0-2 years; and (iii) children aged 3-5 years.

1. Leadership and Governance

Leadership and governance are critical to promote continuity of care. Aboriginal and Torres Strait Islander people live collectively, and governance in this context is the shared decision making that occurs through structures, engagement, leadership and discussions. Aboriginal and Torres Strait Islander people can be leaders by virtue of their community status, or work role, or as part of a governance structure. In SA, Aboriginal and Torres Strait Islander maternal and child health needs prioritisation at a leadership level, across multiple contexts, to achieve integrated service delivery and major reform. This can be enabled through the SA Close the Gap Implementation Action Plan process.

*To increase resources, representation and improve care required by Aboriginal and Torres Strait Islander families and children the following **action items** include:*

Immediate

- The Department of Health and Wellbeing (DHW) to establish an *Aboriginal Strategic Advisory and Implementation Committee* to ensure meaningful engagement with membership inclusive of LHNs, Aboriginal Community Controlled Health Organisations (ACCHOs), Aboriginal Communities and Families Health Research Alliance (ACRA), Health Translation SA, and equal Aboriginal and Torres Strait Islander representation to:
    a. oversee the implementation of the protocol recommendations.

   b. oversee development and implementation of optimal care pathways and service models for Aboriginal women (pregnancy and birthing), mothers of Aboriginal children, children aged 0-2 years, and children aged 3-5 years.
- Aboriginal Health Strategy (AHS) Director to nominate and fund an emerging leader to apply for an Indigenous scholarship for an Executive Master of Public Administration course, or similar.

Medium term:

- DHW to develop and incorporate a comprehensive set of Aboriginal and Torres Strait Islander maternal and child health key performance indicators (KPIs) (aligned with the Australian Institute of Health and Welfare [AIHW] KPIs) to inform strategic and operational plans.
- DHW to strengthen and enhance the quality and safety standards in SA in particular:
   a. mandate LHNs to focus on the six actions in the National Safety and Quality Health Services standards focused on meeting the needs of Aboriginal and Torres Strait Islander people.
   b. identify opportunities to support primary health care services to meet the three Aboriginal and Torres Strait Islander standards within the National Safety and Quality Primary Health Care Standards.
- AHS to build on leadership and governance processes and structures (e.g., develop Board level ACCHO Chief Executive Officer (CEO) and/or Aboriginal and Torres Strait Islander community members; meet existing LHN Aboriginal and Torres Strait Islander board members and discuss and influence the National Standards).

2. Reduce institutional, systemic, and interpersonal racism

Aboriginal and Torres Strait Islander people are exposed to racism across all social, economic and health domains within contemporary society and there is increasing recognition that racism is a major contributor to disparities in health outcomes (2, 20, 21). Racism and discrimination increase chronic stress with ongoing impact on health across the life course and on the health of future generations (2, 22). The evidence highlights discrimination and the lack of cultural safety for Aboriginal and Torres Strait Islander people influences personal decisions to access health care including care during pregnancy (7, 23). In the context of Aboriginal and Torres Strait Islander child health, racism and discrimination also plays out with a lack of access to culturally relevant assessment tools.

To reduce racism experienced by staff working in Aboriginal and Torres Strait Islander services, and Aboriginal and Torres Strait Islander families, women and children in SA across the health and social systems, the following ***action items*** *include:*

Immediate:

- Utilise the *Aboriginal Strategic Advisory and Implementation Committee* to audit previous approaches to address racism in maternal and child health care, assess why they have failed, and monitor actions of the protocol implementation plan.

Medium term:

- Incorporate evidence of maternal and child health experiences of racism and from the above audit into the Whole of Government Anti-Racism Strategy led by Wellbeing SA.
- Develop and implement anti-racism indicators for Aboriginal and Torres Strait Islander women, women of Aboriginal children, children and families (patient reported experience measures), led by Wellbeing SA and/or the Centre for Excellence and Innovation (CEIH). These indicators can be developed and incorporated in service level agreements and monitored by LHN governing boards.
- Develop and implement effective anti-racism and unconscious bias training across LHNs providing maternity and child health services.
- Develop and strengthen effective and respectful partnerships between the Boards and Senior Executives of LHNs, Primary Health Networks (PHNs) and ACCHOs.

Long term:

- Develop and refine tools such as the Ages and Stages Questionnaire-Talking about Raising Aboriginal Kids (ASQ-TRAK), increasing access to culturally relevant screening and assessment tools to promote culturally responsive care for Aboriginal and Torres Strait Islander families.

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3. Provide culturally safe services

Providing a culturally safe environment requires an enabling system to achieve healthy outcomes for both mother and child. This involves key elements from a system level perspective, dynamic governance and leadership, funding drivers and resourcing, and operationalising through the workforce, practice and ongoing monitoring and evaluation (24).

An Aboriginal and Torres Strait Islander woman, for example, may advise that she wishes to only be seen by female practitioners throughout her perinatal care – the employee identifies this (culturally aware), can plan for this (culturally sensitive) and the workplace systems ensure that only females work with the woman (culturally safe). Not all Aboriginal and Torres Strait Islander women or women of Aboriginal children will raise this, due to systemic racism in the hospital system.

Providing a supportive continuous care system means having a holistic care team throughout the perinatal period – this is critical to both cultural safety and the wellbeing of mother and child. The holistic team must include, at a minimum, an Aboriginal Maternal and Infant Care (AMIC) worker. Evaluated models of holistic care exist including the Aboriginal Family Birthing Program (AFBP) in SA and the Birthing on Country program in Queensland. There is opportunity to learn from and improve these programs. The review evidence identified a range of system barriers that influence both accessibility and impact of the AFBP including shortages of AMIC workers, lack of birthing services for women in rural and remote areas, inadequate resourcing of the AFBP, and a lack of referral pathways to support women and families with complex social needs.

Our consultations revealed it is timely to revisit the AFBP and expand to regions where it is not currently being offered. Current funding levels also need to be reviewed to strengthen capabilities (e.g., training and number of AMIC workers) and implement a consistent model of care.

To provide culturally informed and safe services at every access point to ensure healthy Aboriginal and Torres Strait Islander women, women of Aboriginal children and strong and vibrant children who are pre-school ready, the following ***action items*** *include:*

Immediate:

- Develop specific Aboriginal and Torres Strait Islander maternal, infant and child health cultural safety training, as a mandatory human resources requirement, which includes evaluation and monitoring.
- AHS to investigate the feasibility of a trial implementation of the Cultural Pathways Program modified Social Need Screening Tool by Aboriginal and Torres Strait Islander navigators located within ACCHO and LHN maternal and child health sites.

Medium term:

- Implement cultural safety frameworks across all maternity and child health service access points in all LHNs, irrespective of what models of care Aboriginal and Torres Strait Islander women, women of Aboriginal children and families are accessing.
- Build capability in LHN services to undertake quality improvement processes in cultural and clinical indicators.
- Further develop and improve culturally safe maternity, infant and child health service models in SA and advocate/leverage Commonwealth funding (e.g., for smoking cessation, stillbirth) to enhance existing models of care for Aboriginal and Torres Strait Islander women, women of Aboriginal children and families, inclusive of the ACCHO sector.
- Leverage funding allocations for the SA Women's, Child and Youth Health Plan and the Early Years Strategy to implement and evaluate enhanced postnatal care for mothers and infants.

Long term:

- Review and increase current funding levels to expand programs, such as the AFBP equitably to each birthing centre across SA, and incorporate the learnings of previous evaluations into the expansion strategies to promote a consistent, state-wide Aboriginal and Torres Strait Islander specific birthing program.
- Contribute to the re-design and implementation of the SA Cultural Inclusion Framework with core elements including:
    a. Improved accountability and transparency. Examples of culturally inclusive governance, service planning and delivery includes culturally inclusive legislation; policy; service standards; standard operating procedures; customer service charters; and committee terms of reference.
    b. Culturally responsive inter-agency service delivery with joint protocols.

4. Family-Centred Care

Our consultations revealed Aboriginal and Torres Strait Islander women, women of Aboriginal children and families wished health care services would adopt a more family-centred approach. Many examples of health and early childhood systems contributing to discontinuity of care for children were also presented, due to poor understanding of the important role extended family members play, particularly grandmothers, and no acknowledgement of the role of fathers.

While there are examples of family-centred care initiatives being implemented in the Aboriginal and Torres Strait Islander primary health care sector, including evidence on the benefit of access to and satisfaction with care (66), there has been little focus on embedding and strengthening family-centred care practices in hospital and mainstream health settings.

To apply a family-centred framework to Aboriginal and Torres Strait Islander women, women of Aboriginal children and families when engaging with health and community services across SA, the following ***action items*** *include:*

Immediate:

- Develop care pathways across each network (rural, remote, metro services) for Aboriginal and Torres Strait Islander families by mapping current activities and gaps, standardising care, discharge planning, and information sharing.
- Ensure that family centred care is a key practice principle and optimal care pathways are developed.
- AHS to commission or undertake a specific project with ACCHOs and CaFHS which investigates ways to make pregnancy and child health services more inclusive of fathers.
- Collaborate with maternal and child health services to deliver initiatives that are not hospital/health service based (e.g., Tackling Indigenous Smoking initiatives).

Medium term:

- Co-design, with Aboriginal and Torres Strait Islander families and health services, service pathways that include specific Aboriginal and Torres Strait Islander care coordinator and navigator roles.
- Invest resources into LHNs/ACCHOs to build sector capacity in culturally appropriate postnatal support (e.g., breastfeeding practices).
- Invest in preventative maternal and child health (e.g., Aboriginal and Torres Strait Islander health workers to assess and audit patients'/community members' health) to inform service improvements consistent with the National Preventive Health Strategy.

Long term:

- Review child protection policies and their implementation across LHNs to ensure consistent approaches across the system.

- Ensure future recommended child protection KPIs are incorporated into an Aboriginal maternal and child health dashboard to monitor system performance.
- Fund a metropolitan stepdown service for families with children needing acute care and intensive support, in collaboration with CaFHS and Child and Adolescent Mental Health Services (CAMHS). The service would be available early in pregnancy to prevent child protection involvement.

5. Child Safety and Wellbeing

Preventing Aboriginal and Torres Strait Islander child removal and overrepresentation in out-of-home-care (OOHC) is a national priority. Removing an Aboriginal and Torres Strait Islander child has deep and long-lasting consequences – it perpetuates intergenerational trauma, severs the bond from community, country and culture, and triggers poor life outcomes (25). As of 2019, Aboriginal and Torres Strait Islander children were 9.7 times more likely to be residing in OOHC care compared to non-Aboriginal children (25). In 2020, one in 18 Aboriginal and Torres Strait Islander children were in OOHC (26).

One of the most common concerns across SA Aboriginal and Torres Strait Islander families and communities is non-compliance with the Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP) by government departments and agencies (27). While the ATSICPP exists in legislation and policy, and its significance has been widely acknowledged, there are ongoing inconsistencies in its implementation. In SA, it is estimated that only 13% of child protection cases concerning Aboriginal and Torres Strait Islander children have occurred under ATSICPP (27).

For the DHW to implement system-wide reform to improve child safety and wellbeing responses of government and non-government funded health and social services, the following ***action items*** *include:*

Immediate:

- DHW Chief Child Protection Officer to engage Aboriginal and Torres Strait Islander leadership (including the Aboriginal Children and Young People's Commissioner and AHS), ACCHOS, Aboriginal Community Controlled Organisations (ACCOs, which are other social health services such as Aboriginal Family Support Services, Nunga Mi:Minar) and

Aboriginal women and children to inform and provide advice as the model of care for Health Child Protection services in LHNs is developed in 2022.

- Utilise the *Aboriginal Strategic Advisory and Implementation Committee* to advocate for prevention of Aboriginal and Torres Strait Islander infants and children entering the child protection system through referrals to support services such as those funded from the Department of Human Services (DHS), with additional funding to resource existing and new ACCHOs and ACCOs to provide support to vulnerable families.
- Partner with the Commissioner for Aboriginal Children and Young People, to facilitate investigation on the interface between SA Health and Child Protection services (e.g., review LHNs Child Protection procedures to ensure recognition of Aboriginal and Torres Strait Islander parenting practices).
- DHW advocates for the Health and Community Services Complaints Commission to partner with NGOs, to work collaboratively with Aboriginal and Torres Strait Islander communities to develop processes for Aboriginal and Torres Strait Islander parents and families to lodge maternal and child-based complaints in a safe and supportive environment.

Medium term:

- DHW Chief Child Protection Officer supports development of child protection policy and practice within health that seeks to ensure early identification and intervention for families who require additional support.
- DHW to collaborate with LHNs, DHS, NGOs, ACCHOs and ACCOs to ensure standardised approaches with clear pathways to support services from current Strengthening or Early Link programs in major birthing hospitals.
- DHW to co-design with Aboriginal and Torres Strait families and community in collaboration with LHNs, DHS, NGOs, ACCHOs and ACCOs to develop and implement policies and procedures which improve the cultural connectedness for Aboriginal and Torres Strait Islander children aged 0-5 years (including children in OOHC).
- Develop programs to support new Aboriginal and Torres Strait Islander parents, including mothers and fathers in custodial settings.

6. Addressing Access Barriers

Many Aboriginal and Torres Strait Islander families report feeling extremely uncomfortable seeking mainstream health support. Access to timely, effective and appropriate maternal and child health care can contribute to closing the gap for Aboriginal and Torres Strait Islander families (28, 29).

Our consultations revealed four major barriers for Aboriginal and Torres Strait Islander women, women of Aboriginal children and children accessing health care: (i) transportation; (ii) accommodation; (iii) service location; and (iv) inflexible programs and appointment scheduling.

*To reduce and remove barriers to ensure Aboriginal and Torres Strait Islander women, women of Aboriginal children, infants and children can access health care services to complete their care, the following **action items** include:*

Immediate:

- AHS fund and pilot a specific Aboriginal and Torres Strait Islander care coordination program (building on Northern Adelaide Local Health Network [NALHN] Allied Health Continuity of Care program), co-designed with Aboriginal and Torres Strait Islander families and services.

Medium term:

- Improve coordination of acute and community-based outpatient services by enabling opportunistic health checks in LHNs (e.g., when pregnant women or families with a child attend a specialist appointment, accommodate an extended appointment, and include other children who may be present with the patient).
- Women's and Children's Health Network (WCHN) to develop and trial a flexible appointment model for antenatal care and child health outpatients for Aboriginal and Torres Strait Islander people.
- DHW to work in partnership with metropolitan and regional LHNs, CaFHS and CAHMS to review and ensure an increase in local community-based services for antenatal and children's health care.
- Improve transport access to health services by initiating a SA review of existing Patient Assistance Transport Scheme criteria. Advocate for adequate cover of upfront costs for Aboriginal and Torres Strait Islander people, and Commonwealth funding, to support families travelling to metropolitan and larger regional centres within a 100 km radius.

7. Growing and Strengthening the Workforce

Our consultations highlighted an overwhelming shortage of Aboriginal and Torres Strait Islander specific workers. This is evidenced by a lack of Aboriginal and Torres Strait Islander people in mainstream services and compounded by a high turn-over of staff in the maternity and early childhood sector (30). Consultations also revealed there were few specialists (e.g., obstetricians, child health) available outside of Adelaide.

Decolonising health care is the key to health systems' workforce transformation. One of the reasons why Aboriginal and Torres Strait Islander primary health care services successfully attain optimal health outcomes, is that they are often governed by their local communities, are accountable to the communities they serve and reflect their values and principles, and have a culturally appropriate and skilled workforce (31).

*To build and strengthen capacity in the health workforce that meets the needs of Aboriginal and Torres Strait Islander women, women of Aboriginal children, infants and children, and plan for future workforce needs, the following **action items** include:*

Immediate:

- DHW Aboriginal Health Workforce to lead engagement with nurses, midwives, allied health and educators to work in partnership to enhance/develop critical antiracist education and praxis to be incorporated into tertiary health workforce curriculum and into LHN training and education.
- AHS to fund the development and strengthening of AMIC, and child health and development training (currently not available); navigator training; COVID-19 health promotion and other infectious disease accredited units in Aboriginal and Torres Strait Islander Health Worker (AHW)/Aboriginal Health Practitioner (AHP) training; and training and education for Aboriginal and Torres Strait Islander evaluators.
- AHS to advocate for workforce development and employment partnerships between hospital and primary care units in LHN services and ACCHOS and other primary care providers.
- LHNs to review and adopt Aboriginal and Torres Strait Islander workforce targets based on the population of Aboriginal and Torres Strait Islander families and their clinical needs.

- DHW, Aboriginal Principal Workforce Officer to develop a ten-year workforce plan with a focus on:
    a. recruitment and retention of staff with suitable skills and expertise both Aboriginal and non-Aboriginal.
    b. increasing Aboriginal specific roles including a cultural navigator and Aboriginal care coordinator.

Medium term:

- Review employment conditions, retention and recruitment strategies and improve wages parity through the current Aboriginal Affairs and Reconciliation Closing the Gap Implementation plan initiative.
- AHS to support implementation of the next iteration of the SA Health Aboriginal Health Workforce Framework, and LHN workforce plans, and develop specific new roles and skills (e.g., Aboriginal and Torres Strait Islander navigators and coordinators, Aboriginal Maternal and Child Health Evaluation Officers, discharge liaison coordinators, specific skills such as digital technology and, quality and safety assessment and auditing).
- DHW Aboriginal Principal Workforce Officer, in partnership with LHNs, to develop a funding formula and advocate for a national review of activity based funding (ABF) loading for Aboriginal and Torres Strait Islander clients in rural and remote areas.
- Develop consistent cultural competence requirements for health professionals through AHS partnering with Australian Health Practitioner Regulation Agency (AHPRA), Australian Medical Association (AMA), SA Australian Nursing and Midwifery Federation (ANMF), National Aboriginal Community Controlled Health Organisation (NACCHO) and Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINAM).

8. Digital Technologies

Our consultations revealed there is significant room to improve the use of digital technologies to increase communication between health care providers and families to support informational continuity and coordination of care for Aboriginal and Torres Strait Islander mothers, fathers, children, and families.

There is already a suite of digital technologies within the health system in SA, either implemented or in the process of being implemented, indicating there is a need to streamline and improve adoption of these technologies rather than introduce new products. Our consultations found both systemic and individual provider barriers to uploading important health information specifically maternal, infant, and paediatric health care to My Health Record. Some providers also revealed a desire for the hand-held clinical records used in antenatal and infant care (i.e., the "orange" and "blue" books) to be made electronic for families, as these books can be lost or not brought to appointments.

To increase the use and implementation of digital technologies that support and strengthen continuity of care by improving digital health literacy across the health workforce, and among Aboriginal and Torres Strait Islander families, the following ***action items*** *include:*

Immediate:

- AHS to fund pilot projects to expand use of regional referral platforms, such as the one utilised with Yorke and Northern LHN and Lyell McEwin Hospital to expand to other LHNS and include ACCHO sector clinicians.
- WCHN to partner with Digital Health SA to undertake a project to automatically flag inappropriately long waiting times for Aboriginal and Torres Strait Islander families seeking access to paediatric outpatient care at WCHN.
- Develop digital tools, working with LHNs and PHNs, to ensure the Aboriginal and Torres Strait Islander identifier question is asked and recorded at every access point.
- Establish a short-term steering committee to review the Clinical Communication and Patient Identification Clinical Directive, to allow uploading of information from SA Health clinical systems for Aboriginal and Torres Strait Islander patients aged <18 years, where consent is given by the parent or guardian.
- AHS advocates for a project in partnership with LHNs, ACCHO sector and PHNs to improve the sharing of information with My Health Record and improve digital health literacy across the health workforce.

Medium term:

- AHS and LHNs to work with Digital Health SA to promote adoption of digital channels and technologies already available within SA Health (e.g., SA Health viewer and secure messaging service).
- AHS advocates for a project with CaFHS, Aboriginal Health Council of SA (AHCSA) and the Communities of Practice to develop electronic orange and blue books with adaption for Aboriginal and Torres Strait Islander families.

9. Information Sharing, Follow-up Care, Referrals and Discharge Planning

High quality and consistent communication between health services, primary care providers and Aboriginal and Torres Strait Islander women, women of Aboriginal children and families is essential for high quality care. Our consultations identified inconsistent approaches to discharge planning across the system. In some areas, no discharge summaries are received, and in others they are not received in a timely manner disrupting continuity of care and patient safety. There is also a lack of suitable and appropriate referral pathways, as well as duplication, repetition and inefficiencies in referral processes and systems (32, 33).

*To improve high quality information flow, information sharing, referrals, follow up care, and discharge planning, the following **action items** include:*

Immediate:

- AHS and AHCSA to establish formalised agreements between the LHNs and the ACCHO sector to incorporate collaboration, communication, and cooperation to improve relationships and partnerships and sharing of information.
- Develop and implement mechanisms that ensure Aboriginal and Torres Strait Islander women, women of Aboriginal children and child's health information is communicated in a timely manner to the families treating doctor(s)/health provider (see also Recommendation 4 concerning care pathways and care coordination roles).

Medium term:

- Establish annual consultations to assess and recommend changes to maternity and child health and social services (e.g., social and emotional wellbeing assessment tools for pregnant women).

10. Sustained Investment

Health systems that function well have certain shared characteristics: they have solid procurement and distribution systems; they are staffed with sufficient trained and motivated health workers, they innovate and evaluate, and they operate with financing systems that are sustainable, inclusive, and fair (34).

Our consultations found core funding was grossly inadequate for maternal and child health service delivery and was not distributed equitably across SA regions according to need. Philanthropic organisations were identified as potential sources of additional funding;

however, this is not always easy to attract. Competitive tendering processes across the State create issues amongst service agencies, for example, one organisation loses funding while another one gains.

Our consultation and reviews identified the need to provide opportunities to fund innovation to support continuity of care. The importance of a strong program logic design, accountability to funders, and community and funding continuity across the service system, must be part of supporting this important work.

To investigate and act on opportunities to sustain investment over the next 10 years to meet the health needs of SA's Aboriginal and Torres Strait Islander mother's, children and families, the following ***action items*** *include:*

Immediate:

- DHW and AHS to include requirements for organisations supporting Aboriginal and Torres Strait Islander children with a disability to demonstrate how they are genuinely working with relevant organisations (e.g., ACCHOs) and monitor this.

Medium term:

- Develop an activity-based formula to ensure sustainable program funding and workforce growth in future.
- AHS to provide opportunities to fund small projects for innovation and workforce capacity building.
- Increase the Aboriginal and Torres Strait Islander maternal and child health workforce through development of cohorts in roles reflecting local needs (e.g., AMIC, AHP, midwife, nurse, allied health, navigator, coordinator).
- Develop a business case to extend the life of this protocol to 10 years, and examine the actual costs required to adequately address disparities in Aboriginal and Torres Strait Islander maternal and child health outcomes.

Long term:

- Provide secure ongoing funding for women's and children's health for: (i) core programs including their evaluation; and (ii) evidence-based site-specific tailored activities.

11. Excellence Collaboration

Our consultations have drawn attention to many instances where the system provides siloed, fragmented care to Aboriginal and Torres Strait Islander families. To aid the operationalisation of systems leadership, we recommend the development of an Excellence Collaboration to build leadership capacity in Aboriginal and Torres Strait Islander maternal and child health.

We recommend the core functions of the collaboration will include: (i) connecting services delivering care for Aboriginal and Torres Strait Islander women, women of Aboriginal children, children and families with a shared vision and governance structure; (ii) connecting services with training and research organisations to integrate research, policy and education with care delivery to translate evidence for reform; (iii) monitoring program and service delivery to identify opportunities for practice and policy improvement; (iv) growing a culturally competent workforce and provide opportunities to enhance training and professional development; (v) uniting service providers and Aboriginal and Torres Strait Islander communities to share knowledge and information on health care improvements; and (vi) supporting and advising the *Aboriginal Strategic Advisory and Implementation Committee.*

To lead and monitor clinically and culturally safe evidence-based improvements across the health and social care systems to promote integrated, family-centered care for Aboriginal and Torres Strait Islander women, women of Aboriginal children, children and families, the following ***action items*** *include:*

Immediate:

- AHS to undertake an economic analysis to establish a business case for an Excellence Collaboration.
- AHS to provide the opportunity and budget to consult widely towards the Excellence Collaboration in Aboriginal and Torres Strait Islander maternal and child health.
- AHS to work with the CEIH and Wellbeing SA to scope the data system requirements to centralise data relating to Aboriginal and Torres Strait Islander families for monitoring purposes.

Medium term:

- Support the collaboration to lead the translation and evaluation of culturally validated screening and assessment tools for maternal/carers/families mental and physical health and child health.
- AHS to facilitate training and education for key monitoring stakeholders (e.g. governing boards/senior executives across LHN, PHN funded and ACCHO sectors) and connection to the National Health Quality and Safety Standards.

Long term:

- Sustain the Excellence Collaboration to lead, monitor and evaluate service and system improvements for Aboriginal and Torres Strait Islander families supported by evidence, data, and consumer voices about community needs.

12. Living with COVID-19

Community consultation feedback about COVID-19 was varied. Services changed and disruptions to delivery occurred, which made it difficult for women and families to access appointments and critical follow-up care. Staff were taking precautions by wearing personal protective equipment, social distancing, and regularly handwashing. There was some telehealth innovation, particularly from ACCHOs, where appointments were held by phone, zoom, or face time on mobile phones.

There was overwhelming support from ACCHO workers that routine primary health care, allied health and specialist services for Aboriginal and Torres Strait Islander mothers, mothers of Aboriginal children and children must continue regardless of COVID-19.

*To maintain commitment to continuity of health care during the COVID-19 pandemic, and ensure access to resources and preventative actions for Aboriginal and Torres Strait Islander families, the following **action items** include:*

Immediate:

- AHS to advise on a zero-separation policy for parents and infants during hospital admissions.
- Increase access to information and services through: (i) effective sharing of information to patients (e.g., orange and blue books), and other health care providers; and (ii) providing internet access to vulnerable patients.

- Continue/intensify support for Aboriginal and Torres Strait Islander communities to increase vaccination uptake.
- Provide a free call information service to support and refer Aboriginal and Torres Strait Islander families needing mental health and social and emotional wellbeing services addressing parental anxiety, stress and depression during lockdowns, quarantines and isolation.

Medium term:

- AHS to advocate for safe face-to-face visits to continue wherever possible, outside of the hospital setting.
- Evaluate the level of preparedness communities and ACCHOs felt.

13. Living with Disabilities and/or Chronic Illness

Aboriginal and Torres Strait Islander children are 30 times more likely to require support with communication and learning and have a greater prevalence of profound or severe disability compared to non-Aboriginal Australian children (35).

Our consultations revealed the National Disability Insurance Scheme (NDIS) is extremely hard to navigate including the application process and determining eligibility for children aged 0-5 years. Participants felt the NDIS does not work for Aboriginal and Torres Strait Islander families due to the many barriers to access, including lengthy wait times for assessments and approvals (up to 12 months). Once families are approved, there are still long waiting lists to access NDIS service providers.

*To increase resources and improve care required by Aboriginal and Torres Strait Islander families and children living with disabilities and/or chronic illness, the following **action items** include:*

Immediate to Medium term:

- AHS to ensure that disability and safeguarding advocates gain feedback from SA Health and ACCHOs on issues for Aboriginal and Torres Strait Islander children and families.
- AHS to advocate for rapid access to Child Development Unit’s and LHN community based maternal and child allied health services (e.g., ear nose and throat specialists, speech pathologists, occupational therapists, psychologists, physiotherapists). See also

Recommendation 4 concerning care pathways, and Recommendation 10 concerning requirements for organisations supporting a child with disability.

- Strengthen capability of ACCOs and ACCHOs to provide support to families, via increased funding for allied health positions, care coordination/navigator roles, and Aboriginal and Torres Strait Islander health practitioners.
- AHS to work with the Office of the Early Years to raise awareness of referral pathways including via the NDIS.
- AHS to develop strategies that build community awareness of developmental issues and support services available (including data reporting and accountability).

SUMMARY

Monitoring and Accountability

The Excellence Collaboration (Recommendation 11) is ideally placed to lead monitoring and promote and encourage shared accountability for implementation of this protocol and establish the KPIs that will measure the spectrum of components of culturally responsive continuity of care. We have identified potential indicators to facilitate monitoring, however, these need to be co-designed in consultation with experts from Aboriginal and Torres Strait Islander leadership, community, and sectors including clinicians and researchers. The responsibility for finalising and formalising the KPIs will sit with the DHW (Recommendation 1).

To monitor changes, and measure what matters most to the Aboriginal and Torres Strait Islander community in relation to maternal and child health outcomes, all recommendations need to be implemented. When considered together, each of the recommendations will promote systemic change that will be interlinked and strengthened by the others. To implement only part of this protocol will risk fostering an environment that is not conducive to providing effective continuity of care and making the gains required to achieve health equity for Aboriginal and Torres Strait Islander women, women of Aboriginal children, children and families.

Future Collaborative Research Priorities

Specific opportunities for future collaborative research includes evaluation of: (i) cultural safety and anti-racism interventions in the maternity care system; (ii) the impact of care coordination and navigator positions; (iii) strategies to promote inclusion of fathers in pregnancy, birthing and infant care; and (iv) strategies to operationalise family centred care.

This protocol was developed by a rigorous review of available evidence and substantial State-wide consultations with communities, health care providers and subject matter experts. The recommendations and actions outlined provide a blueprint for sustainable long-term system change that will lead to better health outcomes for Aboriginal and Torres Strait Islander women, women of Aboriginal children and children. Our full report contains more actions and levers for consideration.

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1. *Purpose and Aim*

In mid-2021, SAHMRI was contracted by the Department of Health and Wellbeing (DHW) to lead a 10-month project aimed at developing a protocol to improve *continuity of care* to support Aboriginal and Torres Strait Islander maternal and child health (up to 5 years of age). The team were tasked to support consultations with stakeholders involved in providing care for Aboriginal and Torres Strait Islander families across the acute and primary health care sector in South Australia (SA).

The aim of these consultations was to identify current barriers to providing continuity of care and identify potential solutions that could be incorporated into a state-wide systems protocol. The consultation and engagement process also provided opportunities for stakeholders to feedback where accountability and monitoring functions sit for the recommendations and actions developed. The consultations contributed towards preparing the health system for this protocol. The Department asked the team to focus on three aspects of continuity of care: (1) relational; (2) management; and (3) informational, as defined by Reid and colleagues (10).

Our protocol draws on these consultations, and the academic literature, to provide a series of recommendations and actions to address entrenched health disparities experienced by Aboriginal and Torres Strait Islander women, women of Aboriginal children, families, and children up to five years of age by improving continuity of care and the systems to support this. Our overarching aim was to reduce the isolated and siloed administrative and service delivery elements so that all parts of the system could work together effectively and in ways that are culturally responsive.

2. *Introduction*

Aboriginal and Torres Strait Islander women and women of Aboriginal children, have been bringing healthy babies into the world and raising strong, healthy children connected to culture, family, and the community for thousands of years. Today, Aboriginal and Torres Strait Islander people continue connections to their culture and language, identity, ancient knowledges, and country as it relates to each kinship group. At the same time, Aboriginal and Torres Strait Islander children, young people and families experience stark inequities in health and wellbeing compared to non-Aboriginal and Torres Strait Islander children, young people and families. These health inequities start early life and are "unnecessary, avoidable, unfair and unjust" (36).

The health care system continues to contribute explicitly and implicitly to health inequities experienced by Aboriginal and Torres Strait Islander people (1). The Australian health care system has been built upon and informed by Eurocentric, biomedical discourses and dominated by western worldviews (2). Western health practices (biomedical model) have not been informed by historical and/or cultural perspectives of Aboriginal and Torres Strait Islander societies (2), and have, therefore, contributed to a culturally unsafe health care system lasting hundreds of years since colonisation.

In SA, important gains have been made in access to antenatal care in the first trimester, yet Aboriginal and Torres Strait Islander women and women of Aboriginal children, are still less likely to attend antenatal care than non-Indigenous women. In 2017, 17.2% of Aboriginal and Torres Strait Islander babies born in SA were of a low birthweight, 2.5 times higher than other babies (3). Data from the Aboriginal Families Study (AFS) – a population based birth cohort of 344 Aboriginal and Torres Strait Islander infants and their mothers/carers – demonstrates that one in five Aboriginal and Torres Strait Islander women and women of Aboriginal children, did not see a general practitioner (GP) in the first four to nine months after giving birth (4, 5). In addition, one in seven women in the AFS did not recall seeing a Child and Family Health Services (CaFHS) nurse during the postnatal period.

Many Aboriginal and Torres Strait Islander women and women of Aboriginal children, in SA also experience social health issues during their pregnancy, of particular concern is housing instability, exposure to family and community problems and grief resulting from loss of family members. Furthermore, one in four Aboriginal and Torres Strait Islander women and women of Aboriginal children in the AFS experienced between five and twelve social issues during their pregnancy contributing to significant stress (Figure 2) (6).

Unpublished data from AFS Aboriginal Advisory group, (see Appendix B) also found that just under half (45%) of the children were living in Adelaide at the time of the second wave of follow-up (5-7 years following initial study enrolment), 36% were living in regional areas, and 19% were living in remote areas of SA. Over 90% of study children were living with their mother, and 9.6% were living with a carer (often a family member). The mean age of the AFS children at follow-up was 6.5 years (range 5-9 years of age), with the majority (65%) of children living with their mother in households where two or more adults were living in the household. Just over a third (34%) were in households with no other adults apart from their mother. It was also common for mothers to be caring for three or more children, with half (49%) of those mothers not being in a relationship at the time of follow-up. Overall, 58% of mothers had three or more children, with most mothers in receipt of a health care concession card, and very few (11.5%) had private health insurance. Over a third of the mothers had moved house three or more times in the 5 years prior to the second wave of study follow-up. Aboriginal and Torres Strait Islander children also carry a disproportionate burden of child health issues.

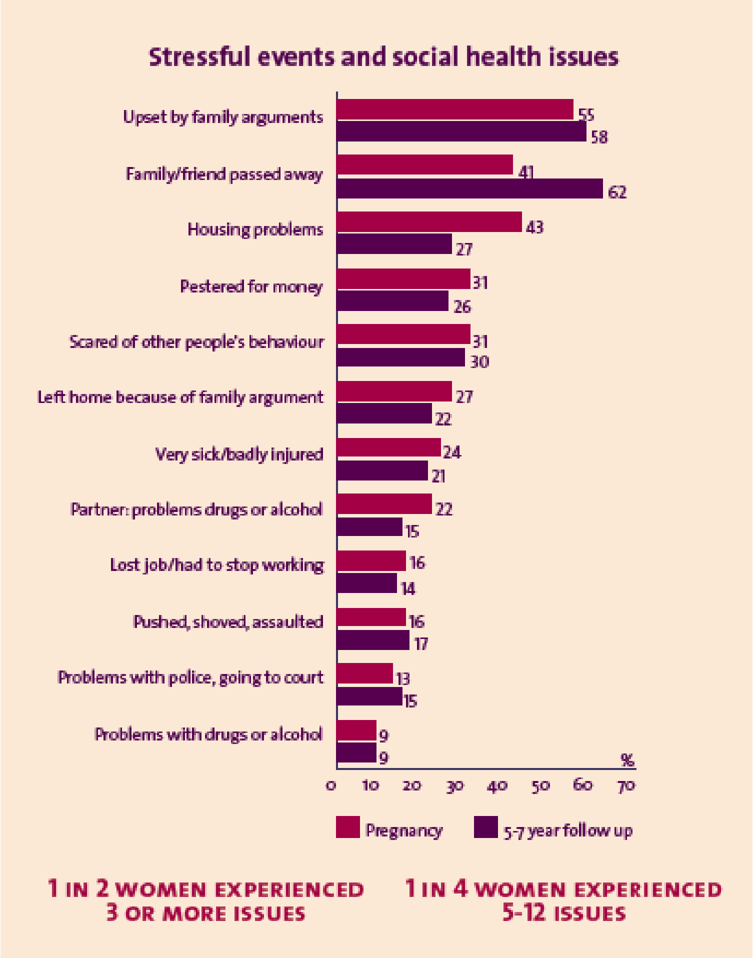

Figure 2. Stressful events and social health issues reported in the Aboriginal Families Study

The evidence in Australia identifies that the health care system, including maternal and child health, is complex, often disjointed and operates in isolation from other disciplines across the health care landscape (37). This is problematic for Aboriginal and Torres Strait Islander women, women of Aboriginal children and children, who often fall through the gaps and experience a lack of continuity of care throughout their health care experience, from primary care through to hospitalisation for birthing and postnatal care (38). Decades of research evidence indicates that maternal health and wellbeing is inextricably linked to child health outcomes (39) and, therefore, coordinated holistic health care has greatest potential to improve the health of Aboriginal and Torres Strait Islander mothers and children. Consequently, significant reorientation, reform and investment across the health and community services systems will be required to address these long-term systemic problems. McCalman and colleagues and others argue health professionals alone are unable to lead and influence practice change required to improve culturally safe care, without a systems level approach to driving reforms (13, 40) .

This is evident because unfortunately there have been long term systemic failures in implementing changes based on the existing evidence. There is a plethora of evidence, that if implemented, would result in improving health and wellbeing outcomes of Aboriginal and Torres Strait Islander people. In 2004-2005, the National Aboriginal and Torres Strait Islander Health Survey (41), reported Aboriginal and Torres Strait Islander people had much poorer health status, and did not access health care due to difficulties with associated costs, transport, accommodation, distance to travel and lack of other available services and cultural barriers (41). In 2012, the Standing Council on Health, undertook the development of a framework that characterised culturally competent Maternity Care for Aboriginal and Torres Strait Islander women and women of Aboriginal children. These reports, and public health research, support the findings of our consultations. In essence, 16 years later, our consultations have identified nearly identical issues and problems across the system.

The Australian Aboriginal and Torres Strait Islander community is the most over-researched peoples yet relevant action to address full recommendations has translated very little policy change. There is a complacency across government agencies and a demonstrated history of recommendations from Commonwealth inquiries (Royal Commission into Aboriginal and Torres Strait Islander Deaths in Custody 1987 (42), National Aboriginal and Torres Strait Islander Health Strategy 1989 (43) and Bringing them Home Report 1997 (44)), and other evidence-based reports not being fully implemented, which results in the same reoccurring issues with worse outcomes. The timeframes of these critical reports span more than one generation.

There continues to be long-term system failures to implement evidence which would result in improved health and wellbeing outcomes for Aboriginal and Torres Strait Islander people. The 2004-2005 National Aboriginal and Torres Strait Islander Health Survey (41) found that Aboriginal and Torres Strait Islander people had much poorer health status, could not access health care due to difficulties with associated costs, transport, accommodation, distance to travel, lack of other available services and cultural barriers. In addition, Aboriginal and Torres Strait Islander non-government organisations have an overabundance of reporting requirements, and research highlights this (45).

While more resources are needed, government ministers seek ways of doing more with existing resources. They are seeking innovative ways of harnessing and focusing the energies of communities, non-governmental organisations (NGOs) and the private sector. They recognise that there is no guarantee those in need will benefit from reforms unless they are carefully designed with this end in mind. Furthermore, they acknowledge that only limited success will result unless the efforts of other sectors are brought to bear on achieving better health outcomes. All of these are health systems issues (46). Our protocol suggests extending the timeframe for implementation of the actions described herein to 10 years, and in that time to examine the actual costs required to adequately address closing the gap in Aboriginal and Torres Strait Islander maternal and child health outcomes and seek additional and appropriate government funding.

Importantly, the implementation of this protocol will aid the South Australian Aboriginal Community Controlled Organisation Network (SAACCON) and SA Government to fulfil their commitments under the National Partnership Agreement on the refresh of Closing the Gap initiative at the Commonwealth Government level. The SA Closing the Gap Implementation Plan (state-wide government initiative) (47) commits to ensuring Aboriginal and Torres Strait Islander children are born healthy and strong, that Aboriginal and Torres Strait Islander children thrive in their early years, that Aboriginal and Torres Strait Islander children are not overrepresented in out-of-home care (OOHC), and that culture and language remain strong. Our protocol also supports the aspirations outlined in the SA Aboriginal Affairs Action Plan and its priorities to improve Child and Family Support services to Aboriginal and Torres Strait Islander families, children and young people. The Plan embeds all five elements of the Aboriginal and Torres Strait Islander Child Placement Principle and includes key actions such as funding an Aboriginal Community Controlled Organisation (ACCO) to deliver family group conferencing targeted to support Aboriginal and Torres Strait Islander children and their families, and developing a model for a SA Peak Body for Aboriginal Children and Families for implementation in 2023 (48).

Racism, discriminatory and biased practices were identified through our consultation process with evidence of these practices still occurring within the SA health care settings. These practices, and their negative impacts, are of deep concern to Aboriginal and Torres Strait Islander stakeholders and non-Aboriginal health professionals. A growing body of evidence, over decades, identifies racism as a critical public health issue (49, 50). This requires action to address individual racist beliefs, racist interactions and racist assumptions and practices embedded in social institutions, including health care systems (51).

We have undertaken a comprehensive consultation with health and social services stakeholders combined with conducting rapid reviews of pregnancy and birthing and child health research focused on identified system-level interventions. The protocol team supported and worked in partnership with the Aboriginal Community Controlled Health Sector to ensure Aboriginal and Torres Strait Islander voices are privileged and informed the development of this protocol.

Consultations across health stakeholders identified that a system framework to support continuity of care should be based on recognition that all service systems are linked. Mutual understandings of how each health area operates, however, was often absent, suggesting services in many areas are operating in a silo (including Local Health Networks [LHNs]). There was also recognition that LHNs and other services across the sector have a remit to focus on specific groups and, therefore, understandably there are differing policies, procedures, legislative and funder requirements which determine the spread and scope of services provided. Furthermore, funding and/or reporting arrangements are often inflexible despite families moving within and across these systems.

Strengthened administrative agreements, therefore, are required to facilitate and support a safe and quality experience across the health system.

Importantly, many of the recommendations in our protocol, when implemented, would support hospitals in LHNs to meet regulatory requirements under the National Safety and Quality Health Care Standards (11). These standards are critical to improving long term outcomes for Aboriginal and Torres Strait Islander maternal and child health (11). The protocol also identifies opportunities to support primary health care services to meet the three Aboriginal and Torres Strait Islander specific standards within the National Safety and Quality Primary Health Care Standards (12). Furthermore, full implementation of the protocol would contribute to meeting the strategic imperatives identified in the SA Women's Child and Youth Health Plan 2021-2023, with Aboriginal and Torres Strait Islander families identified as a priority population (14). Furthermore, enabling health care system reforms requires organisation wide cultural safety protocols and must include addressing discriminatory and racist practices and behaviours (13), with adequate resourcing and monitoring of outcomes. A quality and safety framework is one way to address this.

This protocol has been designed to align with other national and state government initiatives for Aboriginal and Torres Strait Islander families, which may provide opportunities to leverage support and resources for implementation as well as avenues to monitor outcomes. These include National and SA Closing the Gap initiatives located in the Department of Premier and Cabinet - Aboriginal Affairs and Reconciliation (AAR) branch, which coordinates and consolidates an Annual Report of Closing the Gap related initiatives, activities and outcomes (CTG Annual Report) to comply with the requirements of the National Agreement on Closing the Gap (52).

This National Agreement provides high-level accountability and reporting mechanisms which encompass SA including the Productivity Commission publicly accessible dashboard, the Productivity Commission comprehensive three yearly progress review, independent Aboriginal and Torres Strait Islander-led reviews carried out within 12 months of each Productivity Commission review, and establishment of a National Agreement on Closing the Gap Implementation Reference Group which will have a monitoring role, and considers outcomes of reviews and feedback from the Close the Gap national Joint Council. Notably, the SA Government and SAACCON commit to independent oversight and progress towards the SA Closing the Gap Implementation Plan.

3. Equity

This protocol is premised on the view that equity is not the same as equality (53). That is, in order to address disparities in health, it should not be the aim of health services to treat all people the same way. This is not always understood by many non-Aboriginal and Torres Strait Islander health workers

(8). The factors that drive the health and wellbeing of Aboriginal and Torres Strait Islander children and families are strongly grounded in the history and legacy of colonisation; disconnection from land, language and culture; and ongoing experiences of racism and discrimination.

Western health systems operating within a medical paradigm that focuses primarily on identification of disease and disease risk factors are not well equipped to identify and respond in culturally safe ways to many of the issues affecting the health and wellbeing of Aboriginal and Torres Strait Islander children and families. These issues include: lack of or no access to interpreters, lack of or no understanding of Aboriginal and Torres Strait Islander kinships and cultural needs, extreme social disadvantage, housing insecurity, financial insecurity, legal problems, family and community violence, drug and alcohol problems and fear of the child protection system. Effective responses to these social and historical determinants of health requires a holistic approach to health and wellbeing that centres around families and communities, rather than disease processes.

Strong leadership by and collaboration with Aboriginal and Torres Strait Islander people is key to effective responses to the adversities faced by Aboriginal and Torres Strait Islander children, young people and families. It is essential for health services and systems to adapt and act in ways that address current inequities, and for systems change to be led by the voices of Aboriginal and Torres Strait Islander organisations and communities.

4. Required Cultural Considerations

Aboriginal and Torres Strait Islander people and communities are a part of the oldest living culture in the world (54, 55). For many Aboriginal and Torres Strait Islander peoples and communities their culture and beliefs have survived through colonisation, dispossession, and assimilation, these cultures and beliefs are protective for health and wellbeing (15-17). Aboriginal and Torres Strait Islander views on health see all aspects of life as interconnected, including our social, emotional, spiritual and culture and physical health (16). Cultural considerations are critical factors that need to be considered in the planning, design, implementation and delivery of culturally safe programs and services (2). Without them, culturally unsafe practices occur across systems and programs, which devalues and disempowers people and becomes a significant barrier to accessing services (2).

The concept of culturally responsive maternity services for Aboriginal and Torres Strait Islander women and women of Aboriginal children is not new. It was clearly identified by the Australian Health Ministers' Advisory Council in 2012, and in a number of strategies recommended within the National Maternity Services Plan in 2010 (18). Disappointingly, despite these recommendations many of the key characteristics of providing culturally competent care to Aboriginal and Torres Strait Islander women, women of Aboriginal children and families remain unchanged. Consultations across SA for this protocol have reiterated many of the findings of earlier reports (some written more than a decade ago), and highlighted that Aboriginal and Torres Strait Islander people want to receive health care services that recognise their culture and respects the values and beliefs of Aboriginal and Torres Strait Islander families.

Social and emotional wellbeing: The widely used Edinburgh Postnatal Depression Scale (EPDS) has not been validated with Aboriginal women. The Kimberley Mum's Mood Scale (KMMS) has been co-designed with Aboriginal women in the Kimberley to provide a culturally secure screening process. It has been validated in a local trial and has high levels of acceptability from health professionals and women

Within SA, there are specific cultural considerations for the context of Aboriginal and Torres Strait Islander maternal and child health, these must be recognised to ensure health professionals and services are equipped to deliver culturally respectful services.

Key elements include:

- ***Creating physical environments that are welcoming***
    - This includes designated areas where women and their families are accommodated in a welcoming, culturally safe environment, which is also suitable for male partners, and considerate of young mothers. This could include an indoor or outdoor space that is warm and inviting, has comfortable places to sit, native plants, an acknowledgement of the country where the service is based, local Aboriginal and Torres Strait Islander artwork, a TV, children's toys, and is appropriately named in local Aboriginal and Torres Strait Islander language.
- ***Family-centred care***
    - This involves providing health care from a family-centred perspective. Health staff must understand that Aboriginal and Torres Strait Islander concepts of family are much broader than western views, and services need to incorporate cultural and family obligations, by being flexible and including Aboriginal and Torres Strait Islander kinship structures and families.
- ***Gender sensitivities***
    - Aboriginal and Torres Strait Islander women and women of Aboriginal children generally have a preference to receive care from Aboriginal and Torres Strait Islander female health professionals. In the absence of Aboriginal and Torres Strait Islander

    women, they preference a female health provider. From a cultural perspective, reproduction and birthing is women's business and due to these cultural protocols, Aboriginal and Torres Strait Islander women and women of Aboriginal children may not engage or feel culturally safe with male health providers.

- ***Relationship based health care***
  - This requires consistency of care providers, where relationships are established to support on-going engagement of Aboriginal and Torres Strait Islander women, women of Aboriginal children and families with health care.
- ***Elders and grandmothers***
  - This involves recognising that in Aboriginal and Torres Strait Islander cultures, elders are important figures, are knowledge holders, and are treated with the utmost respect. Grandmothers play a very important role in raising children and grandchildren, and often play a significant role in supporting families. Elders play a crucial part of the fabric of Aboriginal and Torres Strait Islander life (19).
- ***Appropriate communication styles***
  - Good communication is critical and an integral factor in not only providing high quality, safe health care to Aboriginal and Torres Strait Islander families and children, but also in providing culturally responsive care. Insufficient training, and lack of support of Aboriginal and Torres Strait Islander health professionals, can give way to cultural misunderstandings and ill-informed health care practices, which can contribute to relational discontinuity.
  - Providing care to Aboriginal and Torres Strait Islander people requires skills to accommodate various styles of communication and understanding the context of Aboriginal and Torres Strait Islander people. This includes the importance of building trust, understanding history and language, providing adequate time to support effective communication, the inclusion of family as well as Aboriginal and Torres Strait Islander staff as a part of the health care team (19, 57, 58). Communication needs to reflect that staff are listening to the needs of the women and their families, enabling and encouraging them to specify their needs. This can include having other family members accompany them to help with communication, sourcing and providing interpreters, and understanding and interpreting body language. Staff need to be able to self-reflect and be open to consumer feedback to identify and resolve misunderstandings, to avoid discontinuity of care being interpreted as a problem stemming from women and families, rather than from staff or service actions, and decisions contributing to 'non-compliance' or 'no-shows' for instance.

- ***Significance of place / Country***
    - For Aboriginal and Torres Strait Islander people, their connection to where they come from is extremely important. Professor Mick Dodson provides a description of the significance and meaning of place in the following quote:

      > *"When we talk about traditional 'Place'…we mean something beyond the dictionary definition of the word. For Aboriginal Australians…we might mean homeland, or tribal or clan area and we might mean more than just a Place on the map. For us, Place is a word for all the values, Places, resources, stories and cultural obligations associated with that area and its features. It describes the entirety of our ancestral domains. While they may all no longer necessarily be the title-holders to land, Aboriginal and/or Torres Strait Islander Australians are still connected to the Place of their ancestors and most consider themselves the custodians or caretakers of their land".*
      > *The SAHMRI Aboriginal and Torres Strait Islander Collective (19)*

      This is important to understand in the context of connecting with Aboriginal and Torres Strait Islander women, women of Aboriginal children, children and families and can enhance understanding of cultural beliefs. It is also important to note that there is great diversity in Aboriginal and Torres Strait Islander women's journeys, regarding their identities and being connected to country. Some women and families may have been affected by the Stolen Generation policies either directly or generationally and could be missing a piece of their history/place stories. Displacement needs to be handled with cultural and emotional sensitivity. For other Aboriginal and Torres Strait Islander women and women of Aboriginal children, there is also a spiritual connection of giving birth on country. Some Aboriginal and Torres Strait Islander peoples believe that to give birth on country facilitates the rebirth of their ancestral line. This is the circle of life for some Aboriginal and Torres Strait Islander peoples. The same occurs with death and dying. The spirit stays with country and can then be reborn.
- ***Recognition of Aboriginal and Torres Strait Islander parenting practices in service models***
    - A common theme reported by Aboriginal and Torres Strait Islander parents and community-based health workers is the failure of existing maternal and child health service models and non-Aboriginal health care providers to recognise Aboriginal and Torres Strait Islander ways of parenting, including the encouragement of early development of child independence around activities such as feeding (59). Multiple caregivers (i.e., aunts, uncles, grandmothers, older siblings) often play an important

role in parenting, and an Aboriginal and Torres Strait Islander child forms multiple, strong, healthy attachments to others. Practices such as this are often viewed as suboptimal and neglectful, contributing to child protection notifications, rather than being considered in a framework of providing culturally responsive care and a strengths-based approach leading to healthy outcomes of children.

- ***Birthing practices***
  - Consultations for this protocol in SA have identified the need for development of a standard birthing protocol to improve and incorporate Aboriginal and Torres Strait Islander birthing practices. In addition, a system wide adaption of the 'cultural care plan' should be developed through the Aboriginal Family Birthing Program and Child and Family Health Services and implemented in partnership with Aboriginal and Torres Strait Islander health professionals or Aboriginal and Torres Strait Islander cultural support persons to ensure cultural safety is applied.
- ***Appropriate terminology***
  - There is acceptable terminology that should be used when speaking to or about Aboriginal and Torres Strait Islander people. Terms that are considered offensive and unacceptable in any context include but are not limited to: Abo, Aborigine, Aborigines, ATSI, coon, native, blacks, mixed blood, half-caste, quarter-caste, full-blood, part-Aboriginal, 25%, 50% Aboriginal (blood quantum) (19)

Preterm birth: One in two preterm births among Indigenous women could be avoided if smoking during pregnancy, pregnancy-induced hypertension, antepartum haemorrhage, and diabetes (pre-existing or acquired during pregnancy) were prevented

5. Strategic Alignment

Key national and local policies are provided below which have informed the development of our protocol.

Policy document	Relevance to this protocol
National Aboriginal and Torres Strait Islander Health Plan 2013-2023	Identifies national health priority areas for Aboriginal and Torres Strait Islander peoples and communities. Key priorities include: • mothers and babies get the best possible care and support for a good start to life • growth and development of children lays the basis for long, healthy lives
National Agreement on Closing the Gap (July 2020)	National agreement by all Australian Governments and the Coalition of Peaks that includes the following four priority reforms

	that focus on changing the way governments work with Aboriginal and Torres Strait Islander people: 1. Priority Reform 1 – Formal partnerships and shared decision making 2. Priority Reform 2 – Building the community controlled sector 3. Priority Reform 3 – Transforming government organisations 4. Priority Reform 4 – Shared access to data and information at a regional level.
SA's Implementation Plan for the National Agreement on Closing the Gap	1. Shared decision-making authority, with governments, to accelerate policy and place-based progress on Closing the Gap through formal partnership arrangements. 2. Building the community controlled sector to be strong and sustainable, delivering high quality services to meet the needs of Aboriginal and Torres Strait Islander peoples across Australia. 3. Improving mainstream institutions: Governments, their organisations and their institutions are accountable for Closing the Gap and are culturally safe and responsive to the needs of Aboriginal and Torres Strait Islander peoples, including through the services they fund. 4. Aboriginal and Torres Strait Islander-led data: Aboriginal and Torres Strait Islander people have access to, and the capability to use, locally relevant data and information to set and monitor the implementation of efforts to close the gap, their priorities and drive their own development.
National Preventive Health Strategy 2021-2030	National strategy to strengthen preventive health action across the health system, identifies the preconception period through to the early years of life as a critical period for optimising lifelong health, and Aboriginal and Torres Strait Islander people are identified as a priority population for preventive health action.
National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families	Identifies key principles, approaches to care and service delivery approaches to support the delivery of culturally competent care for Aboriginal and Torres Strait Islander children and families. Key approaches include building services around a primary health care model, family-centred and relationship-based care, a focus on social and emotional wellbeing and strengths-based approaches. Also identifies enablers to support health services to meet families' needs.
National Framework for Child and Family Health Services – secondary and tertiary services	Identifies key system enablers to optimise health outcomes of children accessing secondary and tertiary child and family health services.
National Digital Health Strategy and Framework for Action	National Framework that outlines seven strategic priorities to support and optimise digitally enabled health and care. Priorities most relevant to this protocol include expanding use of the My Health Record, enabling secure exchange of clinical information via secure messaging services, building capabilities of the health workforce to deliver digitally enabled care, and enhancing models of care including the development of a children's health record and child health data hub as part of the National Children's Digital Health Collaborative.

Clinical Practice Guidelines - Pregnancy care	National guidelines providing evidence-based recommendations about core pregnancy care practices designed for all health care professionals involved in caring for women during pregnancy. This includes specific approaches to care for Aboriginal and Torres Strait Islander women and women of Aboriginal children that are culturally safe, and woman centred.
National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016-2023	Outlines key strategies to build a strong and supportive health workforce to provide culturally responsive health care; this includes building and retaining Aboriginal and Torres Strait Islander health professionals across all disciplines and supporting them to work to their full scope of practice, ensuring cultural safety training is embedded into performance management of health service staff at all levels, and increasing pathways for Aboriginal and Torres Strait Islander people into higher education study and training in health professions.
SA Women's, Child and Youth Health Plan 2021-2031 (draft)	State-wide framework that establishes the key health service directions, strategies and underlying priorities to inform the development of integrated and culturally safe clinical services for women, children and youth in SA over the next decade. Key priorities include improving health equity, empowering women, children and youth and enabling the health workforce to deliver holistic care. Actions across the following 16 areas have been identified as key to addressing these priorities: health promotion, prevention and early intervention; health literacy; workforce capability; family-integrated services for babies; services for expectant parents; addressing family violence; services for children and young people; abortion services; addressing mental health; gynaecology services; services for families at risk; addressing access issues for growing and underserviced populations; evidence and data; ensuring the ongoing sustainability of services; partnering with consumers; and leadership and governance.
SA Digital Health Strategy (draft)	Establishes core program areas to drive digital health innovations in the SA health care system over the next three years, including implementation of digital technologies to improve communication between health care providers and with families, as well as continuity of care.
Early Learning Strategy 2021 to 2031: All young children thriving and learning	SA Strategy to guide investment in an early learning system; this includes short, medium and long-term goals to strengthen access to universal child development checks, the implementation of new developmental screening checks at 12 months and 3 years of age, strategies to raise awareness among families of referral pathways available in the community and hospital and via the NDIS and increasing access to high quality pre-school programs.
SA Rural Aboriginal Health Workforce Strategy 2021-2026	Outlines key actions to promote a culturally safe workplace in health with responsibilities at all levels of rural service delivery, attract and retain Aboriginal and Torres Strait Islander people in the rural health workforce, enhance Aboriginal and Torres Strait Islander leadership in health services, and promote a coordinated health system.
SA Health Aboriginal Workforce Framework 2017-2022	Outlines actions across the health system to promote a positive working environment, to promote career pathways for Aboriginal and Torres Strait Islander employees, to increase the Aboriginal

	and Torres Strait Islander workforce and promote consistent application of role classifications for Aboriginal and Torres Strait Islander people in clinical and non-clinical roles and to build Aboriginal and Torres Strait Islander leadership capacity across SA Health.
National Maternity Services Plan (2010)	Provides a national framework to promote maternity care that is woman-centred, reflecting the needs of each woman within a safe and sustainable quality system. Identifies that all Australian women will have access to high quality, evidence-based, culturally competent maternity care in a range of settings close to where they live. Acknowledges that provision of such maternity care will contribute to closing the gap in maternal and child health outcomes between Aboriginal and Torres Strait Islander and non-Aboriginal populations as well as strengthening the maternity workforce.
The Roadmap for Child and Family Support System Reform 2021-2023	This reform builds the family supports required to prevent children from entering out of home care. The vision is to enable children to live at home in community and culture.

6. Guiding Principles

The following principles were adopted to guide the development of the protocol:

- Privilege Aboriginal and Torres Strait Islander voices, be family-centred, and consider Aboriginal and Torres Strait Islander kinship and families.
- The protocol must be meaningful/useful and a solid piece of work with the intent to make a positive difference to Aboriginal and Torres Strait Islander women, women of Aboriginal children families and children aged up to 5 years.
- Be respectful of all voices.
- Expect differences in thinking and seek support from everyone.
- Be an empowering experience for everyone involved.
- Recognise some ACCHOs may need more support than others.
- Recognise this is an opportunity to influence significant system reform.
- Recognise this is an opportunity to challenge poor practices and institutional racism within systems.
- Deliver services through all parts of health systems including primary and hospital services, that encompass prevention and early intervention to keep people healthy.

7. Method

The protocol has been developed following a rigorous method and has been informed by the current evidence-base in maternal and child health care, combined with state-wide consultation with local

ACCHOs, LHNs, Primary Health Networks (PHNs), state-wide maternal and child health services, other SA government representatives from Digital Health, the Office for the Early Years (OEYs), Department for Human Services (DHS), Housing, and the child protection system, peak professional organisations representing health care professionals involved in maternity and child health care and local Aboriginal and Torres Strait Islander communities.

7.1 Rapid Reviews

Two rapid narrative reviews were conducted to inform our protocol and both local and state-wide consultations. The first rapid narrative review focused on pregnancy and birthing.

Aims of the review were:

I. To describe barriers and enablers in the health system to support improvements in healthy birthweight and a healthy start to life for Aboriginal and Torres Strait Islander children.
II. To describe the key aspects and impact of system level initiatives to improve the proportion of Aboriginal and Torres Strait Islander children with healthy birthweight and healthy start to life.
III. To describe successful system-level approaches that contribute to improving the proportion of Aboriginal and Torres Strait Islander children with healthy birthweight and healthy start to life.

The second review focused on child health up to five years of age.

Aims of the review were:

IV. To describe barriers and enablers in the health system to support Aboriginal and Torres Strait Islander child health and wellbeing.
V. To describe the key aspects and impact of system level initiatives to improve the health of Aboriginal and Torres Strait Islander children.
VI. To describe successful systems-level approaches in other settings that could be applied to improve the health of Aboriginal and Torres Strait Islander children.

The review findings are summarised in Appendix A and where relevant, have been incorporated into the rationale for protocol recommendations.

7.2 Quantitative Data

Quantitative data in relation to pregnancy and birthing, and child health from conception to age five years has been analysed and incorporated into the protocol where relevant and appropriate. This has included various data sets from both Commonwealth, State and public health research evidence including data from the SA Aboriginal Families Study.

7.3 Qualitative Data

Qualitative data through the consultation process have informed the protocol development, and grey literature which may not be identified through the rapid reviews and, where relevant, informed the protocol development.

7.4 Working Groups

Four working groups were established to provide structure and dedicated time to support the progression of the key elements of the protocol action and accountability items.

Rapid Review Working Group

The operations group, as a part of the project, supported team members conducting the two comprehensive rapid narrative reviews.

Consultation and Engagement Working Group

This group supported and defined the engagement approach and consultations. The ACCHO sector Chief Executive Officers nominated maternal and child health leads to form the membership of this group, and to ensure Aboriginal and Torres Strait Islander voices were privileged in this process. Reid's definitions of continuity of care were considered in the formation of the facilitator consultation packs, a resource for facilitating consultation and engagement activities, and feedback preparation.

Pregnancy and Birthing Working Group

A pregnancy and birthing working group was convened to engage experts working in the field to develop appropriate consultation and engagement questions, review consultation findings and consider potential strategies and levers to include in the protocol. The group also considered where accountability and responsibility might lie within the protocol recommendations. Membership comprised of multidisciplinary experts working in acute and primary care, government and non-government, LHNs and ACCHOs, clinicians and non-clinicians, with representations from metropolitan and country areas.

Child Health Working Group

A child health working group was established to engage with experts working in the field to develop appropriate consultation and engagement questions, review consultation findings and consider potential strategies and levers to include in the protocol. Membership comprised of multidisciplinary experts working in acute and primary care with representations from metropolitan and country areas. The group were engaged to support the analysis of findings of the Child Health literature review, including the inclusion of relevant grey literature from both SA and more broadly. The group also considered where accountability and responsibility might lie within the protocol. Membership comprised experts in child health and Aboriginal and Torres Strait Islander child health from across health and community services.

System Champions

Clinicians and health professionals across the health system in LHNs and ACCHOs were identified and were utilised to seek expert advice on specific recommendations.

7.5 Consultations

The SAHMRI project team worked closely with the Aboriginal Health Council of SA (AHCSA) in supporting and aligning the digital health project being led through AHCSA to the preliminary findings of the engagement and consultation through the protocol development. Regular meetings were held with AHCSA and the team including engagement with the AHCSA CEO forum from the initiation phase of the project. Regional engagement of Aboriginal and Torres Strait Islander communities and service providers, including LHNs and social health services, was led by the ACCHO sector with support from the SAHMRI Women's and Kids Theme. A consultation support package was developed which provided background to the project, a consultation template, a set of slides for use in consultation processes and a facilitators' guide. Regular meetings were held with key staff leading the consultations within the ACCHO sector, and with consultants who were brought in by services to conduct local level consultation. The facilitators' guide and consultation template were piloted with an ACCHO service and revised by the Consultation and Engagement Working Group. Regular meetings were held with identified facilitators to support the process. Feedback was received from the ACCHO sector regarding the best way to approach consultations with state-wide services. An experienced consultant was engaged to facilitate consultation with LHNs and state-wide services.

7.6 Data analysis

A thematic analysis method was utilised to determine themes from the consultation data. The consultation data was closely aligned to the findings of the rapid reviews in both maternal and child health. These combined findings have informed the recommendations of the protocol.

7.7 Closing the loop consultation and feedback

The draft protocol and accompanying action and accountability tables were taken back to the key working groups, ACCHO CEO forum, senior LHN staff and were circulated to the Senior Officers Group Aboriginal Health (SOGAH) seeking feedback about specific recommendations. This feedback was incorporated into the final version of our protocol.

8. Recommendations

The recommendations in this protocol are in no particular priority order after the first one. The format of each recommendation is as follows: The number and name of the recommendation, a statement of intent for the recommendation (see List 1), then the full explanation contains a rationale and discussion about the findings from the rapid reviews and consultations. Following this is an action and accountability table for each recommendation. There are a number of actions for each recommendation, and the table indicates whether it is immediate, medium or long term focused; the action and levers; who is accountable (departmental work unit or position); the role of the Aboriginal Health Strategy within the DHW; and who might monitor the implementation and outcomes of the actions. Where available, examples are included.

List 1: Our 13 Recommendations

Recommendation	*Statement of Intent*
Leadership and Governance	*To increase resources, representation and improve care required by Aboriginal and Torres Strait Islander families and children.*
Reduce Institutional, Systemic, and Interpersonal Racism	*To reduce racism experienced by staff working in Aboriginal and Torres Strait Islander services, and Aboriginal and Torres Strait Islander families, women and children in SA across the health and social systems.*
Provide Culturally Safe Services	*To provide culturally informed and safe services at every access point to ensure healthy Aboriginal and Torres Strait Islander women, women of Aboriginal children and strong and vibrant children who are pre-school ready.*
Family-Centred Care	*To apply a family-centred framework to Aboriginal and Torres Strait Islander women, women of Aboriginal children and families when engaging with health and community services across SA.*
Child Safety and Wellbeing	*For the DHW to implement system-wide reform to improve child safety and wellbeing responses of government and non-government funded health and social services.*
Addressing Access Barriers	*To reduce and remove barriers to ensure Aboriginal and Torres Strait Islander women, women of Aboriginal children, infants and children can access health care services to complete their care.*
Growing and Strengthening the Workforce	*To build and strengthen capacity in the health workforce that meets the needs of Aboriginal and Torres Strait Islander women, women of Aboriginal children, infants and children, and plan for future workforce needs.*
Digital Technologies	*To increase the use and implementation of digital technologies that support and strengthen continuity of care by improving digital health literacy across the health workforce, and among Aboriginal and Torres Strait Islander families.*

Information Sharing, Follow-up, Referrals and Discharge Planning	*To improve high quality information flow, information sharing, referrals, follow up care, and discharge planning.*
Sustained Investment	*To investigate and act on opportunities to sustain investment over the next 10 years to meet the health needs of SA's Aboriginal and Torres Strait Islander mother's, children and families.*
Excellence Collaboration	*To lead and monitor clinically and culturally safe evidence-based improvements across the health and social care systems to promote integrated, family-centred care for Aboriginal and Torres Strait Islander women, women of Aboriginal children, children and families.*
Living with COVID-19	*To maintain commitment to continuity of health care during the COVID-19 pandemic, and ensure access to resources and preventative actions for Aboriginal and Torres Strait Islander families.*
Living with Disabilities and/or Chronic Illness	*To increase resources and improve care required by Aboriginal and Torres Strait Islander families and children living with disabilities and/or chronic illness.*

Recommendation 1: Leadership and Governance

To increase resources, representation and improve care required by Aboriginal and Torres Strait Islander families and children.

> ***"We are not separate from the system; we are the system."***
>
> ***(participant in ANZSOG forum by Hogan and colleagues (61)***

Leadership and governance is a key enabler of effective health systems and involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability (46). Leadership and governance are critical for initiatives to promote continuity of care for Aboriginal and Torres Strait Islander mothers and children and requires support across a broad range of contexts to achieve integrated service delivery and major reform. Systems leadership has been described as "leadership across organisational and geopolitical boundaries, beyond individual professional disciplines, within a range of organisational and stakeholder cultures, often without direct managerial control. Its purpose being the intention to effect change for positive social benefit across multiple interacting and intersecting systems" (62).

Within SA, Aboriginal and Torres Strait Islander maternal and child health needs prioritisation at a leadership level across multiple contexts. This can be enabled through the SA Close the Gap Implementation Action Plan processes to reach the kind of impetus and focus seen in initiatives such as the Australian Early Development Census (AEDC). Notably, maternal and child health is already an enduring focus of the National Closing the Gap initiative and is backed by political goodwill. This must be sustained with recurrent investment and be supported by research, evaluation, and evidence.

Lessons learned from initiatives in other jurisdictions indicate the importance of strong, effective leadership to prioritise and drive systems reform to improve child health. This includes the Australia New Zealand School of Government (ANZSOG) Systems Leadership for Child and Youth Wellbeing project (61). Within the ANZSOG project, the key drivers of reform to support child and youth health were identified as: concerted leadership; smarter investment; engaged public and communities; stronger workforces; integrated delivery; and putting data, evidence and learning to work. These drivers are reflected in many of the recommendations included in our protocol.

The new Closing the Gap National Agreement has been developed in genuine partnership between the Australian Government and the Coalition of Aboriginal and Torres Strait Islander Peak Organisations (the Coalition of Peaks). It is underpinned by the belief that when Aboriginal and Torres Strait Islander people have a genuine say in the design and delivery of policies, programs and services that affect them, better life outcomes are achieved. It also recognises that structural change in the way governments work with Aboriginal and Torres Strait Islander people is needed to close the gap. In addition to outcomes and targets that outline 'what' is to be done, the new Closing the Gap National Agreement also articulates four Priority Reforms that address the 'how' of the partnership. These have been directly informed by Aboriginal and Torres Strait Islander people. These reforms are: Formal Partnerships and Shared Decision Making; Building the Community Controlled Sector; Transforming Government Organisations; and Shared Access to Data and Information at a Regional Level (47). These areas are consistent with many of the recommendations in our protocol.

There is also much that individual leaders can do through their own organisations and existing networks and initiatives, including ensuring that Aboriginal and Torres Strait Islander leadership participates in design, development, implementation, delivery and evaluation of health services, as outlined in the National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families (63).

Governance includes decision making and is defined by the Centre for Aboriginal Economic Policy Research as: '*the evolving processes, relationships, institutions and structures by which a group of people, community or society organise themselves collectively to achieve the things that matter to them*' (p. 9). This definition has also been adopted by the Australian Institute of Health and Welfare (AIHW) Closing the Gap Clearing House (64).

Aboriginal and Torres Strait Islander people live collectively, and governance in this context is the contribution to decision making that occurs through structures, engagement, leadership, and discussions. Whatever structures and processes are applied throughout the implementation of this protocol, Aboriginal and Torres Strait Islander governance will underpin its success. Governance includes engagement processes and structures that are ongoing, respectful, and that advice provided by Aboriginal and Torres Strait Islander people informs and shapes the initiatives that are developed. Aboriginal and Torres Strait Islander governance, when carried out responsibly, assists with the engagement of broader Aboriginal and Torres Strait Islander communities and can be a mechanism for the project managers to ensure they are being accountable to community.

Aboriginal and Torres Strait Islander people can be leaders by virtue of their community status, or work role, or as part of governance structures. Where Aboriginal and Torres Strait Islander people participate in decision making activities such as governing bodies, Aboriginal and Torres Strait Islander reference, steering or advisory groups, best practice is to ensure the consumers of the groups should be reflected in the governing membership. Further, Aboriginal and Torres Strait Islander people want to be involved in decision making, but are also busy people with work, family, and cultural obligations. For contributions to be successful, there needs to be a clear purpose for their involvement, and the feedback provided by community must be reflected in the actions and progress of the project, to ensure accountability.

Aboriginal and Torres Strait Islander consumers and leaders, together with maternal and child health experts, should guide and drive the development of the Excellence Collaboration proposed in Recommendation 11, and ensure the priorities being addressed are appropriate, the monitoring methods used are ethical and culturally safe, and that the processes devised to address system challenges are fair.

Short (S) – immediate; Medium (M) – Jun 2022 onwards; Long (L) - Jul 2023 onwards. Aboriginal Health Services (AHS) roles Lead L, Partner P, Influence I

Leadership and Governance								
Rec No.	**Short Med, Long**	**Action**	**Lever/s**	**Accountability owner**	**Accountability method**	**AHS Role L, P, I**	**Monitoring by whom**	**Example**
1.1	M	DHW develop and incorporate a comprehensive set of Aboriginal and Torres Strait Islander maternal and child health KPIs based on evidence and by well-versed experts in Aboriginal and Torres Strait Islander maternal and child health, that inform both strategic and operational plans, at the DHW and LHN levels. Ensure KPI's link to existing KPI's already collected by AIHW at Commonwealth level with additional KPI's as necessary to avoid too many collection points.	SLA – DHW and LHN Strategic Plan Operational Plan	AHS	LHN local data	L	AHS	Maternal and child health expertise available from a range of researchers including SAHMRI, MCRI, SA Universities.
1.2	S	DHW to establish an Aboriginal Strategic Advisory and Implementation Committee to ensure Aboriginal and Torres Strait Islander people are meaningfully engaged in leadership and governance decision making. Membership inclusive of LHNs, ACCHO services and ACRA, ensuring equal Aboriginal and Torres Strait Islander membership.	Strategic Plan Service Level Agreements, Board of Directors Link to 6.5 Aboriginal Strategic Advisory and Implementation Committee in CTG AAR initiative.	AHS	To be developed	L	Excellence collaboration	

1.3	S	Director, AHS nominate and fund an emerging leader to apply for an Indigenous scholarship for this Executive Master of Public Administration course, or similar.	CTG Implement plans – Leadership and governance	AHS	DHW Aboriginal Workforce development	L	CE Health	
1.4	M	AHS builds on existing leadership and governance processes and structures such as: • involve and develop at the Board level (ACCHO CEO and/or Aboriginal and Torres Strait Islander community member – gender considerations) and LHNs. • provide opportunity to meet with existing LHN Aboriginal and Torres Strait Islander board members and discuss the National Standards as they relate to governing board monitoring roles.	CTG implementation plan Leadership development	DHW Workforce	AHCSA	P	CE Health	

Recommendation 2: Reduce Institutional, System, and Interpersonal racism

To reduce racism experienced by staff working in Aboriginal and Torres Strait Islander services, and Aboriginal and Torres Strait Islander families, women and children in SA across the health and social systems.

Racism relates to the systems, beliefs, values and practices which result in unfair, avoidable and unjust inequalities in power, resources and opportunities for minority groups including Aboriginal and Torres Strait Islander people and community (22).. It is important to note that there are distinctions to be made between various types of racism. Interpersonal racism, for example, refers to interactions between individuals; internalised racism refers to the racist beliefs, attitudes and worldviews; and structural and institutional racism refers to racist assumptions and structures that are embedded into social institutions, including health care systems (22). Globally, racism is a social determinant of health, where institutional, systemic, and interpersonal racist practices are embedded into social, structural, and political contexts (20, 22).

Racism and discrimination are known to occur throughout society, including schools, workplaces, health care services and sporting venues. In the Australian context, there has been a growing body of evidence, over decades, that defines racism as a public health issue (1, 2, 65). Aboriginal and Torres Strait Islander people are exposed to racism across all social, economic and health domains within contemporary society and there is growing recognition that racism is a major contributor to disparities in health outcomes (2, 20, 21). Racism and discrimination (a manifestation of racism) increase chronic stress with an ongoing impact on health across the life course and on the health of future generations (2, 22). The evidence clearly highlights that racism, and a lack of cultural safety, is a critical barrier to health care for Aboriginal and Torres Strait Islander peoples (2).

South Australian Aboriginal Women's Experiences

The Aboriginal Families Study is a prospective cohort of 344 Aboriginal children and their mothers and carers.

1 in 3 Aboriginal women perceived that they were 'treated with less respect than other people' and that hospital /health staff service staff talked down them.

1 in 4 perceived that they had been 'insulted, judged or ignored by hospital or health staff' and a similar proportion perceived that they had received poorer care from health and hospital staff than other women.

Half of women (51%) in the Aboriginal Families Study reported that they had experienced discrimination or unfair treatment from a health service providing maternal health care.

Concerningly, this evidence further highlights practices of discrimination and the lack of cultural safety for Aboriginal and Torres Strait Islander people influence personal decisions to access health care including care during pregnancy (23). Data from the AFS demonstrates an association between racial discrimination and adverse birth outcomes, including preterm birth, low birthweight and small for gestational age infants (22). This may be indicative of the 'inverse care law' occurring within perinatal care, meaning those who are most at risk of poor infant health outcomes are less likely to receive the level of care matched to their needs (22). The findings of the AFS are consistent with consultations undertaken for the Women's and Children's Local Health Network Aboriginal Workforce Strategy which found that racism was consistently identified as a significant barrier to effective health care, with individual and systemic or institutional racism being cited as something that needs to stop (66).

The longitudinal study of Aboriginal and Torres Strait Islander children 'Footprints in Time' shows an increasing body of evidence that racial discrimination has negative impacts on child health, particularly experiences of vicarious racism through the experiences of others, including parents, carers and family members. This evidence suggests that racism can influence development in the very early stages of life, including general health and wellbeing, sleep difficulties, and obesity. Much more research, however, is required to understand the role that racism plays as a determinant of Aboriginal and Torres Strait Islander child health, to fully understand the impacts of racism in early childhood (67).
In the context of Aboriginal and Torres Strait Islander child health, racism and discrimination also plays out in a lack of access to culturally relevant assessment tools.

Developmental screening is a critical component of early childhood care to promote early detection and intervention of developmental issues. The validity of routinely used mainstream developmental screening and monitoring tools for Aboriginal and Torres Strait Islander families has been questioned as they identify very large proportions of Aboriginal and Torres Strait Islander children as developmentally vulnerable (68-70). While development and refinement of tools such as the Ages and Stages Questionnaire (ASQ) is occurring (e.g., the ASQ-TRAK), increasing access to culturally relevant tools remains an important priority to promote health care for Aboriginal and Torres Strait Islander families.

Short (S) – immediate; Medium (M) – Jun 2022 onwards; Long (L) - Jul 2023 onwards. Aboriginal Health Service (AHS) role Lead L, Partner P, Influence I

Reduce Institutional, Systemic, and Interpersonal Racism								
Rec No.	**Short Med Long**	**Action**	**Lever/s**	**Accountability owner**	**Accountability method**	**AHS role L, P, I**	**Monitoring by whom**	**Example**
2.1	M	Evidence from this protocol in relation to Aboriginal and Torres Strait Islander maternal and child health experiences of racism are included in the development of Whole of Government Anti-Racism Strategy being led by Wellbeing SA to facilitate family engagement in care and reduce the rate of 'non-attendance' for follow-up care.	NSQHS Standards: 1.4 and 1.21; LHN Aboriginal Health Improvement plans; LHN workforce plans; Wellbeing SA anti-racism strategy	Wellbeing SA	Develop anti-racism strategy; Collaboratively implement anti-racism strategy; Includes anti-racism measures;	I P I	CE Health Wellbeing SA; AHS LHN governing boards; LHN CEO's and Q&S processes.	
2.2	S	Establish Aboriginal Strategic Advisory and Implementation Committee for this protocol to: • Audit and assess internally what hasn't worked in the past and why; • Monitor all actions of the protocol implementation plan	National Agreement on Closing the Gap (July 2020); SA CTG Implementation plan;	AHS AAR	SA CTG reporting against the implementation plan to the Joint Council. (All Australian governments and Aboriginal community controlled).	L and P	CE Health AHS Director AAR	ANZSOG; SAACCON
2.3	M	Wellbeing SA/CEIH lead the development and implementation of anti-racism indicators for Aboriginal and Torres Strait Islander women, Aboriginal and Torres Strait Islander children and families (Patient reported experience measures). Aboriginal and Torres Strait Islander health workforce indicators are developed and incorporated into service level agreements and monitored by LHNs Governing Boards.	NSQHS Standards: 1.4 and 1.33	Wellbeing SA CEIH	To be developed	P	AHS	
2.4	M	Develop and implement effective anti-racism and unconscious bias training across LHNs providing maternity and child health services.	NSQHS Standards: 1.4 and 1.33	Workforce Senior Officers SA Health	To be developed	P	CE Health LHN CEO's	

			WCHN and other LHN Aboriginal Workforce Strategies 2018-2022					
2.5	M	LHNs to develop and strengthen effective and respectful partnerships with their Board of Directors and Seniors Executive, PHN's Boards and Senior Executives and ACCHO Boards and Senior Executives.	NSQHS Standards: 2.13 Women's, Child and Youth Health Strategy – Guiding principles: we are collaborative, we are respectful, we are culturally safe Focus Area: Interagency Collaboration	LHNs AHCSA ACCHOs	To be developed	I	AHS	
2.6	L	Development and refinement of tools such as the ASQ-TRAK, increasing access to culturally relevant tools to promote culturally responsive care for Aboriginal and Torres Strait Islander families.	NSQHS Standard: 1.21	Aboriginal Strategic Advisory and Implementation Committee and Excellence Collaboration	To be developed	P	AHS AHCSA	

Recommendation 3: Provide Culturally Safe Services

To provide culturally informed and safe services at every access point to ensure healthy Aboriginal and Torres Strait Islander women, women of Aboriginal children and strong and vibrant children who are pre-school ready.

It is estimated the Aboriginal and Torres Strait Islander population on this continent pre-colonisation was >750, 000 into the millions. Even at the minimum estimate (750,000 people), this is a large population that existed prior to colonisation and thrived for generations without western medical interventions, particularly in pregnancy and birthing (55, 71).

These traditions remain with Aboriginal and Torres Strait Islander people today, as do connections to culture, identity, knowledge systems and country. Although perceptions may be that 'culture is changing' it must be noted the adverse impact western legal systems have had on cultural traditions date back thousands of years. Aboriginal and Torres Strait Islander culture is still 'living' and existing, albeit not practised in its totality given parts of it are either considered illegal or against today's risk and quality standards (e.g., birthing on country in its literal form) (24, 72, 73). During our consultation, it was evident that metropolitan based women historically have not been offered the option to practice cultural traditions when birthing in Adelaide.

> *"a miscarriage happened (late term) in community and the woman was transferred out to [a hospital] …she wasn't allowed to take the baby on the plane with her - RFDS wouldn't allow it as they considered the baby to be a bio-medical product."*

> *"Sometimes it's not practical to travel with the placenta, and if a baby is premature and mum is staying in Adelaide for a period of time, it would be difficult for her to have the placenta with her."*

Providing a culturally safe environment doesn't just mean knowing and understanding Aboriginal and Torres Strait Islander cultural customs, rather it requires an enabling system to provide what is necessary to achieve healthy outcomes for both mother and child. This involves key elements from a system level perspective, dynamic governance and leadership, funding drivers and resourcing. This includes operationalising through the workforce, practice and ongoing monitoring to address new priorities (24).

Culturally safe service provision requires senior leadership and governance, the structural system, and policies to guide practice in the frontline ensuring that, where possible, individual client needs are identified and planned for. Health professionals should be equipped to identify the needs of Aboriginal and Torres Strait Islander families and to be able to respond by planning for this in a practical sense. The system or environment in which they work must ensure that it is possible for needs to be met. For example, a woman may advise that she wishes to only be seen by female practitioners throughout her perinatal care – the employee identifies this (is culturally aware), can plan for this (is culturally sensitive) and the workplace systems ensure that only females work with the woman (is culturally safe). Not all Aboriginal and Torres Strait Islander women and women of Aboriginal children will advise this, so women should be asked. Achieving this reflects appropriate woman-centred care, which is recommended as standard care in national maternity care policy (24). Care should also take into consideration all needs of the individual (emotional, physical, social, psychological, cultural). Some Aboriginal and Torres Strait Islander women and women of Aboriginal children may not advise this due to the systemic racism in the Australian hospital system.

Workplace culture should dominate in a way that personal bias in the frontline should not jeopardise a safe environment for clients. This also extends to Aboriginal and Torres Strait Islander staff being supported in a culturally safe workplace environment. Leaders in the workplace can set the scene for 'how to work' and 'how to treat people', whether clients or staff.

Aboriginal and Torres Strait Islander women and women of Aboriginal children may access the health system at any stage of pregnancy, maternal and postnatal care, and accessing care for children may involve primary health care services, tertiary care (birthing centres), specialist care and allied health services. At any access point, cultural safety is critical to ensure ongoing engagement with the health system. Our consultations highlighted this is integral to sustain continuity of care (70).

Flexible models of care would privilege Aboriginal and Torres Strait Islander women and women of Aboriginal children the opportunity to access the care of their choosing at any stage of the pregnancy, during birthing and postnatally. In order to be responsive, health services should not treat people the same way. The experience of care at any access point can affect the willingness of mothers to engage and receive ongoing care. A lack of a 'safe place' or continually changing locations, with numerous staff changes, cause a loss of relational care, causing feelings of anxiety and stress. These structures occur due to workforce resourcing constraints in remote and regional areas with high turnover of staff. A culturally insensitive environment can also result in a lack of Aboriginal and Torres Strait Islander health care providers, resulting in a lack of a 'safe place' for Aboriginal and Torres Strait Islander women, women of Aboriginal children and their children to receive health care (70).

Providing a supportive continuous care system means having a holistic care team throughout the perinatal period – this is critical to both cultural safety and the wellbeing of mother and child. The holistic team must include an Aboriginal Maternal and Infant Care (AMIC) worker, at the very least, as a critical part of the team to enable culturally safe care. Our consultations found that women wanted a continuous relationship with a midwife and an AMIC worker, having an integrated holistic team as a ‘wrap-around’ support throughout their perinatal journey. The relational aspect is key to not only ongoing engagement with the service, but for the ongoing wellbeing of the woman to ensure she feels safe and supported up until being connected into other services postnatally. AMIC workers are fundamentally critical to the success of the perinatal support team, in a similar way to an Aboriginal and Torres Strait Islander Liaison Officer in the absence of a social worker (which is still the gold standard of care). Our consultations highlighted the need for a social worker as part of the team to assist the client and the team substantially, especially for those clients experiencing financial and social complexities.

The AFBP has been a critical step in the right direction for SA in responding to the needs of Aboriginal and Torres Strait Islander women and women of Aboriginal children during pregnancy and birthing. The implementation of this program has been underpinned by a long history of collaboration between health service providers, researchers, and community members to develop and evaluate culturally responsive and evidence-based practices. Evidence identified in our rapid reviews demonstrated that compared with women attending standard public antenatal care, women accessing the AFBP have improved access to antenatal care, are more likely to report satisfaction with care, and are more likely to cease or reduce smoking in pregnancy (9, 74, 75). Further, being cared for by AMIC workers, coupled with the provision of transport to appointments, and outreach care, have been critical to improving women’s access to antenatal care. Following birth, women accessing the program in metropolitan Adelaide had higher rates of breastfeeding at 12 weeks than women who accessed standard metropolitan antenatal care (76).

Our rapid reviews also identified a range of system barriers that influence both accessibility and impact of the AFBP. Barriers include the availability of the AFBP in some regions, as well as inconsistent implementation in areas where it is available (7). Shortages of AMIC workers at some sites meant that women may not always be able to see an AMIC worker. More generally, the lack of birthing for women in rural and remote areas and the resulting requirement for women to leave their community to birth continues to be a source of concern for women and a barrier to engagement with antenatal care (9).

Other system barriers include inadequate resourcing of the AFBP and a lack of referral pathways to support women and families with complex social needs (9, 75, 77). While there have been important expansions to the AFBP at one site to include access to Aboriginal and Torres Strait Islander family support workers and social workers, this additional support is not consistent across other AFBP sites. Lack of access to shared electronic records, poor delineation of roles and responsibilities among AMIC staff and midwives, short-term contracts and staff located at different sites, have also been identified by staff as barriers to providing effective case management of women accessing the AFBP and relationship building among staff.

The 2015 evaluation of the AFBP identified the success of the AFBP is underpinned by strong partnerships, including between AMIC workers and midwives, between community-based services and hospitals, and between the local communities and health services. Yet sustaining these relationships has been a challenge at some sites. Varying degrees of hospital and health service management commitment to advocate for the AFBP, and address issues as they arise, and a differing commitment of mainstream staff and management to implementing a cultural respect framework, were identified as impediments to successful partnerships.

This evidence and our consultations for this protocol indicate that it is timely for the AFBP to be revisited and expanded to regions where it is not currently being offered. Current funding levels need to be reviewed to provide adequate resources to strengthen its capabilities and to implement the model of care consistently, including appropriate staffing and allowance for AMIC workers to attend births. Strengthening the training of AMIC workers to include specific issues such as birth care, infant and child development were identified as important issues. Increasing the number of positions was also highlighted as important.

Our consultations also raised concerns about the current eligibility criteria. The exclusion of women >28 weeks' gestation disadvantaged those who are likely to be high-risk and who require immediate access to culturally responsive care. Quality care should be always provided regardless of the 'risk status' and centres should be funded adequately to respond accordingly. Culturally responsive care should have equal weighting to that of clinical governance to ensure the safety of woman and baby and ultimately, their health outcomes. This could include funding birthing programs adequately so that Aboriginal and Torres Strait Islander women and women of Aboriginal children are automatically in the program unless they opt out. Flexibility in service delivery is critical, as some Aboriginal and Torres Strait Islander women and women of Aboriginal children may be equipped (financially and socially) adequately and, therefore, could have less contact with the AFBP team freeing up the team to work more closely with those in most need (8, 53).

Culturally responsive care should have equal weighting to that of clinical safety to ensure the safety of woman and baby and ultimately, their health outcomes. You can't have one without the other.

Acknowledging culturally safe services as critical to healthy outcomes also requires strengthening of cultural safety measures at all access points, including for women who may choose not to or cannot access the AFBP. While cultural awareness training is already implemented across mainstream acute and primary care settings in SA, there is scope to improve training to include a focus on cultural matters specific to care during pregnancy, birthing and early life stages to enable staff to more effectively apply this training to care practices.

Service providers need to adopt a 'cultural lens' from initial access through to care planning and referral back to the home clinic. This also necessitates appropriate identification of Aboriginal and Torres Strait Islander mothers, children and families in the system. Our consultations revealed opportunities to improve identification processes in acute and primary care setting. This needs to be done appropriately, recognising that the woman and her family is likely to be fearing the child protection system.

> *"Aboriginal families constantly fearful of DCP involvement even if something is out of parent/guardian control"*

One proactive step towards woman-centred service provision is to implement cultural birthing plans across birthing centres and standardise cultural care plans across the health care system more broadly. Our consultation feedback consistently highlighted this is one way to consider individual needs and should be discussed at the first antenatal visit and reviewed on an ongoing basis. A final review of the birthing plan should be discussed between 38-40 weeks, so the woman's cultural needs and support system is clear to those involved throughout care and at the birth. The cultural care plan should be ongoing, from initial access for Aboriginal and Torres Strait Islander women and women of Aboriginal children, through perinatal care and for children aged up to 5 years.

Our consultations and rapid reviews identified several gaps in access to high quality, culturally responsive postnatal care for Aboriginal and Torres Strait Islander mothers and infants. Evidence from the AFS identifies specific gaps in appropriate follow-up of maternal medical conditions (e.g., diabetes, hypertension). In the study, while >80% of women reported seeing a CaFHS nurse or GP after birth, a higher proportion of women with identified medical conditions or with a low birthweight baby had no access to primary health care postpartum (4, 8). In addition, less than half (45%) of women in the study described their postnatal care as 'very good' and 40% of women reported difficulties in accessing support with infant feeding.

These findings draw attention to the need to improve culturally responsive care across the continuum of care including targeting key transition points such as when women and families leave hospital after birthing as well as the transition from infancy to early childhood. An extension of woman-centred perinatal care, to establish cross-sector wrap-around services to facilitate continuity of care from antenatal through to children 5 years of age, would be ideal. This would require collaboration cross-government agencies (Health, Human Services, Education), NGOs, ACCHOs and ACCOs and intensive family support services funded external to Health along with an adequately resourced Aboriginal and Torres Strait Islander workforce and a culturally safe environment.

Our consultations revealed disjointed care continues to be present and problematic for Aboriginal and Torres Strait Islander families, and there was strong advocacy for ‘navigator’ or ‘coordinator’ roles to assist women and families to navigate the system. Ideally, this would be an Aboriginal and Torres Strait Islander/cultural navigator with primary health care qualifications to link services cross-sector and would include a warm hand-over (current worker who is known introduces the woman and/ or child to the next worker/service to maintain all three components of continuity of care) with services such as CaFHS.

It should be noted that the actions listed below are likely to be familiar to the Department, and undoubtably to the health sector, therefore, the first recommendation is to assess against each activity, why a recommendation has not worked in the past or was not sustainable once implemented. For example, what hasn’t been achieved in *cultural awareness training* in the past and at what point do these learnings fail to be successful.

Short (S) – immediate; Medium (M) – Jun 2022 onwards; Long (L) - Jul 2023 onwards. Aboriginal Health Service (AHS) role Lead L, Partner P, Influence I

Provide Culturally Safe Services								
Rec No.	**Short Med, Long**	**Action**	**Lever/s**	**Accountability owner**	**Accountability method**	**AHS role L, P, I**	**Monitoring by whom**	**Example**
3.1	L	Contribute to the re-design and implementation of the SA Governments Cultural Inclusion Framework with core elements: • improved accountability and transparency. Culturally inclusive governance and service planning and delivery examples include: culturally inclusive legislation, policy, service standards, standard operating procedures, customer service charters, and committee terms of reference; • culturally responsive inter–agency service delivery with joint protocols.	State and LHN workforce plans; SA Implementation Plan for CTG;	Relevant department	AHS monitoring development relevant to maternal and child heath, feedback to Aboriginal Strategic Advisory and Implementation Committee	I	AHS and proposed Collaboration for Excellence SAACCON	
3.2	S	Commission the development of specific Aboriginal and Torres Strait Islander maternal, infant and child health cultural safety training as mandatory HR requirement across the system, which includes an evaluation and monitoring.	**NSQHS Standard:** 2.13 and 1.21; LHN Workforce strategies and plans ACCHOs AHCSA RTO	AHS	SLA	L and P	AHS CE Health AHCSA	NM Coalition
3.3	S	Work with LHNs and PHNs to ensure that the Aboriginal and Torres Strait Islander identifier question is asked and recorded at any access point, this is critical in ascertaining individualised supports that may be needed. Develop digital tools to capture the data.	NSQHS Standard: 5.8 NSQPCHS: 3.22	LHNs Digital SA to assist with technology to capture information e.g., drop down menu at intake	Accreditation SLA	I	AH Health Q&S unit	

3.4	M	Aboriginal and Torres Strait Islander maternal and child health services are funded to offer and provide flexible and appropriate continuity of care for all Aboriginal and Torres Strait Islander pregnant women and children across SA who use these services, inclusive of the ACCHO sector.	NSQHS Standard: 1.2 Women's, Child and Youth Health Plan LHN Aboriginal workforce plans LHN Aboriginal health improvement plans	LHNs; ACCHOs	LHN Annual reporting SLA SAACCON reporting	I	DHW Planning Quality Information and System Performance AHCSA AH AHCSA	
3.5	M	Cultural safety frameworks are implemented across all maternity and child health service access points in all LHNs irrespective of what models of care Aboriginal and Torres Strait Islander women and families are accessing.	NSQHS Standard: 1.2 and 1.21 Women, child and youth health plan LHN Aboriginal health plans	LHNs	SLA reporting	I	AH DHW Planning Quality Information and System Performance AHCSA	
3.6	M	Build capability in LHN services to undertake quality improvement processes in cultural and clinical indicators.	NSQHS Standard: 1.2 and 1.21	Q&S in LHNs and ACCHOs	To be developed	I		
3.7	M	Sustain culturally safe maternity, infant and child health service models in SA: Advocate for and leverage commonwealth funding and research funding allocations for: • smoking cessation to be directed to SA • Stillbirth research to enhance existing models of perinatal care for Aboriginal and Torres Strait Islander women.	Women's, Child and Youth Health Plan Refunding of the Tackling Indigenous Smoking Program	Pregnancy and birthing community of practice (CoP) AHCSA CEO forum	To be developed	P	AHS AHCSA	Also fits with Rec 3, Family-centred care and Rec 6 workforce
3.8	M	Leverage funding allocations for the SA Women's, Child and Youth Health Plan and the Early Years Strategy to implement and evaluate enhanced postnatal care for mothers and infants.	Women's, Child and Youth Health Plan		Pregnancy and birthing Community of Practice	I	CE Health	

3.9	L	Expand the AFBP equitably to each birthing centre across SA, and incorporate the learnings of previous evaluations into the expansion strategies.	All LHN Aboriginal Health Improvement plans	SOGAH AHCSA CEO Forum	To be developed	L	CE Health	

Recommendation 4: Family-Centred Care

To apply a family-centred framework to Aboriginal and Torres Strait Islander women, women of Aboriginal children and families when engaging with health and community services across SA.

Consultation Findings:

When women are evacuated from their communities and they have other children, it is a very stressful time for mothers, particularly when there is no stable accommodation. Women will therefore leave to return home to be closer to family and their children or return to community soon after birth, due to being isolated with no family supports, this in turn compromises their own health, missing out on vital follow up care. Then when women do turn up for appointments later they are ostracised for missing appointments by health staff, with no recognition of the context in which the mum lives. e.g. not having the finances to pay for travel back to appointments or not having support people available to care for other children.

Findings from the consultations clearly indicated a desire among Aboriginal and Torres Strait Islander women, women of Aboriginal children and families that health care services take more of a family-centred approach in their delivery. Feedback showed a distinct lack of understanding and recognition of Aboriginal and Torres Strait Islander family and kinship structures by the maternal and child health workforce generally. Many examples of health and early childhood systems contributing to discontinuity of care for children were also presented, arising due to poor understanding of the important role of extended family members play, particularly grandmothers, and no acknowledgement of the role of fathers. In fact, there has been very little investment or evaluation of pregnancy and child health services as to how they can be more inclusive of fathers in SA. Further work is required to understand how programs can respond to this need (78, 79).

Many Aboriginal and Torres Strait Islander women and women of Aboriginal children want to have family support with them during birthing and at times including fathers. However, when women must relocate a long distance to give birth, due to lack of maternity services close by, they often go alone, with no family support and have the additional burden of finding stable and affordable accommodation as well as additional living costs close to the birthing hospital. Women can be away from home for up to 4-6 weeks, which creates significant emotional and financial stress for both the mother, but also her family, particularly when she is leaving other children behind in community and having to find appropriate caring options for these lengthy periods. From a financial perspective, 'living away' costs are additional to 'normal day-to-day' bills and financial commitments. Furthermore, there is already a housing crisis with communities experiencing overcrowding and relying on family members, living below the poverty line, to take care of more children is often not feasible.

Building family-centred care systems

Traditional maternal and child health programs generally focus on management of individual women's pregnancies and infant health and development. Family-centred approaches, when implemented correctly, provide a much more holistic approach to health care for the whole family, which includes support for health and wellbeing, and is sometimes provided in an outreach model to family homes (81).

The provision of family-centred care is recognised as a core feature of providing culturally responsive care for Aboriginal and Torres Strait Islander children and families, as outlined in policy documents such as the National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families (63). Precedent exists in the Australian context of successful family-centred models. Indigenous health services in Australia, Canada, New Zealand and United States have defined family-centred care as *'moving beyond providing care to the individual patient, to seeing them as being embedded in a family and providing services on that basis; and taking a life course approach, which, without neglecting adult health, focussed specific attention on establishing early life resilience and advantage through an emphasis on child development'* (81).

These models utilise a strengths-based approach, building on the resilience of Aboriginal and Torres Strait Islander families, such as strong bonds with family including members of extended families, and connection to traditional practices and ways of child rearing. Key features of family-centred approaches include: i) a focus on strengths and strengthening protective factors, including cultural protective factors; ii) ensuring planned care addresses the needs of the whole family; iii) promoting family choice and control over service responses; iv) development of collaborative relationships between families and professionals; v) supporting, and recognising family relationships in positive ways; and vi) promoting culture and community connectedness.

The commonality of these models includes having competent staff, flexibility of access, continuity and integration of care, and culturally supportive care (81). Continuity and integration of care is the provision of health care by linking women and their families across antenatal, birthing, and postnatal services, and providing integrated wrap-around care, and extending this through the child health years too.

While there are many examples of family-centred care initiatives being implemented in the Aboriginal and Torres Strait Islander primary health care sector, including emerging evidence of benefit in terms of access to, and satisfaction with, care (81), there has been very little attention paid to embedding and strengthening family-centred care practices in hospital and mainstream health settings.

Fetal Alcohol Spectrum Disorder (FASD) prevention: In a program run in the Kimberley region of Western Australia (WA), Elders requested that Aboriginal men be involved in FASD prevention, with positive results. Attending education workshops and brief interventions raised awareness about FASD and promoted the responsibilities of being a father from conception, and encouraged fathers to take an active, supportive role throughout the pregnancy by reducing or stopping their drinking (82).

Short (S) – immediate; Medium (M) – Jun 2022 onwards; Long (L) - Jul 2023 onwards. Aboriginal Health Service (AHS) role Lead L, Partner P, Influence I

Family-Centred Care								
Rec No.	**Short Med, Long**	**Action**	**Lever/s**	**Accountability owner**	**Accountability method**	**AHS role L, P, I**	**Monitoring by whom**	**Example**
4.1	S	Regional project positions to: develop care pathways across each network for Aboriginal & Torres Strait families by: • Mapping current activities and gaps. Tailor responses to match family and child health needs during pregnancy; • Standard care e.g., orange and blue book and to include discharge planning; • Universal proportionalism – resourcing for families proportionate with family needs; Include rural, remote and metro services; include discharge planning, facilitated transfers between and across LHNs and ACCHOs (and early return home); include guidelines that maximise sharing of information with the client preferred health provider whilst respecting privacy and confidentiality. • Meeting minimum standards for family-centred care;	**NSQHS Standard:** 1.4 and 1.21 SA CTG Implementation Plans Women's, Child and Youth Health Plan	SOGAH ACCHOs,	Aboriginal Strategic Advisory and Implementation Committee; WCHN	L	DHW Planning Quality Information and System Performance AHS	
	L	Design and commission consistent state-wide Aboriginal and Torres Strait Islander specific birthing programs.	NSQHS Standard: 1.4 and 1.21	WCHN		I	DHW Planning	

	L	• modelled on evaluated features eg AFBP with AMIC workers and family support and social workers; • Aboriginal and Torres Strait Islander governance over the program. • Assess the effectiveness of the referral pathways after 12 months.	SA CTG Implementation Plans Women's, Child and Youth Health Plan commits to providing preferred birthing models at the scale required, recognising cultural and individual needs and preferences.		CaFHS co-design with Aboriginal services (ACCHOs, ACCOs, LHNs) SLA's		Quality Information and System Performance AHS	
4.2	M, L	Co-design, with Aboriginal and Torres Strait Islander families and health services, new pathways with capability for tailoring to family needs, for Aboriginal and Torres Strait Islander families into CaFHS services starting antenatally • Engage with ACCHOs and LHN Aboriginal and Torres Strait Islander services. • Includes Navigator/ coordinator role • Ensure referral to pre-statutory support services and support is linked to care pathway for high-risk infants and vulnerable children • Timely and supported referral to LHN or ACCHO community based Allied Health early childhood early intervention services	Women's, Child and Youth Health Plan	Hospitals Antenatal care providers ACCHOs LHNs	To be developed	I	DHW Planning Quality Information and System Performance AHS	LHN Aboriginal Family Birthing Program Model of Care 2019 WCHN Aboriginal Family Birthing Program Aboriginal birthing suites AMIC – Pt Lincoln, Adelaide

		- Assess the effectiveness of the referral pathways after 12 months.						
4.3	M	Investment of resources into the ACCHOs to strengthen and build the capacity of the sector to provide Aboriginal and Torres Strait Islander maternal and child health family-centred models of care, including locating specialist and allied health within networks e.g., speech pathologists, child/family psychologists with formalised partnerships with the LHNs.	SA CTG Implementation Plan Priority Reforms 1,2,3 Women's, Child and Youth Health Plan – Collaborating, Respectful, Culturally Safe.	AH	SLA	P	CTG AAR joint committee Aboriginal Strategic Advisory and Implementation Committee	
4.4	M,L	Ensure the current and future recommended child protection KPI's are incorporated into an Aboriginal maternal and child health dashboard and reported to the Governing Council of LHNs. To inform systemic reforms within Health Child protection guidelines and procedures. Separate into two actions 1. Review of child protection policy and its implementation to ensure consistent implementation of child protection policies 2. Dashboard to monitor system performance	Women's, Children's and Youth Plan	LHNs DCP ACCHOs	To be developed	L and I	LHNs	
4.5	S	AHS to commission or undertake a specific project which investigates ways to make pregnancy and child health	Consumer satisfaction.	Pilot site	Evaluate project outcomes;	L and P	Aboriginal Strategic Advisory and	NSW

		services more inclusive of fathers piloted through CTG funding.					Implementation Committee; AHS	
4.6	M,L	Provision of a metropolitan stepdown service, for families with children, needing acute care, and intensive supports. Potential for partnering arrangements with CAMHS/CaFHS/ DHS Family Supports Services and Intensive Family Support services, NGOs and ACCOS. CaFHS/ CAMHS have limited family supports as well as exploring options for a virtual service. Service available early in pregnancy to prevent child protection involvement.	The SA Women's, Child and Youth Health Plan identities the need for infrastructure planning changes to be able to provide step-down care for rural and remote patients as well as those without adequate home support following an acute admission.	WCHN	LHNs and ACCHOs	I		Hostel with family focus, Ronald McDonald House.
4.7	M	Invest in preventive maternal and child health, including addressing early-stage symptoms (e.g., metabolic syndrome): Recruit and retain Aboriginal and Torres Strait Islander health workers and practitioners to assess and audit patients'/community members' health e.g., metabolic status; glucose readings; iron status; omega-3 tests for pregnant women and sexual health tests.	Women's, Child and Youth Health Plan	LHNs; ACCHOs	To be developed	L and I	AH ACCHOs DHW Planning Quality Information and System Performance	MOU - RM works across both LHN and ACCHO
4.8	M	Reinvest culturally appropriate support for women across LHNs/ACCHOs with breastfeeding information and practices: • Include in antenatal check appointments and with families;	NSQHS Standards: 2.3,2.5,2.6 and 2.7 Governing Body	LHNs; ACCHOs Breastfeeding guidelines	SLA	I	Aboriginal LHN governing body members;	RM is lactation consultant and based at both ACCHO and LHN

		respectfully allowing for cultural practices. - Provide free or low-cost access to lactation consultants; and/or breast pumps - Education of benefits of breast feeding.					Aboriginal Strategic Advisory and Implementation Committee AHS	
4.9	S	Maternity and child health services collaborate with schemes that are not hospital/health service based, such as the Tackling Indigenous Smoking research which has just been allocated $188M. Explore opportunities for tackling Cannabis use at the same time. These opportunities could work with young families as an incentive to quit smoking in between pregnancies, postnatally. All current effort is in the antenatal period.	Strategic support to gain funding for ACCHO sector and community-based programs	AH AHCSA	Collaborate to develop funding bid, access to funding.	P	AHS AHCSA	Funding for pilot similar to Aboriginal Families and Baby Bundles (ABFABB) research project addressing nutrition and physical activity. Tackling Indigenous smoking projects previously managed by AHCSA and involved negotiating funding and joining up with workforce Pamper days as education incentives.

Recommendation 5: Child Safety and Wellbeing

For the DHW to implement system-wide reform to improve child safety and wellbeing responses of government and non-government funded health and social services.

> *"I have a little brother and sister living with other families. My sister and me sometimes talk through Skype, but I haven't seen my little brother since he was one. He's three now and he's growing up not knowing me. I haven't done anything wrong. Why do they do that? Keeping him and my sister away from each other?" (Aboriginal young person, Fleurieu Peninsula) (27)*

Preventing Aboriginal and Torres Strait Islander child removal and overrepresentation in out-of-home-care (OOHC) is a national priority with over a third of children living in non-Aboriginal and Torres Strait Islander care (83). These children are often denied appropriate contact with Aboriginal and Torres Strait Islander relatives and Aboriginal and Torres Strait Islander workers. There has been a government and systemic failure to implement strategies based on Aboriginal and Torres Strait Islander people's cultural advice on reform across policy, services, and practices (27). Removing an Aboriginal and Torres Strait Islander child has deep and long-lasting consequences for the child, family, and community. It perpetuates intergenerational trauma, severs the bond from community, country and culture, and triggers poor life outcomes (25). Loss of cultural knowledge for disengaged children also has serious repercussions for the passing down of traditional Aboriginal and Torres Strait Islander family and cultural values/beliefs, including those regarding appropriate social behavior (84). Anecdotal evidence provided through community consultation and government reporting clearly show these poor practices are of deep concern to community (26, 27, 85). They are a direct reflection of historical and enduring social and economic disadvantage, founded on intergenerational poverty, trauma, racism, xenophobia, dispossession and socioeconomic disadvantage and dysfunction (84).

The United Nations Human Rights Committee recommended that Australia "should take urgent action to address contemporary forced removal of children from Aboriginal and Torres Strait Islander families" (86). The National Framework for Protecting Australia's Children 2009-2020 states that children need culturally appropriate care, safety and support, within "strong, thriving families and communities to reduce the over-representation of Indigenous children in child protection systems" (87). These recommendations support Target 12 of the Closing the Gap National Agreement: to reduce the rate of over-representation of Aboriginal and Torres Strait Islander children in OOHC by 45% within the next 10 years (88). This target is also supported by the National Framework for Protecting Australia's children (89) .

Despite these positive steps, progress has been slow. To date, the rate of Aboriginal and Torres Strait Islander children leaving OOHC is still lower than the rate of those entering (84). Aboriginal and Torres Strait Islander children come into care at much earlier ages, with infants nine times more likely to be removed at birth than non-Aboriginal and Torres Strait Islander babies (85, 90), often with little to no prior communication with the mother. As of 2019, Aboriginal and Torres Strait Islander children were 9.7 times more likely to be residing in OOHC care compared to non-Aboriginal and Torres Strait Islander children (25). In 2020, one in 18 Aboriginal and Torres Strait Islander children were in OOHC (26). Across 2018-2019, reunification was identified as 'not possible' for almost three-quarters of Aboriginal and Torres Strait Islander children in OOHC nationally, compared to 63% of non-Aboriginal and Torres Strait Islander children (25). Reasons why are not reported, and limited data is available as to why fewer Aboriginal and Torres Strait Islander children are reunified with family.

> *"Stolen Generations is about what we know took place in the past. But its impact is present today and we need to take every measure necessary to prevent future stolen generations."*
>
> *(Aboriginal Elder, Sandra Miller)(27)*

More than two decades ago, the "Bringing Them Home" Report in Australia (25) detailed the high rates of forced child removal from Aboriginal and Torres Strait Islander families, with Aboriginal and Torres Strait Islander children comprising at least 20% of children living in OOHC. The report strongly recommended new policies that would ensure the responsibility of Aboriginal and Torres Strait Islander children be transferred to Aboriginal and Torres Strait Islander people and agencies (25). In Australia, the recent 'Changing Tracks' action plan included a national recommendation to embed an independent Aboriginal Family Led Decision Making (AFLDM) process at key points of the child protection system to empower Aboriginal and Torres Strait Islander families to best support their young people and keep them connected to culture and community. The process also recommends finding strategies to support their safety and well-being, encouraging individual and family-led decision making and choice, and reducing the over-representation of Aboriginal and Torres Strait Islander children in OOHC (84). The process also aims to create culturally sensitive and healthy relationships between child protection specialists, families, and the Aboriginal and Torres Strait Islander community (91). Despite this, one of the most common concerns across SA Aboriginal and Torres Strait Islander families and communities is non-compliance with the Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP) by government departments and agencies (27). While the ATSICPP exists in legislation and policy, and its significance has been widely acknowledged, there are ongoing inconsistencies in its implementation. In SA, it is estimated that only 13% of child protection cases concerning Aboriginal and Torres Strait Islander children have occurred under ATSICPP (27). Decisions are still being made without informed discussion, and child removals are occurring with little or no family involvement in planning and decision-making (92).

Direct quote from consultation:

"The removal of babies at birth is occurring with no cultural considerations in this space, Mum's not been given the complete story by staff, once baby is born and removed with no involvement of the mother at all. During pregnancy mothers are being told everything will be okay, you can spend time with your baby first, but as soon as the baby is born that changes, the baby is taken, sometimes only a few doors away from the mother but she is unable to see the baby. What mothers are being told is opposite to what happens in practice, this causes a lot of distress and mental anguish. The emotional and mental health impacts on the Mum is not considered, neither for the baby who is crying and doesn't know what is going on."

Relative and kinship care are the first option under ATSICPP, with grandparents being the most common relative caregivers globally (91). In 2020, almost two-thirds of Aboriginal and Torres Strait Islander children under child protection orders were placed with Aboriginal and Torres Strait Islander or non-Aboriginal and Torres Strait Islander relatives/kin (26). Relatives and kin provide a stable and familiar environment, and are often dedicated to ensuring the child's right to stay connected to culture and community (93). Despite this, they often receive fewer services and support than foster care families (94), and have described feeling isolated and financially disadvantaged (93). Consultation with services uncovered instances of DCP cases where very little communication has occurred prior to a child being placed into kinship care or moved from one caregiver to another. Families and health services need to know if a child is coming to a caregiver and community, so they can obtain advice on whether a proposed placement is going to be the best option for a child, especially a child who has already been removed. The receiving caregiver needs adequate communication and time to provide an appropriate environment for the child, as they often already have significant complexities occurring in their own lives.

The Child and Family Support System reforms in the Department of Human Services, and the development of the Intensive Family Support Services that are delivered by government and non-government agencies, aim to prevent children from entering OOHC. The services are culturally appropriate (including ACCO delivered services) and trauma responsive, offering in home family support whereby workers build relationships to improve family functioning and child safety. While these programs are promising in their approach, with new outcomes monitoring in place, these programs are insufficient in number and rely on a referral from child protection rather than self-referral or other referrals (e.g., health services staff).

The first five years of a child’s life, including the establishment of parent/carer bonds, are critical for healthy development (95). Aboriginal and Torres Strait Islander parents, especially young mothers and fathers, report feeling very anxious about seeking assistance from mainstream services, due to a lack of Aboriginal and Torres Strait Islander identified services. Many Aboriginal and Torres Strait Islander parents have also reported an overwhelming ‘sense of fear’ and ‘racist attitudes’ in the behaviour of ‘helping professionals’ such as welfare workers, health staff and education officers (27). This creates a significant barrier to seeking help early, which can further entrench disadvantage for both the Aboriginal and Torres Strait Islander child and their family (27).

> *“I could tell when she (social worker) came up to me she was frightened. She was walking real scared way toward me. I’m the one terrified of this worker in front of me telling me they are taking my kid. The other worker was even worse. She was cheeky and talking rough with me. Telling me ‘my baby’s going to be better off’ and that my baby won’t be affected. After that I never saw or heard from them workers again. A Nunga worker came and seen me a couple of days later. My baby is now living with whitefellas forever.”*
>
> *(Aboriginal young mother, Adelaide)(27)*

These reports are consistent with those from previous government and health specific consultations undertaken in SA with Aboriginal and Torres Strait Islander health stakeholders, leaders, and community. Aboriginal and Torres Strait Islander families are living in constant fear of their children being removed and feel powerless to stop it happening. The lack of consistency in the application of child protection policies and procedures across LHNs and other services, as well as insufficient family support services, is very problematic. Procedures are often utilised as a risk identification method rather than a tool to activate a system response to provide referrals to support services or early intervention activities. It flags the system to monitor the number of risks identified, resulting in an overrepresentation of DCP notifications, and an alarming number of child removals, including babies removed at birth in traumatic circumstances. Flagging risk factors in Aboriginal and Torres Strait Islander families, rather than offering family-based support, serves to push more infants and children into the child protection system. This is particularly true of pregnant women whose pregnancies are deemed high risk, yet little support is offered to help them address risk factors while pregnant and prevent child protection intervention at birth. There are many examples of systemic failures, for example, referral pathways to tertiary systems for antenatal country patients. They often experience inflexible appointment scheduling that result in difficulties attending appointments, and follow-up by services is often inadequate. Missed appointments are often through no fault of the patient, yet a "three strikes and you're out" policy exists, especially for appointments in late pregnancy, which can result in a DCP non-compliance notification.

> *"These Nunga Mums in DV (domestic violence) situations don't need their kids removed. They need their bloke removed. To take the kids, that's soul destroying for the Mum and her kids."*
>
> *(Aboriginal Grandmother, Noarlunga)(27)*

There is a well-established connection between socio-economic stress faced by Aboriginal and Torres Strait Islander families, and vulnerability to child protection intervention, which is fuelled by inadequate accommodation, overcrowding, inequitable access to income, health and support services, and alcohol and drug abuse (96). Half of the Aboriginal and Torres Strait Islander child removals in SA are due to reported neglect and family violence (96), yet access to domestic violence and therapeutic healing support services are lacking (27). Recommendations from our community consultations included a need for trauma informed practice, recognising that families who are presenting with complexity 'risk' themselves are likely to have experienced trauma in their lives. Trauma informed practice is holistic in its application, it acknowledges the impact of trauma on an individual's mental and physical health, social and emotional development, and academic and employment outcomes. It provides a framework for practitioners to understand a client's behaviour and needs based on their history of trauma (97).

Challenges have also been reported by Aboriginal and Torres Strait Islander health services. These include resource issues that prevent services from adequately monitoring and supporting families under DCP orders. Alarmingly, services reported they did not receive early communication from DCP about families flagged for child protection involvement. This inhibits services from providing early intervention and wrap-around support for families that could prevent child removal. Inconsistent communication pathways and inadequate information sharing between DCP and Aboriginal health services also results in clients having to repeat their story every time a new service is involved. This is incredibly stressful and traumatic for the family and can result in cases being mishandled. Facilities to support children, especially in remote communities, are scarce. Health staff have witnessed children becoming more traumatised from being removed and becoming sad and withdrawn after being moved from place to place.

The Aboriginal and Torres Strait Islander workforce within the DCP is limited, with only one principal Aboriginal advisor in Adelaide who has a state-wide responsibility. The Aboriginal Action Plan 2021-2022 aims to increase the number of Aboriginal and Torres Strait Islander staff within DCP from 5.5% to 10% (91, 98), in line with the wishes of Aboriginal and Torres Strait Islander children themselves who have said: “Aboriginal and Torres Strait Islander kids deserve an Aboriginal and Torres Strait Islander worker” (27). Children want to build relationships with Aboriginal and Torres Strait Islander staff as they are perceived as a safe and supportive conduit to community, culture and family, which may not otherwise be possible during their experience of ‘removal’ with non-Aboriginal and Torres Strait Islander workers (27) .

There are some pockets of good practice, however, and many Aboriginal and Torres Strait Islander staff work tirelessly to protect and support families and communities. These Aboriginal and Torres Strait Islander staff, many of whom are on the frontline, advocate for a family-led process, and experience the stress of community concern and family anguish of child removal. These are extremely difficult and emotionally complex roles. Many cultural resources have been developed by the Aboriginal and Torres Strait Islander workforce and community, however, there can be barriers to their utilisation. There have been reports of relationships being strengthened between DCP and some regional Aboriginal health services, which occurred following regular meetings that enabled concerns to be raised and discussed to ensure services are put in place to support unborn children and families. These relationships are unique to some regional areas and not consistently applied throughout SA.

An example of an intervention which provides supports to families at risk of having a child removed is the Child and Family Assessment Referral Networks (CFARNS). CFARNS represents multiple agencies working together in a culturally responsive way to support all families, with a priority focus on Aboriginal and Torres Strait Islander families at risk of having infants placed in OOHC. An evaluation by the BetterStart Child Health and Development Research Group found that a CFARNS pilot intervention study improved families’ knowledge of the child protection system, including changes needed to prevent removal of children. Engagement by families with CFARNS enabled a more informed approach to connecting families with relevant supports. The BetterStart evaluation of the CFARNS pilot intervention group was followed for six months; and results included 23% of mothers and 28% of infants identified as Aboriginal or Torres Strait Islander. Data showed that children connected to CFARNS compared to those not connected were: (i) 57% less likely to be the subject of a child protection investigation; (ii) 67% less likely to be the subject of a substantiation of child maltreatment; and (iii) 58% less likely to be placed on an order or into OOHC (99, 100).

> *"Stop punishing vulnerable Aboriginal children and young people. They need to be with their families and community."*
>
> *(Aboriginal young person, father, Mount Gambier) (27)*

Short (S) – immediate; Medium (M) – Jun 2022 onwards; Long (L) - Jul 2023 onwards. Aboriginal Health Service (AHS) role Lead L, Partner P, Influence I

Child Safety and Wellbeing								
Rec No.	**Short Med, Long**	**Action**	**Lever/s**	**Accountability owner**	**Accountability method**	**AHS role L, P, I**	**Monitoring by whom**	**Example**
5.1	S	AHS supports the Chief Child Protection Officer, SA Health, to develop, engage Aboriginal and Torres Strait Islander leadership and advice to inform Aboriginal and Torres Strait Islander and broader child protection policy and practice across SA Health. Formal agreement required which includes reporting requirements.	National Framework for Protecting Australia's Children 2009-2020 SA CTG Implementation Plan Priority Reforms CACYP report	Chief Child Protection Officer in Health	Agreement to be developed between Chief Child Protection Officer and LHN child protection leads and CACYP.	P	CE Health Aboriginal Strategic Advisory and Implementation Committee Commissioner Aboriginal Children and young people	Build on work of WCHN/ SALHN and CaFHS and DHS Safer Families in developing new care pathway in and out of hospital for high-risk infants, (high risk infants to preventing contact with Dept Child Protection.
5.2	S	Set up proposed Aboriginal Strategic Advisory and Implementation Committee that includes following roles: • advocacy for prevention of Aboriginal and Torres Strait Islander infants and children entering the child protection system. Advocating for additional funding from all levels of government to resource existing and new ACCHOs and ACCOs to provide Aboriginal and Torres Strait Islander led timely and sustainable support to vulnerable families;	CACYP report SA CTG Implementation Plan Priority Reforms	SAACCON	AHCSA	P	CTG Vulnerable families working group	

		• support to implement the CACYP report; and • develop partnerships with DHS early intervention programs.						
5.3	S	AHS to influence the Chief Child Protection Officer's agenda within health to include: • partnering with the Commissioner for Aboriginal Children and Young People, to progress the Commissioner's agenda arising from the report; and to facilitate the Commissioner for Aboriginal Children and Young People to investigate the interface between SA Health and Child Protection services. • To lead a review of LHNs Child Protection policies and procedures to ensure recognition of Aboriginal and Torres Strait Islander parenting practices and the ability to record protective factors and strengths of families (resilience, cultural grounding, identifying strong family and community support networks) within patient records and reform of child protection practices. • support change to health mandatory notification to have two parts 'No notification without a referral' to appropriate supports, particularly for unborn child notifications.	SA Implementation Plan for Closing the Gap Women's, Child, and Youth Plan United Nations Declaration on the Rights of Indigenous Peoples that advocates Aboriginal people's right to be self-determining.	Chief Officer Child Protection in Health	Agreement to be developed	I	Aboriginal Strategic Advisory and Implementation Committee Report to SA CTG Aboriginal Affairs Executive Committee, building capacity in vulnerable families working group	'What matters to Aboriginal Children and Young People, their Families and Communities Report' Evaluation of the Child and Family Assessment and Referral Network (CFARN) (99) Safe Kids, Families Together Resources | Kidsafe SA Support Service (NALHN) An Intensive Support System for SA's Children and Families - System reform strategy, 2019

		• Cross government review, led by DHW, of Strengthening Links and High Risk Infant policy and practice to strengthen family functioning; and to empower Aboriginal and Torres Strait Islander families, to best support babies and children to maintain connections to family and culture, and during pregnancy. • Where infants are removed from mothers, for the health service to support mothers directly or through referrals.						
5.4	M	Chief Child Protection Officer, Health advocates for a government transition from removal of Aboriginal and Torres Strait Islander children, to implementing transparent strategies that support early identification and ethical intervention of families at risk could include: • Create strategies that advocate to implement diversion policy, practice, and programs preventing babies and young children entering the child protection system. • Adequate resourcing of intensive family support services (e.g., CFARN) for families who may need support to address risk factors and build on protective factors, early in pregnancy to prevent child protection notification. • Review of current communication procedures with pregnant women,	Aboriginal Affairs Executive Committee, building capacity in vulnerable families working group	Chief Child Protection Officer, Health	Agreement to be developed CACYP Dept of Human Services Director Early Intervention Directorate. WCHN and LHN child protection senior leads	P	Aboriginal Affairs Executive Committee, building capacity in vulnerable families working group LHN Aboriginal governance group members	

	M	parents, families, community, and Aboriginal and Torres Strait Islander support services, before DCP intervention including child removal.						
5.5	M	AHS advocates for the implementation of policies and procedures which improve the cultural connectedness for Aboriginal and Torres Strait Islander children 0-5 (including children in OOHC) Co-design, with Aboriginal and Torres Strait Islander communities including Elders, engagement with NGO's, pre-school and early school settings for delivery and teaching of Aboriginal and Torres Strait Islander cultural knowledge and language, for the benefit of Aboriginal and Torres Strait Islander children and young people.	Office of the Early Years strategy Aboriginal Affairs Executive Committee, building capacity in vulnerable families working group. SA CTG Implementation Plan	AHS and OEY	Agreement to be drafted	L	Aboriginal Affairs Executive Committee, building capacity in vulnerable families working group SA; AHS	'What matters to Aboriginal Children and Young People, their Families and Communities Report' Linked to Family-Centred Care recommendations and Culturally Safe Services recommendations.
5.6	M	Development of programs to support new Aboriginal and Torres Strait Islander parents, including mothers and fathers in custodial settings, to assist them to navigate their way in a family unit.	CTG Implementation Plan: Aboriginal Health Improvement Plans CaFHS Model of Care	CaFHS ACCHOs LHNs Parenting projects	SLA	I	LHN CEO's LHN Building capacity in vulnerable families working group.	

5.7	S	DHW advocates for the Health and Community Services Complaints Commission to partner with NGOs to work collaboratively with Aboriginal and Torres Strait Islander communities and organisations to: • develop dedicated and accessible processes for Aboriginal and Torres Strait Islander parents and families to lodge maternal and child-based complaints in a safe and supportive environment. • Service sectors be open to developing appropriate complaints processes; and, • Aboriginal and Torres Strait Islander community have knowledge of and confidence in who to make complaints to, and who can assist.	NSQHS Standard: 1.2	Health Complaints Commissioner	Annual reports Community reports	I	CTG Implementation plan Aboriginal Strategic Advisory and Implementation Committee	

Recommendation 6: Addressing Access Barriers

To reduce and remove barriers to ensure Aboriginal and Torres Strait Islander women, women of Aboriginal children, infants and children can access health care services to complete their care.

Many Aboriginal and Torres Strait Islander families report feeling extremely uncomfortable seeking mainstream health support, though they are often the most in need. Access to timely, effective, and appropriate maternal and child health care can contribute to closing the gap for Aboriginal and Torres Strait Islander families (28, 29). In 2017, the Council of Australian Government (COAG) target of halving the gap in death rates for Aboriginal and Torres Strait Islander children (aged 0-4 years) within a decade (by 2018) was not on track (28, 29, 101). In the same year, data from the Pregnancy Outcome Unit in SA showed 60% of Aboriginal and Torres Strait Islander women received antenatal care before 14 weeks gestation compared to 82% of non-Aboriginal and Torres Strait Islander women. The number of Aboriginal and Torres Strait Islander mothers who received greater than seven antenatal visits across the pregnancy was significantly lower compared with non-Aboriginal and Torres Strait Islander mothers (65% compared to 83%) (3). There is a persistent and alarming disparity in birth outcomes between Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander women and their babies, including preterm birth (19% compared to 9.6%), perinatal mortality rate (22.7 compared to 7.5 per 1000 births), and small for gestational age (SGA; 17% compared to 7%) (3). Gestational diabetes also disproportionately affects Aboriginal and Torres Strait Islander women (102).

Diabetes: In the Northern Territory, the cumulative incidence (after 2.5 years) of women with diabetes in pregnancy (DIP) or gestational diabetes (GDM) were higher for First Nations women (48%, 13/27, women with DIP, 13%, 11/82, GDM), compared to none in European women (Wood et al 2021). Interpregnancy screening for diabetes is available through the National Gestational Diabetes Register (https://www.ndss.com.au/about-the-ndss/national-gestational-diabetes-register/), but details of Indigenous participation are not known. Addressing diabetes prior to, or in pregnancy (through diet, physical activity or medications), is also likely to decrease the number of large for gestational age babies and thus prevent metabolic syndrome later in life (80).

These disparities can be improved through early access to care and intervention and reliable continuity of care. It is crucial for Aboriginal and Torres Strait Islander children and their families to be supported in developing good health behaviours early in life. This includes timely access to antenatal services for mothers and babies, to ensure early identification of any health issues for mother and baby, including potential birthing issues, to ensure positive birthing outcomes are maximised (103). Continued postnatal care for women, regular health checks, and timely care for young children are also crucially important to ensure sustainable good health. Our consultation coupled with the rapid review findings found a gap exists for some children aged up to 12 months, and those aged 2-5 years. Notably, only 20% of SA Aboriginal and Torres Strait Islander children under 5 years of age receive an Indigenous-specific health check (101). This is well below the target of 69% by 2023, set in the Aboriginal and Torres Strait Islander Health Plan 2021-2031. Nationally, only half of Aboriginal and Torres Strait Islander children receive follow-up care post health check (104). In the literature, several barriers have been identified regarding access to specialist paediatric care in hospital, whether for medical, surgical, or developmental issues. Families report stress and frustration with long waiting lists for initial appointments, delays in between appointments and for those needing hospitalisation, not being given consistent information, and problems with the discharge process and follow-up care (105). Poor communication and/or insensitivity from staff have also contributed to misunderstanding about medications, equipment and treatment once discharged. Families consistently report their worry about staff making notifications to child protection services because of these misunderstandings, and this has been identified as a contributing factor to non-attendance (105).

Our consultations revealed four major barriers for Aboriginal and Torres Strait Islander women, women of Aboriginal children and children accessing health care: (i) transportation; (ii) accommodation; (iii) service location; and (iv) inflexible programs and appointment scheduling.

Ear health (infants/children): Intensive support from better access to ENT (ear nose and throat) clinics in Queensland showed a two-third reduction (from to 18.6 to 5.8%) in middle ear disease in Aboriginal children aged 0 to 4 years in Queensland, 2016 (106).

Transportation: Our consultations found transport was a major barrier to accessing antenatal care, child health specialists and allied health care. Difficulty accessing transportation from remote communities to regional or metropolitan hospitals and clinics, as well as transportation to appointments during those stays, often resulted in late or missed appointments. Limited transport funding is available through the Patient Assistance Transport Scheme (PATS) (107), however, paying upfront, meeting the eligibility criteria and process for receiving funding makes it difficult to access.

Women are required to pay upfront associated costs and cannot access PATS if they reside within a 100 km radius of the hospital/clinic they are referred to. This excludes women, for example, from some areas of the Adelaide Hills travelling to Women's and Children's Hospital. There is a limit on the type of transport available when in metropolitan/regional areas (e.g., the use of taxis to get to appointments is currently not allowed). An increase in funding and widening of the eligibility criteria for access to transport is warranted, such as allowing the use of taxis within regional and metro settings, from accommodation to appointments, and decreasing the distance from home or temporary accommodation to appointment locations. Increasing the capacity for pregnant women to access transport would result in increased appointment attendance.

Personal identification (ID) can also be a barrier to accessing transport; during consultation a community worker reported issues regarding access to greyhound bus services: "*You always need ID for greyhound, not everyone has ID, sometimes they'll accept a letter from a clinic as proof of ID*." For women living in regional SA, the greyhound bus service may be the only mode of transportation available, which means they simply cannot attend appointments if they do not have ID. They also feel discouraged to try and attend future appointments. PATS clients also need to meet residency criteria which is determined by a "principal place of residence (their home), as per their enrolment on the SA electoral roll". Documentation may be requested to confirm place of residence such as driver's license, proof of age card, utility bills or concession card. This can be a challenge, as not everyone has identification. Even to access required documentation, some form of identification is required, such as a birth certificate. The process and cost of obtaining identification and completing forms can be daunting and prohibitive.

Direct quote from our consultation:

"One regional area has tents – but not always available – hard to access and is a very short-term solution. Pregnant women may be able to access a small unit, just a bedroom, kitchen outside, and shared bathrooms but they also have tents, so if you're at 32 weeks, diabetic and its 40 degrees, and you're in a tent….it's not ideal."

Accommodation: Our consultation found a significant lack of suitable accommodation for mothers and families that need to travel away from home to access regional and metro health services, during the antenatal and postnatal periods, and for subsequent child appointments and follow-up care. This is of critical concern when young children need to receive care, specifically surgeries that require a stay in hospital, and caregiver/s have no suitable accommodation during this time.

The unavailability of short-term step-down accommodation is a continual concern in regional areas. Many step-down programs are either closed due to staff shortages, or are generally closed on weekends, forcing mothers to find alternate arrangements.

Pregnant Aboriginal and Torres Strait Islander women and women of Aboriginal children living in regional areas often access short-term transitional accommodation, that provide Wiltja (tents) and unit facilities (108). The Wiltjas can be very confined and unventilated, which is not ideal for pregnant women, especially those who may have complex health needs including comorbidities. This style of accommodation can exacerbate pre-existing health and medical condition, which can be potentially dangerous for both mother and baby (109).

> *"Australia has 'medicalised birth'. We thought we were making things safer for women by moving them into big city hospitals and closing down all our smaller hospitals, [but] we haven't done that at all. We need to wake up and move birth back [to regional and remote areas]."*
>
> ***Sue Kildea - Charles Darwin University, Professor of Midwifery*** (110)

Service Location: Aboriginal and Torres Strait Islander women often want to birth on country (33), but this is not an option for the majority. Over the past 30 years, more than 60% of rural maternal units in SA have been closed due to the cost-saving centralisation of services (111). In 2017, 63% of Aboriginal and Torres Strait Islander women birthed in metropolitan hospitals, 36.5% birthed in country hospitals, and 0.4% birthed at home (3). Over a quarter of women residing in rural Australia relocate to give birth (111). Regional hospitals offer maternity care to low-moderate risk women, but Aboriginal and Torres Strait Islander women categorised as high-risk for labour and birth are transferred to Adelaide to have their baby. This commonly happens between 34 and 37 weeks' gestation, often with no suitable accommodation in Adelaide leading up to the birth or after the birth (112). Women report feeling isolated as they are separated from culture, community, family, and children. Women travelling from regional and remote areas often must leave their partner, children, and support system behind to attend metro hospitals and services on their own (112). These issues coincide with a slower than expected increase in improved health outcomes for Aboriginal and Torres Strait Islander mothers and babies (33).

Direct quote from our consultation:

"Most other agencies/organisations have a "3 strikes and out rule" – they won't continue to follow up clients and the clients miss out. Complex lifestyles require persistence and consistency, and they shouldn't be missing out. Probably not efficient, but it's making sure someone has the access they require."

Inflexible Programs and Appointment Scheduling: The ability for pregnant Aboriginal and Torres Strait Islander women and women of Aboriginal children to get into an antenatal or birthing program can be difficult. There is often a limited quota, and many women are refused. There is also an inherent inflexibility around appointment scheduling during pregnancy, often resulting in difficulties with attending appointments. Aboriginal and Torres Strait Islander women and women of Aboriginal children report being late and turned away for appointments, missing appointments altogether, or having appointments cancelled without any follow-up to reschedule. Eligibility requirements and program rules, such as missed appointments (often through no fault of the woman), can result in missed opportunities to provide early antenatal health care. There is also an informal '*three strikes and you're out*' rule. Hospital appointments are scheduled for 15 minutes, which is too narrow if someone is running late, or there are some complexities.

Increasing flexibility in programs and having woman or child-centred care plans, including understanding family and community constraints around travel and appointments, may increase program and appointment participation. Suggestions from the consultation included an increase in walk-in clinics, and access flexibility to facilitate greater participation. Providing a larger window of time for appointments, such as a week in advance, and planning workloads around weekly patient numbers, may also decrease the number of missed appointments. Adoption of the NALHN Aboriginal Health Framework and Action Plan 2021-2026 continuity of care through outpatient reform is another way to increase health care provided (113; page 47). Establishing systems to ensure follow-up of patients who have missed appointments and specifically determining individual circumstances which lead to missed appointments. The Koorliny Moort Aboriginal Ambulatory Care Coordination Program in Western Australia reported aspects of the program particularly valued by families, include regular nurse check-ins during hospital visits and admissions, assistance to identify relevant support services, and providing family advocacy to both hospital departments and external health services (114). While the program generally received positive feedback, there was also a reported need to increase culturally safe experiences, and a general lack of understanding of personal requirements and follow-up appointments. While this program was nurse led, implementation of this may not require a nurse led approach, an Aboriginal or Torres Strait Islander navigator/coordinator could be employed in this role.

It is important to note that positive health care experiences during pregnancy can have a flow on effect for healthy postnatal care and access to early childhood health checks (0-5 years). It is anticipated that this would also have a generational impact, with young people continuing to attend their health care provider for ongoing health checks. It is also important to offer a holistic health care experience with wrap-around supports. Often the way ‘risk’ is defined for Aboriginal and Torres Strait Islander women, women of Aboriginal children and their families does not consider their broader needs, including mental and emotional wellbeing, and social determinants of health (housing, food security, employment, education, income, intergenerational trauma, racism, kinship structures, cultural needs). The system does not take a preventative and early intervention approach – women and their families often need to be in crisis, or imminent risk, before resources are available to support the family.

Direct quote from our consultation:

“The dots are not joined from pregnancy care to birth to 2 onwards. If there is no support during pregnancy, there won’t be any appropriate aftercare.”

A newly proposed model of care for Aboriginal and Torres Strait Islander women and children in Victoria is showing great promise, including increases observed in: (i) service engagement; (ii) breastfeeding rates; (iii) immunisation rate; (iv) kindergarten attendance; and (v) identification of vulnerable women and children, and a decrease in child removals (115). The Early Assessment Referral Links (EARL) concept has been created to improve engagement with maternal and child services by building partnerships and relationships between hospitals and ACCHOs (115). Another successful model of care includes Wadja Aboriginal Family Place, the central hub of the Indigenous health service at The Royal Children’s Hospital (RCH) in Melbourne. It is a place for Aboriginal and Torres Strait Islander inpatient families to relax and take a break from the ward, and they also provide cultural support for Aboriginal and Torres Strait Islander families admitted to RCH. There is also a Wadja Health Clinic which provides weekly outpatient care for Aboriginal and Torres Strait Islander children, specialised paediatric care to manage Aboriginal and Torres Strait Islander children’s complex medical needs. The team consists of a paediatrician, Aboriginal Case Manager and Aboriginal and Torres Strait Islander Health Worker (28).

Short (S) – immediate; Medium (M) – Jun 2022 onwards; Long (L) - Jul 2023 onwards. Aboriginal Health Service (AHS) role Lead L, Partner P, Influence I

Addressing Access Barriers								
Rec No.	**Short Med, Long**	**Action**	**Lever/s**	**Accountability owner**	**Accountability method**	**AHS role L, P, I**	**Monitoring by whom**	**Example**
6.1	M	AHS, to advocate for a SA Aboriginal 'Birthing on Country' program. At a bare minimum this should include those cultural elements Aboriginal and Torres Strait Islander women seek, which is broader than the bio-medical aspects and is maternity services designed by and delivered for Aboriginal and Torres Strait Islander women and families. Includes: • spiritual, socio- cultural, connectedness, continuity of skilled carer, governance, and cultural guidance. These other options were also raised during consultations: • opening of culturally safe birthing centres in regional areas; and • the re-opening of maternity services in regional locations in partnership with ACCHOs; and • addressing the indemnity issues that exist with AMIC workers providing continuity of care to clients when birthing	**NSQHS Standard:** 1.2, 2.13, 1.25 Women's, Child and Youth Health Plan National Maternity Services Plan	AH	Aboriginal Health Plan	L	Annual reports	'Birthing On Country' Hickey, Roe (73), (116)

6.2	S	Fund and develop a specific Aboriginal and Torres Strait Islander care coordination program (building on NALHN's Allied Health Continuity of Care program) specifically targeting Aboriginal and Torres Strait Islander families with children 5yrs and under, who have difficulties navigating complex systems to enhance greater flexibility and consider personal contexts, difficult to reach families.	Care navigator roles are identified in the Women's, Child, and Youth Health Strategy as a mechanism to support families deemed 'at risk'	AHS	SLA Reporting against the WCYH strategy	P	Real time monitoring and evaluation	Learnings from the Perth Children's Hospital based model (114) Learnings from Accident and Emergency at WCHN. Learnings from regional LHN Aboriginal Children's Pathway learning sites DHS trialling Navigator roles across systems with complex families via Pathways services.
6.3	M	Child and Adolescent Health Community of Practice in partnership with Aboriginal and Torres Strait Islander stakeholders develop an Aboriginal and Torres Strait Islander child health opportunistic check which aims to improve coordination of acute and community-based outpatient services from a family-centred approach, could include OEY 12 month and 3 year check.	Child Health Community of Practice plan. Office of the Early Years (OEY) strategic plan being developed. WCHN Aboriginal Health Plan CaFHS state-wide service	Community of Practice Office of the Early Years AHCSA public health and general practitioners	Reporting against the WCHN Aboriginal Health Plan	I or P	WCHN CEO	

6.4	M	WCHN develop and trial a flexible appointment model for ante-natal care and child health outpatients for Aboriginal and Torres Strait Islander people, in consultation with community and ACCHOs, in metropolitan Adelaide. Further co-design will be required for regional approaches.	Women's, Child, and Youth Health Plan implementation strategies NSQHS Standard: 2.13	WCHN CEO	Reporting against WCYH plan	I	AHS	Perth children's hospital model
6.5	M	WCHN to partner with Digital Health SA to undertake a project to: - automatically flag inappropriately long waiting times for Aboriginal and Torres Strait Islander families seeking access to paediatric outpatient care at WCHN. This could be replicated in other LHNs and will inform staffing adjustments and other strategies to reduce waitlists and improve responses to children from rural and remote locations.	NSQHS Standard: 1.21	WCHN CEO	Internal waitlists and clinic times, include reporting on rural and remote times	I	AHS	
6.6	M	AHS to work in partnership with regional LHNs, CAMHS, CaFHS and Aboriginal Housing for services for women where regional access to birthing is not occurring, and improved accommodation and housing services for rural and remote women is required. This may include priority housing pathways for women and babies relocating or transferred to Adelaide on health grounds	The State Women's, Child, and Youth Health plan identifies the need for investment in: (a) services and infrastructure to provide services in the home or local community for individuals	AH	Service Plans SLA's Aboriginal Housing Strategy	P	LHN CEO's	

		To enable improved access for regional Aboriginal and Torres Strait Islander children to receive specialist care and support in metropolitan Adelaide, in consultation with regional LHNs: • Step-down metropolitan service for transfers from rural and remote locations • Expansion of existing Step–Down services in rural and remote SA to support and meet the needs of Aboriginal and Torres Strait Islander pregnant women and children accessing health care	without transport; (b) improved telehealth access for specialist clinic services; and (c) safe, stable accommodation for families prior to and after birth including provision of advice, support, and links to other services. Aboriginal Housing Strategy					
6.7	M	AHS to advocate for improving transport access to health services by: • initiating a SA review of existing Patient Assistance Transport Scheme (including removing requirements for upfront payments) to be more culturally responsive to regional Aboriginal and Torres Strait Islander women; and • advocating for adequate cover of costs for Aboriginal and Torres Strait Islander people and inclusion of culturally required accompanying person	NSQHS: Standard 1.2	PATS, LHNs	SLA's Reports developed for these reviews	I	AHS	Some ACCHOs have contracts with 'deals', with taxi companies, to cover the cost of travel.

		• advocating for Commonwealth funding to support families travelling in metropolitan and larger regional centres travelling to other regional areas within 100kms for antenatal, birthing and child health appointments; and • advocating for LHNs to review existing transport policies, to increase Aboriginal and Torres Strait Islander women and children's access to their services through developing agreements with taxi companies and private transport providers to attend scheduled health care appointments in metropolitan Adelaide.						

Recommendation 7: Growing and Strengthening Workforce

To build and strengthen capacity in the health workforce that meets the needs of Aboriginal and Torres Strait Islander women, women of Aboriginal children, infants and children, and plan for future workforce needs.

"The right person, in the right job, with the right skills, at the right time: A workforce-planning model that goes beyond metrics" (117)

The above quote from Stokker and Hallam (117) has been iterated in many forums and relates to health workforce planning at a system level. It encompasses the individual and workplace characteristics and relationships required to provide the necessary workforce over time, in the case of this protocol, to improve the Aboriginal and Torres Strait Islander maternal and child health continuity of care.

Our consultation on workforce shortage and impacts found Aboriginal pregnant women were told they would have an Aboriginal worker to care for them, and this didn't happen because there were not enough AMIC workers during the time of their pregnancy.

Our consultation revealed there was an overwhelming shortage of Aboriginal and Torres Strait Islander specific workers including Aboriginal and Torres Strait Islander health workers/practitioners, midwives, nurses, liaison officers, and allied health, administration including management. This is compounded by a lack of Aboriginal and Torres Strait Islander people in mainstream services, and the high turn-over of staff in the early childhood sector (30). There is also differential access to care across urban and remote settings (118). Our consultation highlighted there were few specialists (e.g., obstetricians to allow for birthing close to home, child health, allied health, and other specialists) available outside of Adelaide.

McCalman and colleagues described a system as being made up of several elements that are interrelated and interdependent and working together toward the same outcomes (40). These elements include client care, ancillary services, professional staff, financial, informational, physical and administrative subsystems, consistent with components of health systems described by the World Health Organization (WHO) (46). They go on to provide examples of key features of health systems level thinking in organisations seeking to improve cultural competence. Notably, the principles for implementing systems approaches are user engagement in development of strategies, organisational readiness/commitment, and delivery across multiple sites. Further cultural competence outcomes must be examined across organisational systems, in individual services and policies, and in the client/practitioner health care encounter.

The first principle of user engagement in the development and implementation of any system strategy is to reflect the cultural beliefs, values, and practices of the local Aboriginal and Torres Strait Islander groups (40). The benefits of consumer engagement in co-designing, co-producing and co-working with consumers in health care cannot be underestimated. It teases out the narrative, illuminates the lived experience, and brings fresh insights on how we can better prepare the workforce and provide improved services to Aboriginal and Torres Strait Islander women, children, and families (119).

Decolonising health care is the key to health systems' workforce transformation and, therefore, this needs to be recognised and demystified within mainstream health institutions as an everyday practice. In the context of health care, for providers working within mainstream health organisations, thinking and reflecting beyond the western biomedical knowledge system and ways of knowing is the beginning of decolonising the way services are delivered. Decolonisation requires acknowledging that First Nations Peoples' ways of knowing, being, and doing health care have been historically and institutionally marginalised (2). This reflects the second principle of organisational readiness/commitment espoused in McCalman's system change approach (40).

One of the reasons that Aboriginal and Torres Strait Islander primary health care services are successful in gaining health outcomes, is that they are often governed by their local communities and, therefore, are underpinned by the values and principles of the communities they serve, as well as having a culturally appropriate and skilled workforce (31). Aboriginal and Torres Strait Islander health workers frequently use decolonising healing strategies, such as connection to country, to enable them to move past institutional disrespect of their roles. This, however, is often interpreted as neglect of their roles and positioned as incompetence.

Adelaide Health Innovation Partnership consultation quote:

"AHW's instinctively draw on their cultural knowledge and will take their clients out on country to sit by a river or walk while yarning about their health issues. These relational practices are interpreted as 'gone walkabout', or not 'real' work."

Topp and Tully (120) reflect that the Aboriginal and Torres Strait Islander health worker role is multifaceted and comprises three core functions: (i) health promotion; (ii) clinical service; and (iii) cultural brokerage, ensuring clients are at the centre of their work, and not the disease. Aboriginal and Torres Strait Islander health workers roles use Indigenous strength based ways of knowing, being and doing, therefore, are unique and can shape clinical and service delivery adapted to Aboriginal and Torres Strait Islander peoples' knowledge systems and local understanding of health (120). These service adaptations represent one of the ways to effectively confront and mitigate the effects of continual lack of self or cultural awareness among some non-Aboriginal health professionals (120).

The third of McCalman's principles is delivery across multiple sites, which provides the opportunity to test out the success factors within a variety of worksite settings belonging to the same system. ACCHO, LHN or PHN, and primary or tertiary health care services all have different contexts such as geographic location, proportion of Aboriginal and Torres Strait Islander population in the community, and level of hospital and community-based health care. Working across multiple sites creates the opportunity for partnerships in providing care and supporting the workforce across organisations. This will require leadership, ongoing training, and investment to achieve equal partnerships and respect by all members of multidisciplinary teams (121). The literature indicates that some providers assumed informal linking roles to improve coordination, but this was often ad hoc. It was acknowledged that this requires additional skills that are not necessarily reflected in existing professional qualifications or role descriptions (30).

Our rapid reviews found measures of success reported in existing studies included sustained engagement of families throughout the program, including those with complex needs. Critical factors underpinning the success of these programs included investment in building the Aboriginal and Torres Strait Islander workforce and supporting this workforce with access to clinical support including knowledge exchange between health workers, midwives, and nurses (122, 123).

Our consultations identified some specific workforce factors that would meet their needs including:

- Providing a culturally safe workplace involving leaders, managers and organisational culture;
- Increasing the skills of Aboriginal and Torres Strait Islander workers through upskilling, debriefing and training/professional development, throughout health and in specific and/or identified roles including navigator/coordinator roles, Aboriginal and Torres Strait Islander maternal infant care workers, Aboriginal and Torres Strait Islander health practitioner in other teams relevant to maternal and child health (e.g. liaison officers, community worker);
- Trialling designated care coordination roles, care planning and use of recall and reminder systems;
- Enable worker consistency, which is important for service provision and relational continuity of care;
- Allow workers to have flexibility to work in diverse ways (e.g., outreach, home and/or community visiting) and apply trauma informed care frameworks;
- Having a systems approach, to routinely consider Aboriginal and Torres Strait Islander health workforce/positions, succession planning and future workforce;
- Investing in current workforce through mentoring and cultural supervision; and

- Provide capacity building of the ACCHO sector and Aboriginal and Torres Strait Islander health workers to deliver disability services.

Other consultation feedback included:

- Address structural racism evidenced in wages and conditions being different for the Aboriginal and Torres Strait Islander workforce (e.g., AMIC workers have no shift work or after hours paid work);
- Identify positions as they become vacant, and quarantine them for long term investment for developing Aboriginal and Torres Strait Islander people into key health roles including clinicians; and
- Provide pathways for Aboriginal and Torres Strait Islander people (e.g., Aboriginal and Torres Strait Islander allied health assistant, then pathway to allied health role, pathway to health degrees and career pathways).

The Miwatj Leadership Model (Miwatj is an ACCHO in remote Northern Territory) has contributed to a more stable Aboriginal and Torres Strait Islander workforce. In the past, the delivery of services had been jeopardised by a high turnover of non-Aboriginal staff. Employing staff from the Yolngu community has stabilised the workforce and ensured that local cultural knowledge and organisational corporate knowledge is maintained (124).

An editorial by the Indigenous nurse and midwife educator coalition in 2020 stated the need to increase the nursing and midwifery workforce and for the disciplines to invest in anti-racism initiatives, as nurses and midwives make up about 60% of the Australian health workforce (125). The editorial reiterates calls from the WHO for an increase in health workforce, which must include clinicians and educators from underrepresented populations, in particular Aboriginal and Torres Strait Islander populations. One barrier to increasing numbers of Aboriginal and Torres Strait Islander nurses and midwives, is higher education. Higher education accreditation will soon require that Aboriginal and Torres Strait Islander curricula content is provided across all nursing and midwifery education settings, and graduates will have several opportunities for this education experience during their studies. A coalition of Aboriginal and Torres Strait Islander midwives and nurses has formed. They are clinicians and are also university nurse educators who are developing Aboriginal and Torres Strait Islander culturally strengthened ways of informing the curricula. Community consultation also called for health-related students to have placements in ACCOs and in health services where there are high numbers of Aboriginal and Torres Strait Islander patients.

The literature also raises several ways the Aboriginal and Torres Strait Islander workforce could be supported and was reflected in the Aboriginal and Torres Strait Islander community and service staff consultation feedback (122, 123, 126, 127). Support could take the form of personal and professional mentoring, and with peer networks. Aboriginal and Torres Strait Islander health workers, and community health promoter roles need clear scope of practice, and systemic barriers must be addressed. Strategies to address barriers may include support with financial costs for identification documents, comprehensive induction to the service including code of conduct and expectations of the workplace, and support to attend training and education sessions for community members being recruited (128). Recruitment and retention strategies could include cohorts of Aboriginal and Torres Strait Islander people across LHNs, PHNs and ACCHOs working in partnership. Examples include the University of SA cohort of PhD scholars funded by an NHMRC capacity building grant, and the University of Adelaide cadetships which includes and encourages peer support and work placements (122, 123, 126, 127). It is critical that these positions are genuinely valued, and that other health care professionals understand the role they play, not only to the service but for the client as well.

The current SA Health Aboriginal Workforce Framework 2017-2022 is currently undergoing review and was not available at the time of this project. Upon publication, this review should also be examined. The recently launched SA Rural Aboriginal Health Workforce Plan 2021-2026 has four themes: (i) Culturally safe workplaces; (ii) Growing the Aboriginal health workforce; (iii) Enhance Aboriginal and Torres Strait Islander leadership and engagement in health services; and (iv) Developing a collaborative and coordinated health system. Whilst only the last theme has a systems focus, all themes are consistent with the intent of our protocol (129).

The structure of roles and financing also has an impact. LHNs are responsible for managing their own budgets. SA Health assists with reducing full-time equivalents (FTE) and salary costs with initiatives such as voluntary redundancies, and funds the packages offered. As roles are increasingly being made redundant, however, the systemic problem then arises when the FTE is ceased (after redundancy) and provides no further opportunity to employ other staff in other areas to increase the Aboriginal and Torres Strait Islander workforce. This is risky for Aboriginal and Torres Strait Islander staff positions, as there are already few positions available, especially in key identified roles. For every Aboriginal and Torres Strait Islander staff member taking a voluntary redundancy package, the FTE needs to be transferred to another Aboriginal and Torres Strait Islander staff position. Natural attrition, including due to an ageing workforce, is a way for vacancies to be seen as opportunities for Aboriginal and Torres Strait Islander employment, rather than as short-term savings, perpetuating long-term poor health outcomes for Aboriginal and Torres Strait Islander people. Ensuring more Aboriginal and Torres Strait Islander people are appointed at the Board of Directors level, is another way to increase the Aboriginal and Torres Strait Islander lens and oversight. Increasing workforce capacity, by providing appropriate governing board training to cohorts of 10 potential Aboriginal and Torres Strait Islander people each year to build the ‘pool’ of potential candidates is another important strategy. Value also needs to be placed on the activities of building capacity and capability at the individual level as a strategy for capacity building of the community.

Short (S) – immediate; Medium (M) – Jun 2022 onwards; Long (L) - Jul 2023 onwards. Aboriginal Health Service (AHS) role Lead L, Partner P, Influence I

Growing and Strengthening the workforce								
Rec No.	**Short Med, Long**	**Action**	**Lever/s**	**Accountability owner**	**Accountability method**	**AHS role L, P, I**	**Monitoring by whom**	**Example**
7.1	S	DHW, Aboriginal Health Workforce lead engagement with the nurses, midwives, allied health, educators coalition to work in partnership to enhance/develop critical antiracist education and praxis to be incorporated into tertiary health workforce curriculum and into LHN training and education. Scholarships to be made available through AHS for Aboriginal and Torres Strait Islander staff and their managers to attend	LHN Aboriginal Health Plans 2018-2022 LHN Workforce Director meeting LHN Aboriginal Health Workforce Plans	AHS LHN Health Workforce Directors	LHN Reporting workforce plans	I	AHS	
7.2	S	AHS to fund a project to investigate the feasibility (validating and evaluating) of a trial implementation of the Cultural Pathways Program modified Social Need Screening tool by Aboriginal & Torres Strait Islander navigators located within ACCHO and LHN maternal and child health sites with established KPI's.	NSQHS Standard: 1.2, 1.21	Pilot site/s senior manager	Real time evaluation contract	L	AHS	Link to Culturally appropriate Screening tools recommendation.
7.3	M	Improve/restore trust in healthcare by consistent/continuous staff by reviewing employment conditions and retention and recruitment strategies, with a particular focus on regional and remote locations. Improve wages	Office Commissioner Public Service CTG implementation plan	OCPS	AAR through CTG implementation plan reviewing and improving parity among ACCOs and	P	AHS Workforce AHCSA	

		parity through the current AAR Closing the Gap Implementation plan initiative.	AHCSA Strategic plan - workforce SA Aboriginal Health Workforce Strategies		ACCHOs and government positions.			
7.4	S	Formal workforce development and employment partnerships between hospital and primary care units in LHN services and ACCHOS and other primary care providers, where service design allows this, with clear demarcation of roles and responsibilities and scope of practice of each. (105, 115)	SA Health Aboriginal Workforce Plan LHN and AHCSA Aboriginal Health workforce planning	AHS	Workforce strategies and plans. LHN Aboriginal Health Plan AHCSA partnership strategy	L	AHS CE Health AHCSA	LHN and ACCHO employ the same person e.g., AMIC worker who can then work in both places and provide relational continuity of care.
7.5	M	AHS to support and contribute to the leadership and implementation of the next iteration of the SA Health Aboriginal Health Workforce Framework; and the LHN workforce plans by developing the following specific new roles: • Aboriginal and Torres Strait Islander navigator/coordinator role based within LHNs and ACCHOs with an Aboriginal and Torres Strait Islander family focus for pregnancy and birthing, and child health • Investigate the establishment of a linking service for rural and remote women and children in partnership with LHNs, the ACCHO sector and PHN commissioned services to	SA Health Aboriginal Health Workforce Framework; and the LHN workforce plans	AHS - Workforce Senior officer	All LHN and AHCSA Workforce officers	L	CE Health	

		determine the level of need, for an Aboriginal and Torres Strait Islander navigator role which focus' on Aboriginal and Torres Strait Islander children requiring acute services outside of their home community • Male navigator role • Aboriginal Maternal and Child Health Evaluation Officer funded to conduct evaluation of Aboriginal and Torres Strait Islander programs and services across SA in LHN and ACCHO settings • Dedicated Aboriginal and Torres Strait Islander workforce to support and enable the information sharing, communication and follow up care • Discharge liaison coordinators in hospitals • Post discharge follow up • Pre-admissions coordinators prior to surgery and any appointments within the hospital • COVID-19 and other preventative Health Promotion / Literacy function with a Maternal, Family and Child health focus, and working in languages.						
7.6	S	AHS to fund the development and strengthen specific maternal and infant (AMIC) and child health and development training (currently not available); Navigator training; COVID-19	SA Health Aboriginal Health Workforce Framework;	AHS - Workforce Directors	LHN and AHCSA Senior Workforce officers	L	SAAHP CE Health AHCSA	

		health promotion and other infectious disease and accredited units in AHW/AHP training; and training and education for Aboriginal and Torres Strait Islander evaluators – all to include continuity of care and trauma informed components/units.	the LHN workforce plans; and AHCSA strategy	AHCSA Registered Training organisation				
7.7	S	LHNs review and adopt Aboriginal and Torres Strait Islander workforce targets based on the population of Aboriginal and Torres Strait Islander families and their clinical needs e.g., Number of AMIC workers funded in the LHN is linked to the number of Aboriginal and Torres Strait Islander pregnancies and future demographic projections – and move away from generic % workforce target. Include ACCHOs in these partnerships discussions. This is an urgent workforce shortage role. Recruitment and retention of Aboriginal and Torres Strait Islander staff is urgent.	NSQHS Standard: 1.2; 1.21, 1.4, NSQPCHS: 1.4, 1.9, 1.17 All workforce plans	AHS	LHN, AHS and AHCSA Workforce senior officers	L	SAAHP CE Health	
7.8	M	Department of Health and Wellbeing Aboriginal Principal Workforce Officer in partnership with LHNs develop: • a funding formula which quarantines the loading of Activity Based Funding for Aboriginal and Torres Strait Islander patients and remoteness in both acute and outpatient settings • Advocates at national level for a review and increased ABF loading for Aboriginal and Torres Strait Islander clients in rural and remote	Regional Aboriginal health and workforce plans need for additional specific health programs and services	AHS – Workforce	LHN Aboriginal Health SOG AHCSA senior workforce position	L	SAAHP CE Health	

		areas based on MMM remoteness index in both acute and outpatient settings • Inclusion of Aboriginal health practitioners (AHPRA registered) attracting revenue as for all other professions including in acute and outpatient settings to ensure on-going growth and sustainability of Aboriginal and Torres Strait Islander workforce and programs						
7.9	S	Department of Health and Wellbeing, Aboriginal Principal Workforce Officer undertake workforce planning, of the ageing workforce and natural attrition of the workforce: • that these positions are quarantined to support the growth and sustainability of an Aboriginal and Torres Strait Islander workforce to meet the growing and future demand; and • enables LHNs to meet their Aboriginal and Torres Strait Islander workforce targets.	Regional Aboriginal health and workforce plans need for additional specific health programs and services	AHS – Workforce	LHN Aboriginal Health SOG; and AHCSA senior workforce position	L	SAAHP CE Health	
7.10	M	That AHS facilitates and partners with AHPRA, AMA, SA ANMF and CATSINaM to develop consistent cultural competence requirements for the health professionals including allied health professional bodies working with Aboriginal and Torres Strait Islander maternal and child health and social health (e.g., social work, psychologists, speech pathologists).	Code of conduct and Charters of the relevant credentialing bodies outlining cultural competence as a requirement of the particular health	AHS	LHN and AHCSA Workforce officers	L	SAAHP CE Health	

			professional group.					

Recommendation 8: Digital Technologies

To increase the use and implementation of digital technologies that support and strengthen continuity of care by improving digital health literacy across the health workforce, and among Aboriginal and Torres Strait Islander families.

Consultation revealed that there is significant room to improve the use of digital technologies to increase communication between health care providers and families to support informational continuity and coordination of care for Aboriginal and Torres Strait Islander mothers, children, and families. There is already a suite of digital technologies within the health system in SA, either implemented or in the process of being implemented, indicating there is a need to streamline and improve adoption of these technologies rather than introduce new products. Importantly, SA has a draft Digital Health Strategy that is expected to be endorsed in early 2022 (130). This provides the framework to drive digital health innovations in the health care system over the next three years. There are several deliverables from this strategy that are targeted at improving continuity of care across all populations. This includes the continued implementation of an electronic medical record, and provision of the SA health viewer providing a single view of patient records across access points, secure messaging services to digitise referral and discharge processes to improve handover, and expansion of the use of telehealth for outpatient follow-up. We recommend the DHW, Aboriginal Health Division work closely with Digital Health SA and LHNs to partner on the implementation of the Digital Health Strategy for Aboriginal and Torres Strait Islander families.

Our consultations identified some examples of specific technologies that could be utilised to improve care for Aboriginal and Torres Strait Islander families. An important example is the regional referral platform implemented as part of the Midwifery Caseload Model of Care pilot in the Yorke and Northern LHN. This platform is used to facilitate communication between health care providers in country areas and the Northern Adelaide Area Local Health Network, provide access to specialist obstetric care, in some cases virtually, to reduce the need for families to travel for specialist appointments, and develop management plans and to facilitate referrals and follow up care as needed. An important feature of this platform is the ability to invite approved health care providers working outside of acute settings to securely access and share medical information within the platform which is housed on a SA Health server. There is significant scope to: (i) replicate this platform in other LHNs with refinement according to local needs; (ii) expand the program beyond communication and referrals related to antenatal care to include maternal and infant postnatal care and paediatric care information; and (iii) expand access to the platform to include health care providers working in the ACCHO sector, and those working in CaFHS and Child and Adolescent Mental Health Services.

Our consultations revealed instances where medical records that are accessible for Aboriginal and Torres Strait Islander families are not being used to their full potential. This includes 'My Health Record' which is recognised in Australia's National Digital Health Strategy as a key initiative to improve integration and coordination of health care delivery. The National Quality and Safety Standards for both acute and primary health care settings also include recommendations to increase the provision of clinical information into the My Health Record system.

The consultations found both systemic and individual provider barriers to uploading important health information, specifically maternal, infant, and paediatric health care to individuals' My Health Record. Across the LHNs there appears to be inconsistent practices regarding routine uploading of maternity discharge summaries to My Health Record, indicating the need for a review of current processes and responsibility for uploading information. In addition, information about children is not routinely uploaded as current SA Health policy states that information about individuals aged under 18 years should not be uploaded due to concerns about disclosing information that could compromise the safety of women and children experiencing family violence (131). This policy is not present in other jurisdictions, signalling scope for a review to allow sharing of information about children when there is parental/guardian consent. This could be incorporated as part of the discharge planning process. We also heard that there is inconsistent uploading of clinical information by health care providers working in primary health care, and a perception among some health care providers that Aboriginal and Torres Strait Islander families do not use My Health Record due to difficulties navigating the requirements for two-factor verification. There is a need to increase digital health literacy including raising awareness of the My Health Record across the health workforce, and among Aboriginal and Torres Strait Islander communities. Notably, increasing digital health literacy is a key priority of SA Digital Health Strategy, so there are opportunities to leverage initiatives being developed to support the implementation of this strategy.

Addressing barriers to the use of My Health Record will help ensure there is more complete information about women, children, and families at critical access points across the continuum of care, particularly among families that are highly mobile. Increasing the information that is shared with My Health Record will also empower families during their health care encounters. On a broader level, increasing the use of My Health Record as a repository for information about child health status strongly aligns with initiatives being undertaken by the National Children's Digital Health Collaborative – a key initiative of the National Digital Health Strategy (132). This includes the Child Data Hub designed to support a shared, longitudinal digital health record for children and pregnant women, which includes exchange of information with My Health Record. This is being developed as a proof-of-concept project in New South Wales, with a view to being implemented nationally. The Government of SA/SA Health is a partner organisation in the collaboration.

Our consultations revealed some providers wished for the hand-held clinical records used in antenatal and infant care (“orange” and “blue” books) to be made electronic for families, as these books can be lost or not brought to appointments. This may particularly affect families that are highly mobile. Importantly, SA Health and CaFHS are working towards making these books electronic, but this is a long-term goal with the implementation of the electronic medical record implementation taking priority.

Short (S) – immediate; Medium (M) – Jun 2022 onwards; Long (L) – Jul 2023 onwards. Aboriginal Health Service (AHS) role Lead L, Partner P, Influence I

Digital Technologies								
Rec No.	**Short Med, Long**	**Action**	**Lever/s**	**Accountability owner**	**Accountability method**	**AHS role L, P, I**	**Monitoring by whom**	**Example**
8.1	S	AHS to fund pilot projects to expand use of the regional referral platform such as the one utilised with Yorke and Northern LHN and LMH to: (a) allow other LHNs to centrally refer to a service according to care needs; (b) allow health care providers from ACCHOs to access and upload relevant client information to the secure platform; (c) expand the scope of the platform to cover maternal postnatal, infant and paediatric services; (d) expand access to CaFHS and CAMHS staff; I encourage first appointment virtually.	NSQHSS Standard 6	AHS	Pilot project funding agreement	P	Pilot site senior manager	Platform developed by Operations and Research manager, iCCNet for Yorke and Northern LHN.
8.2	M	AHS and LHNs to work with Digital Health SA to promote adoption of digital channels and technologies already available within SA Health such as the SA Health viewer and secure messaging service to digitise referral and discharge processes and improve system handover.	Implementation initiatives for the SA Digital Health Strategy LHN regional plans	AHS	Digital Health SA plans	P	CE Health	WCHN novel approach to managing patients in the Emergency Department. An urgent Virtual care technology platform.
8.3	S	AHS in partnership with LHNs to set up short term steering committee to review current processes regarding	NSQHS Standard 1	AHS	LHN negotiated short term	L	CE Health	

		sharing of information from SA Health clinical systems with My Health Record and monitor the proportion of maternity discharge summaries uploaded for Aboriginal and Torres Strait Islander mothers.			steering committee			
8.4	S	AHS to work with the SA Health Safety and Quality Unit to review the Clinical Communication and Patient Identification Clinical Directive to allow uploading of information from SA Health clinical systems for Aboriginal and Torres Strait Islander patients under the age of 18 years where consent is given by the parent or guardian.	NSQHS Standard 1	AHS	Quality and safety standards	P	CE Health	
8.5	S	AHS advocates for a project in partnership with LHNs, ACCHO sector and PHN's to improve the sharing of information with My Health Record and improve digital health literacy across the health workforce, including identifying and addressing barriers for communities in collaboration with Digital Health SA, Australian Digital Health Agency and AHCSA.	NSQPCHS 1.17 Implementation initiatives for the SA Digital Health Strategy	AHS	Digital Health SA, LHNs, ACCHO sector, PHN's plans	P	CE Health	
8.6	M	AHS advocates for a project with CaFHS, AHCSA and the Communities of Practice to develop electronic orange and blue books with adaption for Aboriginal and Torres Strait Islander families to ensure they are culturally responsive, including in other languages.	This is a priority of the National Children's Digital Health Collaborative of which SA Health is a partner	SA Digital Health	Aboriginal Health	I	CE Health	

Recommendation 9: Information Sharing, Follow-up Care, Referrals and Discharge Planning

To improve high quality information flow, information sharing, referrals, follow up care, and discharge planning.

High quality and consistent communication between health services, primary care providers and Aboriginal and Torres Strait Islander women, women of Aboriginal children and families is essential if they are to receive high quality care. In order to communicate respectfully and effectively with Aboriginal and Torres Strait Islander women and women of Aboriginal children it is important that practitioners have a sound understanding of the context of the women's circumstances, and the ability to communicate and engage effectively and respectfully (38, 57). Effective communication must also consider the importance that many Aboriginal and Torres Strait Islander people place on the need to spend time in developing a rapport with a health professional, who is often not known to the person before the 'business' of the health visit takes place (57). Aboriginal and Torres Strait Islander stakeholders in SA also recommend that appropriate time be taken to develop rapport and understand the context of women and families. Aboriginal and Torres Strait Islander women and women of Aboriginal children value not having to tell their story repeatedly, and report having to do this often with mainstream services (133). It is well documented that relational continuity can be adversely impacted where disjointed, poor communication within and across agencies and organisations occurs. It also has the potential to compromise Aboriginal and Torres Strait Islander women, women of Aboriginal children, children and family's safety and quality of care (18).

The consultations for this protocol identified inconsistent approaches to discharge planning across the system. In some areas, no discharge summaries are received, and in other areas they are not received in a timely manner disrupting continuity of care and ultimately, patient safety. This anecdotal evidence is further supported by the literature which reports discharge from maternity care and the transition to community-based care, including ACCHOs and child and family health services, as an area that requires focused attention (33). Our rapid reviews found that care is often fragmented and operates in silos, resulting in families receiving care from multiple service providers who all have different priorities. This is problematic from both a referral and management continuity of care perspective. Additionally, there is also a lack of suitable and appropriate referral pathways, as well as duplication, repetition and inefficiencies in referral processes and systems (32, 33).

The lack of information sharing between health professions and services is evident across the entire system (30). Information sharing between an Aboriginal and Torres Strait Islander women's primary care provider and the tertiary system should be formalised across systems to improve relational continuity, including standardisation of information sharing that incorporates and prioritises the timely provision of discharge summaries to women and their relational care providers. Improvement in the quality of information included in the discharge summary can be achieved through the development of appropriate Aboriginal and Torres Strait Islander maternal guidelines. Midwives and AMIC workers may be the appropriate health professionals to support the coordination of the discharge process to limit delays in summaries being sent.

Annual health checks for Aboriginal and Torres Strait Islander people can result in the development of a health management plan. The monitoring focus is currently counting the number of checks. There is no formal mechanism to ensure that follow up happens, or ability to monitor this. In some cases, appropriate follow-up would be with a GP, but there is currently no way of knowing whether this is happening across the system, and not all general practices have appropriate systems for ensuring follow-up occurs. Current recall systems are often inadequate in primary and tertiary care for this purpose when families are experiencing challenges.

Short (S) – immediate; Medium (M) – Jun 2022 onwards; Long (L) - Jul 2023 onwards. Aboriginal Health Service (AHS) role Lead L, Partner P, Influence I

Information Sharing, Follow-up Care, Referrals and Discharge Planning								
Rec No.	**Short Med, Long**	**Action**	**Lever/s**	**Accountability owner**	**Accountability method**	**AHS role L, P, I**	**Monitoring by whom**	**Example**
9.1	M	AHS to establish annual consultative structures to assess and recommend changes to maternity and child health and social services, to include: • develop/ adapt social and emotional wellbeing assessment tools for pregnant women; and • assessing e.g., smoking, drug and alcohol, family and domestic violence, general health and social and emotional wellbeing.	NSQHS Standard: 2.13 LHN service agreements	AHS	To be developed		Aboriginal Strategic Advisory and Implementation Committee	Develop and/or adapt emotional wellbeing assessment tools for pregnant women. Consider adopting "Baby coming – ready or not' tool – link to screening tools recommendation
9.2	S	Ensure that Aboriginal and Torres Strait Islander women and child's health information is communicated in a timely manner directly to the families General Practitioner and/ or home clinics other treating doctor(s).	NSQHS Standard 6	LHNs and ACCHOs	To be developed	P	AHS DHW Planning Quality Information and System Performance	Link to My Health Record actions ICCnet Pathways for Aboriginal Families being developed by CaFHS. Aboriginal Children's Pathway being developed by LHNs

9.3	S	AHS and AHCSA establish mechanisms to develop respectful formalised agreements between the LHNs and the ACCHO sector which incorporates: • Collaboration • Communication • Cooperation To improve relationships and partnerships that will improve continuity of care for Aboriginal women, families, and children at a local community level.	NSQHS Standard: 2.13	AHS	AHS Plans and this protocol	L	CE Health	NALHN has a MOU with PHNs for paediatric specialists

Recommendation 10: Sustained Investment

To investigate and act on opportunities to sustain investment over the next 10 years to meet the health needs of SA's Aboriginal and Torres Strait Islander mother's, children and families.

As health systems are highly context specific, there is no single set of best practice that can be put forward as a model for improved performance. Health systems that function well, however, have certain shared characteristics. They have procurement and distribution systems that deliver core interventions to those in need. They are staffed with sufficient health workers who have the right skills and motivation to provide these core services, to innovate and to evaluate, and they operate with financing systems that are sustainable, inclusive, and fair (34).

Consultation feedback for this protocol clearly stated that core funding is inadequate for maternal and child health service delivery and funding is not distributed equitably across SA regions according to need. Philanthropic organisations were identified as potential sources of additional funding, however, this is not always easy to attract. Competitive tendering processes across the State create issues amongst service agencies – one organisation loses funding while another one gains. This can lead to fractured relationships and adversely impacts employment retention; people lose their jobs, disrupting relational and management continuity as programs disappear, and this does not foster an environment for genuine collaboration. The upshot is the client is the one being disadvantaged. Funding is scarce with stringent reporting requirements and deadlines are often very tight, resulting in sub-optimal capacity to best meet client needs, such as timely outreach or following up referrals and ongoing continued care. The one positive piece of funding feedback from our consultations was an organisation that received funding without any key performance indicator (KPI) requirements, allowed innovation, flexibility and better reach to families, and enhanced their ability to cater to client needs.

These findings from our consultations were consistent with the research of Lloyd and colleagues which identified three factors contributing to the under-resourcing of Aboriginal and Torres Strait Islander health including: (i) inefficient funding arrangements; (ii) mainstream programs being inappropriate for Aboriginal and Torres Strait Islanders; and (iii) competing interests determining the allocation of resources (134). Many participants in Lloyds study across all levels of the health care system cited a lack of political imperative to improve Aboriginal and Torres Strait Islander health care as the major underlying reason for inadequate resources (134).

The costs of health care should not force impoverished households even deeper into poverty (46). Non-government not-for-profit organisations, such as ACCHOs, predominantly funded by the Australian government and ACCOs, have a critical role in meeting health needs and filling social service gaps for Aboriginal and Torres Strait Islander people, that State government and other providers have not addressed to date (135). There are a number of barriers to provide services to address health inequities experienced by Aboriginal and Torres Strait Islander people. Lavoie and colleagues argue these barriers are consistent for community based primary care services in many nations, including ACCHOs and ACCOs, and include: (i) the use of accountability metrics/indicators that are not matched to an equity mandate; (ii) patterns of funding and allocation of resources that are poorly tailored to needs; and (iii) the lack of support for continuous change management (135). They argue that these services had a key leadership role in educating providers across the health system regarding appropriate models of care, and that for health care systems to fully realise the potential of ACCHOs and ACCOs to address inequity, five policy conditions must be met:

1. System-wide recognition of the unique and critical role these services have in promoting equity, including understanding how they complement other state-funded services.
2. Use of performance indicators that reflect the needs and issues of local populations to ensure accountability for the use of public funds.
3. Specific resourcing to support innovation and responsiveness to community needs to benefit from the agility of these services.
4. Feedback pathways to ensure a system-wide understanding of emerging needs.
5. System uptake of appropriate models of care for specific populations.

Governments have the responsibility to ensure all health services are culturally safe, however, funding parameters and reporting of service targets can result in perverse incentives to move funding in short term cycles. To facilitate continuity of care for Aboriginal and Torres Strait Islander maternal and child health, programs must balance targeted and universal population, proportionate to the needs and levels of disadvantage in a population. The National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families (104) supports and builds on the Universal Services Framework (136), which outlines core services that should be available to all Australian children and families based on proportionate universalism. This Framework also emphasises the importance of ensuring that all Aboriginal and Torres Strait Islander children and their families have access to culturally appropriate services, universal and targeted, that are appropriate to their needs. Importantly, when services change, trust of services (and funders) is lost by Aboriginal and Torres Strait Islander people and hard to regain. KPIs can take a long time to reflect positive outcomes following changes to service structures or even individuals. ACCHOs must, therefore, have sustained funding to secure core women’s and children’s primary health care activities over time.

Recognising the considerable diversity of Aboriginal and Torres Strait Islander communities (and families within communities), the Universal Framework reflects the need for services to be tailored in scope and approach. Core funding to ACCHOs and other services catering to Aboriginal and Torres Strait Islander women, women of Aboriginal children and children must allow for tailored, evidence-based programs which meet the needs of specific, higher-needs groups. Dwyer and colleagues in their *Overburden report* (45), used the contracting theory as the framework for their study. They compared *classical contracting*, as the traditional model for an exchange of goods or services for money, whereas *relational contracting* recognises the interdependence of contractor and supplier and seeks to maximise the common interests of the parties in the enterprise. Research shows *relational contracting* is more suited to ACCHOs as the services are broad ranging (not specific), there is no competitive market, and maintains long term relationships with health service providers. The long term nature of ACCHOs providing health services is very important for continuity of care, workforce sustainability and system development, ultimately, maximising the primary health care contribution to closing the health gap (45). Policies such as competitive tendering is an impediment to *relational contracting* and undermines the important work undertaken by community-based health services through ACCHOs and ACCOs. Improved alignment of the funding purpose with Aboriginal and Torres Strait Islander community priorities, relational monitoring, reducing the burden of measuring improvements would support improved health for Aboriginal women, children and families.

Our consultations and rapid reviews revealed a lack of funding for urban based services for Aboriginal and Torres Strait Islander families relative to the population size and needs. This results in fewer community health workers to support follow up care across multiple providers in urban areas (reflecting poor relational continuity) (30). A solution is that activity based funding (ABF) loadings should be quarantined to fund programs and a workforce to support a sustainable model going forward, as it currently goes to the bottom line and there's no accountability for it. Furthermore, weighted funding is required for Indigenous people and for rural and remote settings.

Greater attention is required in evaluating the performance of governments meeting the needs of Aboriginal and Torres Strait Islanders, with emphasis on effective and appropriate funding and resourcing of Aboriginal and Torres Strait Islander care. Lavoie, Varcoe (135) argue for the sort of policy enabling environment that adopts state-NGO relationships which require joint decision making and maintaining organisational identity. These are featured in SA's Implementation Plan for the National Closing the Gap Agreement, namely: Transforming government services. This provides a potential avenue to monitor many of the actions proposed in our protocol. Importantly, monitoring and facilitating government performance on how funds are invested, as well as the amount spent, is an important step towards the more effective implementation of Aboriginal and Torres Strait health policy (134).

A dedicated and focused approach is required to ensure appropriate evidence is used to support investment in programs to improve the health of Aboriginal and Torres Strait Islander people, and that resources are prioritised to interventions that demonstrate the greatest return. The moral and political case for overcoming disadvantage, therefore, needs to be augmented by, rather than supersede, economic evidence. While recognition of rights-based arguments has differed according to political affiliation, economic arguments have appeal across the political spectrum and can help ‘future proof’ effective programs from the vagaries of the short-term political cycle. Health economic evaluations built on Aboriginal and Torres Strait Islander values and preferences will provide a means to prioritise interventions and policies to ensure that the resources that are available to improve health are used in the most effective ways possible (137).

Our consultations and rapid reviews identified the need to provide opportunities to fund innovation to support continuity of care. The competitive-based funding approach leads to considerable time writing funding proposals and/or are costly if outsourced, with a high chance of being unsuccessful. More often, these tenders offer insufficient funding relative to the project/program proposed (135). For ACCHOs, this problem is compounded by having to compete against larger NGOs, that have more resources and capacity to write successful grant proposals using Aboriginal and Torres Strait Islander intellectual and cultural property.

Inadequate resources for Aboriginal and Torres Strait Islander health undermines the potential to generate support and implement policy aims, and it also undermines the capacity of the health care system to adopt innovative ideas and to reflect on the effectiveness of their work (134). Innovations in continuity of care can arrive anew or can be facilitated through short-term grants which include funding for appropriate evaluation over time. The importance of strong program logic design, accountability to funders, and community and funding continuity across the service system must be part of supporting this important work.

Our consultations revealed a need to invest in learning organisations. Workforce retention within ACCHOs has been an ongoing issue well before the COVID-19 pandemic. Newer members of the workforce, who provide services to women and children, are often women of child rearing age (i.e., Aboriginal and Torres Strait Islander health workers, AMIC workers, Aboriginal and Torres Strait Islander health professionals, nursing staff, doctors and other clinical, evaluation and administrative staff). They may quickly gain skills and transition to new roles, often in the broader health sector. They are also more likely to have short-term contracts, part-time work, and career interruptions for family responsibilities.

ACCHOs will continue to shoulder a disproportionate burden of recruiting, developing and retaining the workforce in comparison to other health sector organisations. Although this can be seen through a deficit lens, where the organisation is one staff member away from a workforce crisis, with support for workforce employment and partnerships to enable workforce development within, ACCHOs can increase the Aboriginal and Torres Strait Islander maternal and child health workforce. Investing in ACCHOs as learning organisations will involve government, other NGO organisations and philanthropy investing in additional personnel FTEs within ACCHOs to build sustainable workforce structures. The Aboriginal and Torres Strait Islander maternal and child health workforce could be expanded through development of cohorts of potential workers from across the state in key roles reflecting local needs (e.g., AMIC, AHP, midwife, nurse, allied health, navigator). Workforce capacity building in ACCHOs could include study scholarships and cultural, pastoral, and educational supports. In addition to this support, regular small activity grants with minimal KPIs would facilitate staff capacity building by enabling these staff to innovate, evaluate and learn from early pilot programs, rather than risk 'failure' threatening ACCHOs core funding.

Our rapid reviews found many authors identified a problematic lack of coordinated governance across services highlighting the need for greater accountability in mainstream services. Policy directives in the mainstream non-government sector to target Aboriginal and Torres Strait Islander families were identified as a major impediment to improving continuity of care for pregnant women, mothers, babies, and young children. Such policy directives have led to increased competition between services for Aboriginal and Torres Strait Islander clients, rather than strengthening local partnerships and collaboration. These stringent requirements also lead to less incentives to refer to other agencies and have occurred with limited guidance or additional funding to enable NGOs to build relationships with communities (30). A potential solution identified in the rapid reviews is to have requirements for organisations to demonstrate how they are genuinely working with relevant organisations (e.g., ACCHO) built into funding agreements.

Effective State-NGO (including ACCHOs) relationships require a high degree of trust, coordination, mutual accountability, and the maintenance of organisational identity. These are consistent with the principles of SA's Implementation Plan for the National Closing the Gap Agreement, namely: formal partnerships and shared decision making, and building the community controlled sector. To support this implementation plan, we propose funding the Aboriginal and Torres Strait Islander primary health centres located in LHNs, such as NALHN and CaFHS, to undertake a specific project to identify the amount of activity based funding weighted for Indigenous and rural and remote patients, and complexity, and allocated to LHNs, as there is limited current monitoring and accountability on this. There are also opportunities to partner with and leverage bigger projects to provide impactful health initiatives targeting maternity and child health services. An example could be joining up with Tackling Indigenous Smoking, recently allocated $188M nationally. Aboriginal and Torres Strait Islander maternal and child health services located in primary care, collaborating with such schemes, should involve negotiated funding and joining with the community sector (e.g., AHCSA and ACCHOs). We propose that the DHW, Aboriginal and Torres Strait Islander Principal Workforce Officer could undertake workforce planning reviews of the aging workforce and natural attrition of the workforce with a view to quarantining current positions. This would support the growth and sustainability of an Aboriginal and Torres Strait Islander workforce to meet the current and future demand and enable LHNs to meet their Aboriginal and Torres Strait Islander workforce targets.

The actual cost of system reforms required to provide Aboriginal and Torres Strait Islander maternal and child health continuity of care are unknown, due to lack of investigation and cost evaluation of existing initiatives. Notably, the purpose of the Closing the Gap maternal and child health funding in SA has been to provide 'seed' funding to trial new ways of ensuring Aboriginal and Torres Strait Islander maternal and child health relational, informational and management continuity of care. Our consultations revealed, however, that many health services viewed the provision of seed funding, rather than long term programmatic funding, as problematic.

The longstanding discontinuities and fragmentary relationships between health and other social services prevents services from meeting the needs of Aboriginal and Torres Strait Islander families. It is reasonable to follow the Closing the Gap approach led by the Aboriginal Affairs and Reconciliation and plan over a 10-year timeframe, rather than use a short term approach. Long term impactful changes could be made such as growing an Aboriginal and Torres Strait Islander workforce of health professionals and evaluating several current and future initiatives. We suggest an initiative be undertaken to cost an effective and innovative financing program that includes all parts of the maternal and child health continuity of care systems (i.e., LHNs, ACCHOs, PHN funded services) to develop a business case for ongoing funding to make a real difference to future generations of Aboriginal and Torres Strait Islander people.

Short (S) – immediate; Medium (M) – Jun 2022 onwards; Long (L) - Jul 2023 onwards. Aboriginal Health Service (AHS) role Lead L, Partner P, Influence I

Sustained Investment								
Rec No.	**Short Med, Long**	**Action**	**Lever/s**	**Accountability owner**	**Accountability method**	**AHS role L, P, I**	**Monitoring by whom**	**Example**
10.1	L	Provide secure dependable funding for women's and children's health for both (i) core programs and (ii) evidence-based site-specific tailored activities	Condition of Accreditation	AHS	LHNs PHNs AHCSA State and Commonwealth government	I	CE Health	
10.2	M	Development of an activity based formula to ensure sustainable program funding and workforce growth in future	SLA NSQPCHS 1.17	AHS	DHW Finance LHN COO and CEO's.	I	CE Health	
10.3	M	AHS provide opportunities to fund small projects for innovation and workforce capacity building	SA Health workforce plans	AHS	LHNs PHNs AHCSA Rural university programs State and Commonwealth government	I, P	CE Health	
10.4	S	Department of Health and Wellbeing, Aboriginal Principal Workforce Officer undertake workforce planning, of the ageing workforce and natural attrition of the workforce: • that these positions are quarantined to support the growth	NSQPCHS 1.17	DHW	DHW workforce LHNs	I	CE Health	AHCSA Workforce Development Workshops site profile

		and sustainability of an Aboriginal and Torres Strait Islander workforce to meet the growing and future demand; and • enables LHN's to meet their Aboriginal and Torres Strait Islander workforce targets.						
10.5	L	Increase Aboriginal and Torres Strait Islander maternal and child health workforce through development of cohorts of potential workers from across the state in the key roles reflecting local needs (AMIC, AHP, midwife, nurse, allied health, navigator) Including scholarships and cultural, pastoral and educational supports.	SA Health workforce plans Regional workforce plans SLA's RTO and University placements	AHS	DHW workforce AHCSA workforce	I	CE Health	This is a long term recommendation and needs to start immediately, in anticipation of a further 10 years of CTG eg could train doctors and psychologists.
10.6	S	AHS fund the addition of ACCHO and ACCO sectors to the NALHN WCHN, Yorke Peninsula LHN digital platform.	NSQHS Standard: 1.2 Digital Health SA	DHW	MOU SLA	I	CE Health	
10.7	S	Include requirements for organisations supporting children with a disability to demonstrate how they are genuinely working with relevant organisations such as ACCHOs as a requirement of their funding agreements.	SLA	DHW AHS	SLA	I	CE Health	
10.8	M	This Protocol suggests an action to extend the life of this protocol to 10 years, and in that time to examine the actual costs required to adequately address closing the gap in Aboriginal and Torres Strait Islander maternal and child health outcomes.	Sustainability	DHW	To be developed	L	CE Health Minister for Health and Minister for Aboriginal Affairs	Previous successful business cases

Recommendation 11: Excellence Collaboration

To lead and monitor clinically and culturally safe evidence-based improvements across the health and social care systems to promote integrated, family-centred care for Aboriginal and Torres Strait Islander women, women of Aboriginal children, children and families.

Our consultations have drawn attention to many instances where the system provides siloed, fragmented care for Aboriginal and Torres Strait Islander families reflecting disconnections and a lack of coordination of care between hospitals, primary health care sector and specialists. This was particularly evident at key transition points for mothers and children. For example, when women leave the tertiary care system following birth needing extra care, support, and follow-up in the primary care sector. Our findings mirror that reported in the literature. To create sustained change, we recommend strategies to strengthen systems leadership and lead quality improvement activities across the system. This was identified as a key enabler in our rapid reviews.

"Systems leadership" and "systems thinking" have emerged in recent decades as key theoretical concepts to help address issues that require collective action (138). To aid the operationalisation of systems leadership, we recommend the development of an excellence collaboration within SA Government to build systems leadership capacity in Aboriginal and Torres Strait Islander maternal and child health. This collaboration will unite key stakeholders in health care, social services and education supported by an Aboriginal and Torres Strait Islander governance structure, and timely access to data related to Aboriginal and Torres Strait Islander families. We envisage core functions of the collaboration will be to:

- Connect services delivering care for Aboriginal and Torres Strait Islander women, women of Aboriginal children, children and families with a shared vision and governance structure to share power to lead culturally responsive, evidence-based service delivery across the continuum of maternal and child health care.
- Connect services with training and research organisations to integrate research, policy and education with care delivery and translate evidence for reform.
- Monitor program and service delivery across the state identifying opportunities for practice and policy improvement across the health system.
- Help grow a culturally competent workforce through identification of critical workforce needs and opportunities to enhance training and professional development across the system.
- Unite service providers and Aboriginal and Torres Strait Islander communities to share knowledge and information about health care improvements and place

Aboriginal and Torres Strait Islander families at the centre of health care delivery reform and evaluation.

An excellence collaboration offers a number of opportunities to leverage SA Government initiatives concerning systems redesign, data access and digital health. We envisage that in addition to the Aboriginal Health Division and LHNs, key government partners would include Systems Leadership and Design, the CEIH, Wellbeing SA, CaFHS, CAMHS, DCP and the OEY. Key external partners include: Aboriginal Health Council of SA, ACCHOs, primary health care networks as well as community representatives.

A staged approach to establishing this collaboration would enable appropriate consultation with relevant stakeholders to develop a shared vision and priorities, and build a long-term strategy for sustainability. We recommend that co-funding arrangements be explored to support key personnel required to start and sustain the collaboration including contributions from individual LHNs. As the Department of Treasury and Finance (DTF) manage the Social Capital Venture projects for SA, with joint funding and priorities, this would be worth exploring, to commence the Excellence Collaboration and develop a long-term strategy.

Short (S) – immediate; Medium (M) – Jun 2022 onwards; Long (L) - Jul 2023 onwards. Aboriginal Health Service (AHS) role Lead L, Partner P, Influence I

Excellence Collaboration								
Rec No.	**Short Med, Long**	**Action**	**Lever/s**	**Accountability owner**	**Accountability method**	**AHS role L,P,I**	**Monitoring by whom**	**Example**
11.1	S	AHS provide the opportunity and budgetary requirements to consult with health service and community stakeholders to seek feedback on the core membership, governance, key positions, priorities, and funding opportunities for an excellence collaboration in Aboriginal and Torres Strait Islander maternal and child health. Governance to include consumers – mothers, fathers, caregivers, ACCHOs, LHNs, researchers.	Public Health (Governance) Act AS07 Strategic positions being funded through AHS branch into LHNs could take carriage of special projects of this nature. NSQHS Standard: 2.12 CEIH plan	AHS	CEIH definitions of excellence	P	AAR through CTG action plan AHCSA	Governance structure, vision and strategic priorities established. See https://www.anzsog.edu.au/ structure
11.2	S	AHS to work with the CEIH and Wellbeing SA to scope the data system requirements to bring together data in a centralised platform about Aboriginal and Torres Strait Islander families to enable collaboration to monitor service delivery and outcomes across the continuum of care.	Both the Women's, Child and Youth Health Plan and SA Digital Health Strategy include a range of strategies to increase timely access to data across the health system to inform service and	AHS CTG AAR action planning	SA Digital Health CEIH WCYH plan	P	CE Health AAR CTG action plan report to joint council	

			system design, planning and evaluation. In particular, the WCYH Plan promotes the development of an integrated whole of government databases to allow sharing of information and coordination of data across agencies.					
11.3	S	AHS fund a project to undertake an economic analysis including potential for cost savings by improving continuity of care that could be used to establish the business case for an excellence collaboration. This could include exploring the Social Venture Capital projects with the contact person in DTF.	CTG SA Implementation plan	AHS	AAR CTG action plan	L	AHS	Matthew Winefield DTF social venture capital.
11.4	M	Support the collaboration to lead the translation and evaluation of culturally validated maternal/carers/families mental and physical health and child health developmental screening tools (trauma informed care, culturally appropriate, acknowledge cultural strengths as protective) across both Government and other health	CTG SA implementation plan includes partnerships	AHS	CEIH plan	P	Aboriginal community CE Health AHCSA	

		services, including ACCHOs and PHN funded services.						
11.5	M	AHS facilitate training and education for key monitoring stakeholders such as governing boards and senior executives across LHN, PHN funded and ACCHO sector about the monitoring requirements for this protocol and connections to the National Quality and Safety Standards.	SA CTG Implementation plan NQSHS	LHN Aboriginal governing board members	AHS	L	AHS	Induction packs and workshops for incoming LHN governing Board members.
11.6	L	Sustain the excellence collaboration to lead, monitor and evaluate service and systems improvements for Aboriginal and Torres Strait Islander families supported by evidence, data and consumer voices about community needs.	The Women's, Child and Youth Health Plan identifies the need for visible leadership to drive culture and policy across the systems, increase interagency collaboration and promote consistent implementation of policy.		AHS		CEIH	

Recommendation 12: Living with COVID-19

To maintain commitment to continuity of health care during the COVID-19 pandemic and ensure access to resources and preventative actions for Aboriginal and Torres Strait Islander families.

Consultation feedback on COVID-19 was varied. At the time of consultation, although very few had experienced COVID-19 cases in their communities, there was a lot of information about preparation and planning, about what to do if/when it happens, and vaccinations. Services changed and regular disruptions to service delivery occurred, which made it difficult for women and families to access appointments and critical follow-up care. A continuing issue since the start of the pandemic is a lack of access to masks. Staff were taking precautions by wearing personal protective equipment (PPE), social distancing and regular handwashing. Appointments changed significantly, with reduced or postponed face to face appointments. Once vaccines became available, there was more preparation and safe home visits once staff were vaccinated and PPE was available, although not from every community or agency.

There was telehealth innovation particularly from ACCHOs, where appointments were held by phone, zoom, or even face time on mobile phones. The literature provided information on the importance of telehealth, however, there is also an opportunity for programs to do more home visits or follow-up care outside of a hospital environment. This may promote family centred care and require hospitals and services to be flexible. Sometimes packages of information and items needed by families were dropped off at the client's home, including masks and hand sanitiser. The expectation is that services will be prepared for COVID-19 and there will be agreements across the different services, including hospitals and other allied health services, about how they will continue to provide services during the pandemic.

There was overwhelming support by ACCHO workers that routine primary health care, allied health and specialist services for Aboriginal and Torres Strait Islander mothers and children should continue regardless of COVID-19. ACCHO workers argued it was up to the organisation to work out case by case the best way to have appointments, and to share the information with patients. It was important for children to continue with their health and development checks so that needs can continue to be identified as soon as possible. Telehealth increased access to some services, but left gaps in the ownership and transmission of information previously held in handheld maternity (orange) and child health (blue) books. Work is required at a health service level to compensate for this challenge, providing a balance between confidentiality and access to a client's own information.

Staff recognised that both staff and community clients were scared by the unknowns of COVID-19. Community people were anxious. Grannies caring for grandchildren were anxious and would seek to have appointments outside their house as they were afraid to get too close to anyone else. Staff spent significant amounts of time discussing COVID-19 with community. Communities were interested in hearing about COVID-19 and what this meant for accessing services. Our consultations also highlighted the difficulties associated with the constantly changing information on ways of managing a potential outbreak.

Our consultations identified difficulties with hospital appointments, including reduced appointment times and women had to attend alone for antenatal checks and could attend with one child for children's appointments. In the community clinics, reduced numbers meant there was reduced engagement with some patients and continuity of care was worse.

With the lock down restrictions impacting some travel from regional and remote areas, there was reduced access to alcohol and other drugs. This meant some families and communities were better off, with no serious issues occurring. In other families managing complex issues, sometimes the families contact with health services dropped off. Families were dealing with all their issues themselves, sometimes ending up in crisis, and others ended up in accident and emergency. There were also some families where there was an increase in family violence. COVID-19 has created an additional risk for women due to increased household pressures and social isolation. Ensuring access to the provision of information, support, triage, and emergency accommodation services has been a challenge during the COVID-19 pandemic.

In relation to vaccination, some staff did not want to have the vaccine and left the workplace rather than be vaccinated. Consultation feedback highlighted concern about this, as there is such a strong need for Aboriginal and Torres Strait Islander workers in community organisations. There was also not a huge uptake of vaccinations by community people. Vaccine hesitancy and barriers to increasing COVID-19 vaccination rates were beyond the scope of this project, however, it is recommended this issue be investigated and addressed.

COVID-19 has stopped some elements of collaboration between services, for example, meetings are still via videoconferencing. In-person meetings allowed for incidental discussions and conversations, which is important in regional areas, potentially sparking relationships, and putting faces to names. Furthermore, our consultation revealed training and joint agency training has reduced or stopped, when previously there had been a lot of training in the community, meaning that the chance to connect and get to know other workers was lost.

Digital health was raised as a tool to assist with providing information and support about caring for a baby and family and COVID-19 impacts. This risks more inequalities as some families will not have access to data, or the equipment to use for telehealth or videoconferencing to access health materials.

Our consultations identified COVID-19 information in an Aboriginal and Torres Strait Islander language had not been seen and would be useful. Since our consultations commenced, communities across the state have experienced COVID-19. New and different ways of providing support for those in isolation, including offering temporary shelter in country towns and an evaluation of the levels of preparedness of Aboriginal communities, may be needed.

Research from Europe (139) on the care of vulnerable newborns after birth during COVID-19 has shown the restrictive measures have resulted in limited parental and family presence for infants admitted to neonatal intensive care units (NICUs). Moreover, a reduction in care-seeking by parents, lack of guidelines regarding preterm newborns and infants with low birthweight and discontinued or discouraged kangaroo mother care (skin-to-skin contact) due to restrictions on parental presence during the pandemic have been observed. This is despite a lack of evidence of harm from kangaroo mother care (140).

The COVID-19 pandemic related restrictions have had a major impact of the provision of infant and family-centred developmental care (IFCDC), which is considered an essential set of practices for intensive care of newborns. Evidence from 56 countries demonstrates an alarming rate of parents (>20%) were not permitted to be present with their newborn receiving special/intensive care in the first year of the pandemic, which means the infant did not have the opportunity to experience and benefit from the closeness of the parent(s), neither in form of skin-to-skin contact or simply in terms of hearing the parents' voice and smelling their scent. The parents' role in the care of their newborn is of paramount importance, and their experiences provide unique insights to the challenges of providing IFCDC during the COVID-19 pandemic (139).

While COVID-19 related restrictions are generally necessary to stem transmission, disregarding evidence-based cornerstones of the IFCDC such as kangaroo care increases the risk of morbidity and mortality of vulnerable infants across the globe. Accordingly, the WHO and many others have recommended that mothers and infants should not be separated to avoid unnecessary suffering of the youngest and most vulnerable members of society (141). Within SA, there have been reduced numbers of all parents in the NICU and this protocol seeks to promote a zero separation policy of parents and infants.

Importantly, the national COVID-19 Clinical Evidence Taskforce (140) provides important recommendations on the provision of maternal and newborn care, which is consistent with many of the issues raised in our consultations including:

- For pregnant women with COVID-19, mode of birth should remain as per usual care.
- Early skin-to-skin contact after birth and during the postnatal period is supported, independent of the presence of COVID-19. Parents with COVID-19 should use infection prevention and control measures (mask and hand hygiene).
- Breastfeeding is supported irrespective of the presence of COVID-19. Women with COVID-19 who are breastfeeding should use infection prevention and control measures (mask and hand hygiene) while infectious.
- For women with COVID-19 who have given birth, support rooming-in of mother and newborn in the birth suite and on the postnatal ward when both mother and baby are well. Women with COVID-19 should use infection prevention and control measures (mask and hand hygiene).

Short (S) – immediate; Medium (M) – Jun 2022 onwards; Long (L) - Jul 2023 onwards. Aboriginal Health Service (AHS) role Lead L, Partner P, Influence I

Living with COVID-19								
Rec No.	**Short Med, Long**	**Action**	**Lever/s**	**Accountability owner**	**Accountability method**	**AHS role L, P, I**	**Monitoring by whom**	**Example**
12.1	M	Although telehealth is important, safe face to face visits to continue wherever possible, outside of the hospital setting.	NSQHS Standard: 1.4 State pandemic emergency response	AHS COVID team AHCSA, ACCHOs	Working with Aboriginal communities state-wide; command centre; Minister and Chief MO office	L	CE Health	
12.2	S, M	AHS advise zero separation policy of parents and infants during hospital admissions to avoid unnecessary suffering.	NSQHS Standard: 1.4	AHS	SLA's SOGAH AHCSA	L	LHN CEO	
12.3	S, M	Increase patient access to information and services through: - Effective sharing of patient information usually contained in hand held antenatal(orange) and child health (blue) books to patients, and other health care providers - Providing access to distance technologies with internet capability to vulnerable patients to enable provision of health information and access to care	State pandemic emergency response – prevention, keeping safe	AHS COVID team	Working with Aboriginal communities state-wide; command centre; Minister and Chief MO office LHN, ACCHOs	I	LHN CEOs AHCSA ACCHO	
12.4	S, M, L	Support Aboriginal and Torres Strait Islander communities to increase vaccination uptake, including through the provision of evidence-based,	NSQHS Standard: 1.4 and 1.2 State pandemic emergency	AHS COVID team	Working with Aboriginal communities state-wide;	I	LHN CEOs AHCSA ACCHO	

		trusted, culturally and linguistically appropriate information.	response – prevention, keeping safe		command centre; Minister and Chief MO office LHN, ACCHOs			
12.5	S, M, L	All health services provide a free call information and support triage to support and refer Aboriginal and Torres Strait Islander families needing mental health and social and emotional wellbeing services addressing parental anxiety, stress and depression, during lockdowns, quarantines and isolation due to COVID-19.	State pandemic emergency response – prevention, keeping safe	AHS COVID team	Working with Aboriginal communities state-wide; command centre; Minister and Chief MO office LHN, ACCHOs	I	LHN CEOs AHCSA ACCHO	
12.6	M	Evaluation of the level of preparedness communities and ACCHOs felt.	NSQHS Standard: 1.4	AHS	Aboriginal and Torres Strait Islander communities around SA	L	CE Health	

Recommendation 13: Living with Disabilities and/or Chronic Illness

To increase resources and improve care required by Aboriginal and Torres Strait Islander families and children living with disabilities and/or chronic illness.

Aboriginal and Torres Strait Islander children experience higher rates of disability in comparison to non-Aboriginal and Torres Strait Islander children. Failure to address the social, physical, and psychological factors can have a long-lasting impact into adult life and are a precursor to persistent health inequities (35). Aboriginal and Torres Strait Islander children are 30 times more likely to require support with communication and learning and have a greater prevalence of profound or severe disability compared to non-Aboriginal Australian children (35).

Of the SA Aboriginal and Torres Strait Islander children who participated in the second part of the AFS, caregivers reported 27% suffered with ear infection health issues, dental problems (26.4%), allergy/eczema (21.9%), anxiety (19.5%), asthma/chronic cough (19.2%) and sleep problems (13.5%), hearing problems (10.0%), skin infections (11.8%) and injuries (9.7%). Almost one in four of the AFS children (23.9%) experienced one or more developmental and/or emotional and behavioural difficulties that had been diagnosed by a medical practitioner (see Appendix B).

In addition, data collected as part of the Australian Early Development Census (AEDC) indicated the urgent need for improvements in access to appropriate assessment and follow up of developmental needs among Aboriginal and Torres Strait Islander children, with approximately 41% of children nationally classified as developmentally vulnerable on at least one AEDC domain by the time they commence schooling (142). This is twice as high as the rate for all Australian children and the gap is widening. In SA, 46% of Aboriginal and Torres Strait Islander children are classified as developmentally vulnerable on at least one domain (compared with 24% of SA children).

Our consultations revealed for children aged 0-5 years, the National Disability Insurance Scheme (NDIS) is extremely hard to navigate, including the application process and determining eligibility. Participants felt the NDIS does not work for many Aboriginal and Torres Strait Islander families due to the many barriers to access, including lengthy wait times for assessments and approvals (up to 12 months). Once families are approved, there are still long waiting lists to access NDIS service providers, which is of real concern when families are in urgent need of support particularly for treatment and the ongoing management of conditions. Combined with this, is the lack of NDIS workforce continuity, which makes it extremely difficult for case workers and service providers to build rapport and trusting relationships with community and families requiring access to services. We identified scant literature concerning the delivery and quality of health care for Aboriginal and Torres Strait Islander children living in SA, indicating a lack of attention to this important area.

Challenges were particularly prominent in the discussion of care for a child with a suspected or identified developmental issue or disability. Interviews with carers and other family members revealed difficulties and frustrations with navigating multiple different health care providers in the community, often with different criteria for accessing services and different treatment priorities for the child. Delays in receiving a diagnosis caused by long waitlists for assessment, lack of follow up of children leading to missed opportunities to access treatment and support (sometimes due to simple clerical errors), and difficulties getting to appointments due to lack of private transport options have also been reported (30, 143). Carers identified rigid eligibility criteria including age-based funding structures which restricted access to support services, with limited assistance from some care providers in accessing funding for other support services (143). These are issues common to Aboriginal and Torres Strait Islander families across jurisdictions, including those living in metropolitan areas, where dedicated disability services are available (30, 35, 143). When asked to consider ways to improve care, carers participating in the study by Green, Abbott (143) expressed a preference for family centred care, described as inclusive of a holistic view of the needs of the child and carer, a one-stop-shop for services with a centralised team approach. Some reported being able to access this through a local ACCHO, but access to some services was still limited. Coinciding with the need for improved care delivery, carers have identified the need for strategies that build community awareness of developmental issues and services and support available (35, 143).

Interviews with health care providers working in childhood disability services also revealed an array of challenges reflecting impediments to achieving informational, relational and management continuity. Providers reported a lack of effective communication and sharing of information between professionals and across sectors, a lack of availability of certain services, high workloads and high staff turnover in early childhood services, which resulted in inconsistent sharing of information and poor care coordination (30).

At a leadership level, providers identified a problematic lack of coordinated governance across services. Policy directives to the non-government sector to target Aboriginal and Torres Strait Islander families were identified as a major impediment to improving management continuity. These directives have led to increased competition between services for Aboriginal and Torres Strait Islander clients, less incentive to refer to other agencies to “protect caseload targets”, and have occurred with limited guidance or additional funding to enable NGOs to build relationships with communities (30).

There is a lack of detailed information about other strategies to improve aspects of care coordination including information sharing. In the case of children with a disability, although not formally evaluated, these suggested strategies are relevant to improving coordination of care and culturally responsive care not only for children with disability, but also those with complex social needs. Suggested strategies include (30, 35):

- Having standardised processes to identify needs for specific conditions and how to connect to relevant services, such as care plans.
- Promoting a stronger role for specialist disability support in ACCHOs and Aboriginal and Torres Strait Islander health worker positions.
- Use of case conferencing and other formal communication channels between the education and health sectors.
- Cross-sector networking and committees to share information and supports available.
- Promoting a shared goal and vision for the family between providers and the family.
- Provision of cultural mentorship of mainstream service providers, including specific resourcing for mentorship within service provision.
- Having requirements for organisations to demonstrate how they are working with relevant organisations such as ACCHOs (e.g., as a requirement for funding).
- Cross-sector governance to promote education and training providers to collaborate across sectors.

Short (S) – immediate; Medium (M) – Jun 2022 onwards; Long (L) - Jul 2023 onwards. Aboriginal Health Service (AHS) role Lead L, Partner P, Influence I

Living with Disabilities and/or Chronic Illness								
Rec No.	**Short Med, Long**	**Action**	**Lever/s**	**Accountability owner**	**Accountability method**	**AHS role L, P, I**	**Monitoring by whom**	**Example**
13.1	M	AHS ensure that the disability and safeguarding advocates gain feedback from SA health and ACCHOs on issues for Aboriginal and Torres Strait Islander children and families.	SLA	AHS		L	CE Health	
13.2	S	Rapid access to Child Development Unit's and LHN community based maternal and child allied health services such as ENT, speech pathologists, OT, psychologists, physiotherapists by: • Health and community services complaints Commissioner role in relation to advocacy; and • SLA's	SLA Health and Community Services Complaints Commissioner	AHS	Child Development Units	I or P	AHS	
13.3	M	Strengthen capability of ACCOs to provide support to families, via increased funding for allied health positions, navigator roles and Aboriginal and Torres Strait Islander health practitioners.	CTG state action plan and workforce plans SLA	AHS	DHW funding	I	AHS	
13.4	S	Work with OEY to raise awareness of referral pathways including via NDIS.	Early Years Learning Strategy	AHS	OEY strategic planning	I	AHS CE Health	
13.5	S	AHS drive the inclusion of accountability and data reporting, particularly for community-based services, in the service agreement where organisations are funded to provide services to	SLA CTG Action plan	AAR CTG action plan LHNs	To be developed	L	AHS	

		pregnant women, children and their families.	SA Health policy directive					
13.6	M	Develop strategies that build community awareness of developmental issues and services and support available.	NSQHS Standards	SOGAH LHNs ACCHOs	AHS	P	CE Health	

9. Monitoring and Accountability

Monitoring the implementation of the recommendations and actions outlined in our protocol is essential to continuing efforts to redesign services, policies and systems to improve continuity of care. Ongoing monitoring and evaluation are also essential to enable services to adapt to new challenges and emerging priorities as the system changes. Establishing the right mechanisms to monitor outcomes will be crucial to maintaining momentum and identifying where accountability mechanisms are required to be established or strengthened. The proposed Excellence Collaboration is ideally placed to lead monitoring and to promote and encourage shared accountability for implementation. This Excellence Collaboration can work between institutions and ensure that the National Quality Health and Safety Standards are being met across the system. Further, it would be able to provide early identification of instances where standards are not being met and offer support from collaborators to remedy any shortfalls.

An effective Excellence Collaboration will allow for clear and consistent channels of communication between all stakeholders involved in implementing the recommendations of the protocol. These ‘de-siloing’ efforts will have far reaching and positive consequences for protocol partners and their understanding of each other’s work, as well as the health consumers they provide services to. The Excellence Collaboration will provide the platform for effective cross-institutional communication and reduce duplication of effort. Clearer lines of communication and higher instances of collaboration will increase the likelihood that the system will begin to measure what matters for Aboriginal and Torres Strait Islander communities in earnest, as it would encourage a system where their voices are at the centre of program design and are influential in the institutions that have the most system-wide influence.

The need for ‘systems thinking’ is clear here. A ‘business-as-usual’ approach to Aboriginal and Torres Strait Islander maternal and child health risks reproducing the same outcomes of inequality and slow, or no progress. By focusing on what needs to be developed and improved, a ‘systems thinking’ approach will be best placed to allow for institutional reflexivity and change. Embedding initiatives to measure success based on our findings from robust community consultations will mean that system changes are likely to gain traction, disrupting the cycle of ineffectiveness. Uniting key monitoring stakeholders for critical collaboration will create the conditions required for system change.

To support this collaboration, we propose establishing KPIs that measure the spectrum of components of culturally responsive continuity of care, along with progress towards implementation of this protocol and health outcomes for Aboriginal and Torres Strait Islander women, women of Aboriginal children, children and families. Over the course of the development of this protocol we have begun to identify relevant indicators to facilitate monitoring, however, these need to be co-designed with input from the sector, from researchers and from community members over the coming months, to ensure they are measuring what matters for Aboriginal and Torres Strait Islander families and services. The indicators will take some time to design, as key to the success of this protocol will be the implementation of the recommendations. In close consultation with well-versed experts from Aboriginal and Torres Strait Islander leadership, community, and the sector including clinicians and researchers, the responsibility for finalising and formalising the KPIs will sit with the DHW (see Recommendation 1).

Finally, to monitor changes, and measure what matters most to the Aboriginal and Torres Strait Islander community in relation to maternal and child health outcomes, all recommendations need to be implemented. This protocol has been developed through comprehensive consultation with the community in a process that privileged Aboriginal and Torres Strait Islander voices. Recommendations need to be implemented in full to honour the generosity of their insights and the aspirations of the SA Government. When considered together, each of the recommendations will promote systemic change that will be interlinked and strengthened by the others. To implement only part of this protocol will risk fostering an environment that is not conducive to providing effective continuity of care and making the gains required to achieve health equity for Aboriginal and Torres Strait Islander women, and women of Aboriginal children, children and families.

10. Future Collaborative Research Priorities

Much of the evidence generated to inform our protocol has occurred through comprehensive collaborations between health care providers, executives, researchers, and community members in SA. Continuing to build and sustain these multisector and multidisciplinary collaborations and partnerships is essential to build and translate the evidence-base for health system focused interventions for Aboriginal and Torres Strait Islander families. Examples of specific opportunities for future collaborative research include evaluation of: (a) cultural safety and anti-racism interventions in the maternity care system; (b) the impact of care coordination and navigator positions; (c) strategies to promote inclusion of fathers in pregnancy, birthing and infant care; (d) the key strategies to operationalise family centred care; and (e) enhancing the role of clinician researchers in all health service settings to improve health service quality of care. The proposed Excellence Collaboration is well placed to facilitate opportunities for further research and identify key research partners in SA through collaborations such as the Aboriginal Families and Communities Health Research Alliance.

11. In Closing

The development of this Protocol has been informed by a rigorous review of available evidence and substantial state-wide consultations with communities, health care providers and subject matter experts. The recommendations outlined in this protocol provide a blueprint for sustainable long-term system changes leading to healthy outcomes for Aboriginal and Torres Strait Islander women, women of Aboriginal children and children. The protocol recommendations, subsequent actions and accountability table has been developed to support an efficient transition for the Department to commence early stages of implementation where possible.

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APPENDICES

Appendix A Rapid Review Summaries

We used a broad search strategy to identify: (a) publications relevant to Aboriginal and Torres Strait Islander maternal and child health published in academic journals (e.g., via Pubmed); (b) grey literature sources identified from government websites and clearinghouses; (c) searching the reference lists of identified publications; and (d) knowledge of relevant papers from within the investigator team. Papers published before 1990 were excluded and we also excluded interventions delivered outside of the health system (e.g., school-based interventions).

We identified and screened >1900 papers, that were dominated by descriptions of the health status of Aboriginal and Torres Strait Islander women during pregnancy, including antenatal and birth outcomes and descriptions of the disparity in child health outcomes between Aboriginal and Torres Strait Islander children and non- Aboriginal and Torres Strait Islander children. Among the papers focused on health service delivery, the majority of literature assessed patterns of access to maternal and child health care, the development of culturally valid screening tools or resources, and descriptions of care programs. There is considerable literature assessing the impact of culturally responsive maternity care programs or models of care for Aboriginal and Torres Strait Islander women. Regarding child health outcomes, there are many descriptions of programs or interventions designed to address specific health issues including eye disease, otitis media and rheumatic heart disease. Summarising the complete evidence for these individual models and programs is beyond the scope of this project.

We identified very few published papers that explicitly focused on the evaluation of strategies to drive system change in either Aboriginal and Torres Strait Islander maternal or child health. Some initiatives have been proposed (e.g., in framework documents), very few have been evaluated, and demonstrating impact is made difficult due to the small size of the target populations. As a result, we focus on summarising the health system issues identified and strategies that either enhance or impede the implementation of care programs or models of care, and where available, discuss data regarding impact.

We also discuss issues relevant to the informational, relational and management components of continuity of maternal and child health care, as well as consideration of the key health system building blocks identified in the WHO Health Systems Framework (service delivery, health workforce, health information systems, access to essential medicines, financing, and leadership/governance). In addition, we draw attention to literature concerning system enablers outlined in the National Framework for Child and Family Health Services – secondary and tertiary services[1] which include: accessibility; workforce; information access, use and management; referral pathways; infrastructure; and access to research and evidence-based practice.

Notably, because of the lack of evidence concerning rigorous evaluation of system level approaches, we have combined the third aim of each review to present examples and case studies in the literature.

Review 1.

AIM 1. To describe barriers and enablers in the health system to support improvements in healthy birthweight and a healthy start to life for Aboriginal and Torres Strait Islander children

There are many examples in the literature of models of pregnancy and birthing care that are culturally responsive and preferred by Aboriginal and Torres Strait Islander women and women of Aboriginal children. These are models that: incorporate Aboriginal and Torres Strait Islander health care providers caring for Aboriginal and Torres Strait Islander women; provide continuity of care; facilitate community engagement and allowance for cultural practices; provide flexibility in appointment times; address social health issues; and promote partnerships between health care providers, including tertiary services and community controlled services. The evidence is clear that these models are highly valued by Aboriginal and Torres Strait Islander women, women of Aboriginal children and their families, increase engagement in antenatal care and contribute to improved birth outcomes[2-7]. In addition, although few studies have formally evaluated costs, a midwifery group practice program for remote dwelling women in the Northern Territory was found to be cost-effective and associated with shorter length of stay of infants in the special care nursery[8].

Provision of culturally responsive perinatal care

SA has had a key leadership role nationally in improving access to culturally responsive care for Aboriginal and Torres Strait Islander women and women of Aboriginal children during the perinatal period, through the development, roll out and adaption of the AFB for more than a decade. This includes developing the critical role of AMIC workers delivering care, in partnership with midwives and doctors, as well as the recent inclusion of social health support workers into the model. The implementation of this program has been underpinned by a long history of collaboration between health service providers, researchers and community members working together to develop and evaluate culturally responsive and evidence-based approaches.

There is a considerable body of evidence which demonstrates the importance and impact of this program in SA. This includes evidence collected during the 2015 evaluation of the program commissioned by SA Health, and from successive waves of the AFS, a longitudinal study of 344 women having a baby in SA (this includes Aboriginal and Torres Strait Islander women and non-Aboriginal women having an Aboriginal and/or Torres Strait Islander baby).

The key learnings of these projects demonstrate that compared with women attending standard public antenatal care, women accessing the AFBP have improved access to antenatal care, are more likely to report satisfaction with care, and are more likely to cease or reduce smoking in pregnancy[6,7,9]. Being cared for by AMIC workers, coupled with the provision of transport to appointments as well as outreach care have been critical to improving women's access to antenatal care. Following birth, women accessing the program in metropolitan Adelaide had higher rates of breastfeeding at 12 weeks than women who accessed standard metropolitan antenatal care[10].

The evidence also points to a range of system barriers that influence both accessibility and impact of the program, as well as the quality of care for women accessing mainstream antenatal care. These are summarised below.

Inconsistent resourcing and implementation of the Aboriginal Family Birthing Program

Currently, not all Aboriginal and Torres Strait Islander women and women of Aboriginal children giving birth in SA who would like to access the program can, as it is not available in all areas. Even when there is a commitment to implement the program, this does not always occur consistently[6], and shortage of AMIC workers at some sites means that women may not always be able to see an AMIC worker. The closure of significant numbers (>60%) of rural maternity units in SA[11] and the resultant requirement for women to leave their community to birth continues to be a source of concern for women and a barrier to engagement with antenatal care[12].

Another major impediment has been inadequate resourcing of the AFBP and a lack of referral pathways to support women and families with complex needs[6]. This is evident for women accessing standard antenatal care as well. The AFS demonstrates that pregnant women giving birth in SA have substantially higher rates of medical and social complexity, than other women in SA. Aboriginal and Torres Strait Islander women and women of Aboriginal children are markedly more likely to experience three or more stressful life events and social health issues during pregnancy, such as insecure housing, family violence and grief and loss. These issues are particularly evident among young women and those living in metropolitan areas and contribute to very high levels of postpartum psychological distress[13]. Further, women who experience three or more social issues or stressful events during pregnancy are more likely to have a baby that is born with a low birth weight or small for gestational age[14] identifying the need to strengthen social support during pregnancy.

Drawing on this evidence, one site has expanded the model to include access to Aboriginal and Torres Strait Islander family support workers and social workers to assist with provision of social support, appropriate referral, and client advocacy. While this is an important step forward, access to this additional support is not consistent across other program sites.

Inadequate information systems, unclear roles of AMIC workers and workforce precarity

The 2015 evaluation of the AFBP in SA also identified a range of systemic barriers related to difficulties with organisational and information sharing systems and the precarity of the workforce. Notably, lack of access to shared electronic records, poor delineation of roles and responsibilities among AMIC staff and midwives, part time contracts and location of staff at different sites were all noted by staff as impediments to effective case management of clients and relationship building.

The evaluation revealed the critical importance of building strong partnerships across the program, including between AMIC workers and midwives, between community-based services and hospitals, and between local communities and health services. Yet sustaining these relationships was identified as a major challenge in many sites. Varying degrees of hospital and health service management commitment to advocate for the program and address issues as they arise, as well as differing commitment of mainstream staff and management to implementing a culturally respectful framework were identified as impediments to successful partnerships.

Poor access to high quality postnatal care

The evidence from the AFS also points to gaps in the provision of postnatal care in SA, particularly around appropriate follow up of maternal medical conditions such as diabetes and hypertension. While over 80% of women in the study reported seeing a CAFHS nurse or GP after birth, a higher proportion of women, with identified medical conditions or with a low birthweight baby, did not access primary health care postpartum suggesting suboptimal postnatal care[15]. In addition, less than half (45%) of women in the study described their postnatal care as 'very good' and 40% of women reported difficulties in accessing support with infant feeding[10].

Lack of access to culturally safe care in mainstream settings

It is important to note that Aboriginal and Torres Strait Islander women and women of Aboriginal children want choice in the model of antenatal care they receive, which includes the choice of standard antenatal care. This underscores the importance of providing culturally responsive care, irrespective of where women access maternal health care. Aboriginal and Torres Strait Islander women and women of Aboriginal children accessing standard antenatal care in SA have reported both positive and negative experiences. An in-depth study with Aboriginal and Torres Strait Islander women at one tertiary perinatal centre in SA found that women felt their physical needs were well met, and they felt supported in birth, but some felt that their cultural needs were not recognised[12]. Others reported feeling judged because of their culture. Midwives also report misunderstandings around the interpretation of cultural safety in the context of midwifery care[16]. Disappointingly, half of women (51%) in the AFS reported that they had experienced discrimination or unfair treatment from a health service providing maternal health care. Women who reported these experiences were also more likely to have a low birth weight or small for gestational age baby[10]. Thus, improving cultural competency across the health system for women during and after pregnancy remains an urgent priority.

Consistency with research with Aboriginal and Torres Strait Islander women in other regions

The evidence from SA aligns with studies reporting the experiences of Aboriginal and Torres Strait Islander women during and after pregnancy in other jurisdictions. Whether it be for general antenatal care or a program to address a specific issue such as smoking in pregnancy. Aboriginal and Torres Strait Islander women and women of Aboriginal children have said that they value care that is relationship based and provides continuity of care, is flexible, includes Aboriginal and Torres Strait Islander staff and is culturally oriented[2,17,18].

Across programs, investment in relationship building and the development of partnerships are identified as key enablers to support this type of care[2,19]. Further, a recent review of continuity of care approaches for Aboriginal and Torres Strait Islander women identified several system factors that could be strengthened to improve culturally responsive continuity of care[2]. This includes designated coordination to improve communication and handover between hospital and primary care services, improving communication between midwives, Aboriginal and Torres Strait Islander staff and families, ongoing cultural competency training for staff and allowing more flexibility in hospital policies to support cultural safety. The review also highlighted the need for partnerships between mainstream services, universities, and communities to help develop pathways into midwifery and other health care professions to strengthen the Aboriginal and Torres Strait Islander workforce in maternal health care.

Conversely, there are also common themes in the challenges women face navigating care during this time. Experiences of discrimination and racism in maternal health care is not isolated to SA[20] nor is the dissatisfaction with being relocated for birthing, and the associated costs and available travel and accommodation as well as negative impacts on wellbeing[19,21-23]. Inadequate access to primary health care post birth for the infant and mother has also been reported, and women report being dissatisfied with the lack of continuity of care in the postnatal period[24,25]. In addition, poor discharge planning and communication between hospitals and primary health care services have been identified as serious risks to the health of mothers and infants, that related to lack of clinical governance of postnatal care and the lack of a designated position responsible for postnatal discharge planning[26].

AIM 2. To describe the key aspects and impact of system level initiatives to improve the proportion of Aboriginal and Torres Strait Islander children with healthy birthweight and a healthy start to life

Interventions specifically addressing health system initiatives to support Aboriginal and Torres Strait Islander women and women of Aboriginal children during pregnancy are scarcely reported in the literature. A notable exception is the Birthing in our Community (BiOC) program in Queensland, which is a complex, health system intervention implemented to support women giving birth to an Aboriginal and Torres Strait Islander baby. The intervention includes the following components:

1. Aboriginal and Torres Strait Islander governance of maternity care comprising of multi-agency partnerships between ACCOs and hospitals and a joint Statement of Commitment.
2. Provision of continuity of midwifery care through pregnancy, birth and up to six weeks postnatally, with care provided in a caseload midwifery model. Antenatal care is provided in a community hub and birthing care occurs in the hospital.
3. Building the number of Aboriginal and Torres Strait Islander staff in the program across different roles, by offering and resourcing professional and vocational pathways e.g., cadetships for midwifery and human services students, inclusion of family support workers.
4. Implementation of a cultural safety framework for frontline staff that includes regular clinical and cultural supervision, orientation, and cultural training via the partner organisations.
5. Provision of 'wrap-around services' at the community hub that includes cultural activities, transport, community drop-in days, and access to parenting support and social work support.
6. A dedicated BiOC service manager employed by the ACCHO to coordinate the team and be the single point of reference for all partners and manage referrals to community support agencies. Managers from partner organisations meet monthly.

When compared with outcomes for women accessing standard care, comprising antenatal care in a hospital clinic or the local ACCHO but with no continuity into birth or postnatal care, or support from Aboriginal Liaison Officers during business hours, women in in the BiOC model were significantly less likely to give birth preterm and more likely to have five or more antenatal visits and to be breastfeeding when discharged from hospital[5]. The model is based on promoting birthing on country principles, which are described as: community governance, community based, allowance for cultural practices, cultural competency, holistic views of health and wellbeing, a connection to land and country, services developed by and with Aboriginal and Torres Strait Islander people, with appropriate risk assessment, and value placed on Aboriginal and Torres Strait Islander knowledge as well as non-Aboriginal knowledge.

To support implementation of similar models in other communities, the authors developed the RISE framework[27], which recommends four key areas to target to strengthen health service reform to promote birthing on country principles, these are: redesign the health service; invest in the workforce; strengthen families and embed Aboriginal and Torres Strait Islander community governance and control. Notably this framework and the broader BiOC model builds on many years of collaborative activities undertaken by the research team to improve maternity care for Aboriginal and Torres Strait Islander women and women of Aboriginal children living in remote and urban areas[4,8,28,29].

Within SA, although not explicitly focused on Aboriginal and Torres Strait Islander women and women of Aboriginal children, the Midwifery Caseload Model of Care Pilot in the Yorke Peninsula and Northern Local Health Network, has implemented a number of promising system initiatives to improve access to midwifery continuity of care among women in the country[30]. This included processes that were introduced to improve communication and 'warm' handover of services across the five participating hospital sites and with local primary health care providers. An important first step was the implementation of a consistent management structure to promote and implement a common vision across sites, supported by dedicated workshops, with staff, to support workplace cultural change to realise this vision. Another key element has been the coordinated rostering of midwives across the sites rather than being restricted to individual hospitals, which has reduced midwifery workforce shortages significantly and allowed staff to take on and mentor early career midwives to promote sustainability. This has also improved relationships with family and clinicians, as there is now a consistent team of midwives known to them. As a result, collaborative arrangements with many local doctors have improved.

Communication has also been facilitated by the implementation of a referral platform in conjunction with the Northern Adelaide Local Health Network to provide access to specialist care, in some cases virtually, in which women and families are triaged and a management plan is developed including any referrals needed. An important outcome of this process has been a reduction in unnecessary travel for women and improved care coordination.

Importantly, women accessing the program consistently reported positive experiences with their care and would seek care in this model for future pregnancies. Rates of birth interventions including caesarean section were comparable or lower than state indicators. There was also high satisfaction with postnatal care, as midwives continued to provide support after birth. The number of Aboriginal and Torres Strait Islander women and women of Aboriginal children accessing this model is not reported, yet many of the initiatives utilised in the model could be incorporated to strengthen care for Aboriginal and Torres Strait Islander women and women of Aboriginal children, both within and outside of the AFBP.

The Northern Territory Diabetes in Pregnancy Partnership[31] is another model that is currently being implemented to improve the quality of care including continuity of care for Aboriginal and Torres Strait Islander Women. The intervention was designed with input from an Aboriginal Reference group and Clinical Reference group and includes a comprehensive range of strategies including:

1. Workshops and regional meetings to build relationships and engage clinicians in the development of referral pathways.
2. Development of a clinical network to share knowledge and deliver educational activities to raise awareness of diabetes in pregnancy and its management.
3. Standardised preconception care plans, postpartum care plans and reminders, and discharge summaries.
4. Greater access to specialist care via telehealth and improved access to allied health.
5. Development of a clinical register of diabetes in pregnancy with weekly lists of women generated, plus regular local and aggregate reports generated.
6. Guideline development, including postnatal care guidelines.
7. Development of culturally relevant resources for women.
8. Patient journey modelling to understand processes and experiences of care.

While evaluation is ongoing to assess clinical care outcomes, a process evaluation involving interviews with care providers has revealed that this approach has led to improved case conferencing and relationships between specialists and midwives and women, increased clinician awareness of diabetes in pregnancy resulting in improved testing, reporting of diabetes, earlier referral for specialist care and improved coordination of care suggesting a positive impact on care systems[32] and continuity of care.

There is a lack of evidence regarding strategies and systems to engage and support Aboriginal and Torres Strait Islander dads and to address any health and social health issues they may be experiencing during pregnancy and raising children. In a recent study[33], three main areas were identified as being needed by Aboriginal and Torres Strait Islander male parents: 1) the necessary resources and support to navigate the realms of parenting in a beneficial way for their children and families 2) the number of appropriate parenting and early years services available need to be increased and improved, and 3) they need to feel ready and determined to fulfil their roles and responsibilities as parents to the best of their ability for their children and families.

SUMMARY OF SYSTEMS ENABLERS AND BARRIERS TO SUPPORTING HEALTHY BIRTHWEIGHT AND A HEALTHY START TO LIFE FIRST 2000 DAYS

Enablers	Barriers
Aboriginal and Torres Strait Islander governance and leadership of programs	Not all models/programs are resourced to address social complexity of some families, and lack of referral pathways to address social health (drug and alcohol issues, family violence)
Aboriginal and Torres Strait Islander staff providing clinical and social care in models of maternal health care with clear demarcation of roles and responsibilities and partnerships with all team members caring for pregnant woman.	Requirement to relocate for birthing, and the availability and costs of transport and accommodation associated with the relocation
Continuity of care provider	Experiences of discrimination and racism, which are associated with poor birth outcomes and contribute to inappropriate child removals at birth, early discharge against medical advice and mistrust of mainstream services
Investment in relationship building through formal partnerships between hospitals and primary health care services, workshops, regional planning meetings	Lack of clarity of roles of Aboriginal and Torres Strait Islander staff in existing service models including the AMIC worker scope of practice
Inclusion of culturally appropriate social support during and after pregnancy	Inconsistent implementation and funding of the AMIC model across SA, reflecting workforce shortage and differing

	commitment to the model by health service management
Provision of transport to attend appointment as well as outreach services to provide care close to home and telehealth (where appropriate)	Inadequate existing tools for mental health concerns
Cultural safety frameworks implemented in mainstream settings and flexibility in hospital policies to promote cultural safety	Lack of access to shared electronic record, inconsistent communication pathways when women leave hospital and move into primary health care support (CaFHS, GPs, ACCHOs)
Dedicated discharge planning and coordination positions, care planning, clinical registers and reminder systems, engagement of clinicians in the development of referral pathways	Fragmented postnatal care (infant feeding, management of maternal chronic conditions), that may not be culturally appropriate, poorer access by those with identified medical problems
Provision of wrap-around/family-centred services	
Participation in quality improvement initiatives	

Review 2

AIM 1. To describe barriers and enablers in the health system to support Aboriginal and Torres Strait Islander child health and wellbeing

The literature demonstrates that there have been important gains in the provision and timeliness of childhood vaccinations for Aboriginal and Torres Strait Islander children. The immunisation goals for children aged 1, 2 and 3 years outlined in the implementation plan for the Aboriginal and Torres Strait Islander Health Plan are all on track to be met or are being exceeded[34]. The development of an Aboriginal and Torres Strait Islander immunisation workforce has been identified as a key factor contributing to these gains[34,35].

In the last decade there have also been small improvements in the proportion of Aboriginal and Torres Strait Islander children under 5 years of age receiving an Indigenous-specific health check (MBS items 715, 228 and temporary telehealth items). However, the national rate has decreased slightly in the last two years and remains at 26% of children in this age group for 2020-2021[34]. This is well below the target rate set in the Aboriginal and Torres Strait Islander Health Plan (69% by 2023). The rate of Aboriginal and Torres Strait Islander children in this age group in SA receiving a health check in 2020-21 was 20%[36,37]. Of these, 48% were undertaken in ACCHOs and 52% in the non-ACCHO sector.

There are some data available about the proportion of children who received an Indigenous-specific follow up within 12 months of a health check. Nationally, for health checks undertaken in 2018-19, the rate of follow up within 12 months among male children was 48% and 46% among females. Steady improvements in the rate of follow up have occurred in the last decade (e.g. the rate of follow up of checks undertaken in 2011-2012 was 8.6% for male children and 8.2% for female children). There are important caveats with this data, as not all checks will require follow up care, and the data available only relate to follow up that include Medicare Benefits Schedule items provided by an Indigenous health practitioner, practice nurse or allied health professional. Data on follow up care by specialist paediatric services are not publicly available.

Data collected as part of the Australian Early Development Census (AEDC) indicates the urgent need for improvements in access to appropriate assessment and follow up of developmental needs among Aboriginal and Torres Strait Islander children. Approximately 41% of children are classified as developmentally vulnerable on one AEDC domain by the time they commence schooling[38]. This is twice as high as the rate for all Australian children and the gap is widening. In SA, 46% of Aboriginal and Torres Strait Islander children are classified as developmentally vulnerable on at least one domain (compared with 24% of SA children overall)[39].

We identified very little published academic literature concerning the delivery and quality of health care for Aboriginal and Torres Strait Islander children living in SA. Unpublished data from the AFS prepared for this protocol are included in Appendix B. Here we summarise the common themes reported in the academic literature concerning the challenges Aboriginal and Torres Strait Islander families in other jurisdictions face in navigating the health system to support child health and wellbeing.

Difficulties engaging with specialist services in hospital

A number of barriers have been identified regarding access to specialist paediatric care in hospital, whether for medical, surgical or developmental issues. Families have reported stress and frustration about long waiting lists for initial appointments, delays in between appointments and for those needing hospitalisation, not being given consistent information about the discharge process and follow up care[40]. Poor communication and/or insensitivity from staff have also contributed to misunderstanding about medications, equipment and treatment once discharged. Families consistently report their worry about staff making notifications to child protection services as a result of these misunderstandings, and this has been identified as a factor contributing to non-attendance[40].

Families also consistently report financial barriers to accessing care in hospitals, including costs associated with transport to get to appointments, parking fees and accessing food during the hospital visit. This was present for those living in urban and rural/remote areas[40,41]. There were added difficulties for those living long distances away from services, including accessing accommodation, the safety of this accommodation and stress and other difficulties associated with leaving family for extended periods of time.

While progress is being made in many hospitals, families identified the need for greater recognition of cultural needs in specialist services in hospitals, including the understanding of Aboriginal and Torres Strait Islander cultural issues and obligations and the impact that these have on attendance[40].

Challenges to accessing community-based services

Challenges were particularly evident in the discussions of care for a child with a suspected or identified developmental issue or disability. In this context, interviews with carers and other family members revealed difficulties and frustrations with having to navigate multiple different health care providers in the community, often with different criteria for accessing services and different treatment priorities for the child. Delays in receiving a diagnosis, caused by long waitlists for assessment, a lack of follow up of children leading to missed opportunities to access treatment and support (sometimes due to simple clerical errors), and difficulties getting to appointments due to lack of private transport options have also been reported[42,43]. Carers also identified rigid eligibility criteria including age based funding structures, limited access to support services, with limited assistance from some care providers in accessing funding for other support services[42]. These are issues common to families across jurisdictions and are present for those living in metropolitan areas despite dedicated disability services being available in these areas[44].

When considering ways to improve care, carers participating in the study by Green et al[42] expressed a preference for family centred care described as inclusive of holistic view of the needs of the child and carer, a one-stop-shop for services and having a centralised team approach. Some reported being able to access this through a local ACCHO, but access to some services was still limited. Coinciding with improved care delivery, carers have identified the need for strategies to build community awareness of developmental issues and services and support available[42,44].

Interviews with health care providers working in childhood disability services also revealed an array of challenges reflecting impediments to achieving informational, relational and management continuity. Providers reported a lack of effective communication and sharing of information between professionals and across sectors, lack of availability of certain services, high workloads and high staff turnover in early childhood services, which resulted in inconsistent sharing of information and poor care coordination[43]. Some providers took on informal linking roles to improve coordination, but this was often ad hoc. Further, it was acknowledged that this requires additional skills that are not necessarily reflected in existing professional qualifications or role descriptions.

At a leadership level, providers identified a lack of coordinated governance across services as problematic. Policy directives to the non-government sector to target Aboriginal and Torres Strait Islander families were identified as a major impediment to improving management continuity. Such directives have led to increased competition between services for Aboriginal and Torres Strait Islander clients, less incentives to refer to other agencies to "protect caseload targets" and have occurred with limited guidance or additional funding to enable NGOs to build relationships with communities[42].

Access to culturally relevant developmental screening tools

Developmental screening is a critical component of early childhood care to promote early detection and management of developmental issues. Yet the validity of routinely used mainstream developmental screening and monitoring tools for Aboriginal and Torres Strait Islander families has been questioned, as they identify very large proportions of Aboriginal and Torres Strait Islander children as developmentally vulnerable[45,46]. While development and refinement of tools such as the ASQ-TRAK is occurring, increasing access to culturally relevant tools remains an important priority to promote culturally responsive care for Aboriginal and Torres Strait Islander families.

Recognition of Aboriginal and Torres Strait Islander parenting practices in service models

A common theme reported by parents and community-based health workers is the failure of existing maternal and child health service models and non-Aboriginal and Torres Strait Islander health care providers to recognise Aboriginal and Torres Strait Islander parenting styles, including the encouragement of early development of child independence around activities such as feeding[47]. Practices such as this are often viewed by some providers as suboptimal and neglectful, contributing to notification to the child protection system, rather than being considered in a framework of providing culturally responsive care.

Differential accessibility in urban and rural/remote areas

There is some evidence that Aboriginal and Torres Strait Islander children living in metropolitan areas have the same level or even more unmet needs than those living in a rural or remote community. In a study of the quality of care for child anaemia assessed in 109 primary care services across Australia, Mitchinson et al[48] found that a greater proportion of children receiving care in an urban primary health care service had suboptimal care than those receiving care from services in remote and regional areas. Suggested reasons for the poorer quality of care included greater fragmentation of care across multiple providers in urban areas (reflecting poor relational continuity and collaboration), greater difficulties locating children in this environment, fewer community health workers to support follow up and a lack of funding for urban based services relative to the population size and needs.

In addition, while there have been small gains in addressing ear health including hearing loss among Aboriginal and Torres Strait Islander children these improvements have occurred predominantly in remote areas and not urban areas[34]. Yet the burden of disease remains high among children living in either urban or rural areas. Notably prevalence of ear health issues is similar for children living in Adelaide (31.2%) and children living in remote communities (34.8%) from the AFS (see Appendix B). Failure of primary care providers to detect hearing problems, as well as long waiting lists and lack of specialist ear health service are ongoing systemic issues with long term consequences for children's language and social development.

AIM 2. To describe the key aspects and impact of systems level initiatives to improve the health and wellbeing of Aboriginal and Torres Strait Islander children

Improving care coordination between tertiary services and primary health care for children: partnerships and relationship building, care coordinators, information sharing, strengthening referral, flexibility and outreach care

There are important examples in the literature that demonstrate improved care coordination for Aboriginal and Torres Strait Islander children requiring the use of hospital services. The Aboriginal Ambulatory Care Coordination (AACC) project based at the Perth Children's Hospital focuses on re-engaging families who have previously failed to attend appointments or who have children with very complex needs. The program accepts referrals from ACCHOs, GPs, allied health staff, community workers, specialists and self-referrals. The program centres on creating partnerships with primary care providers to deliver community clinics and outreach care (supporting relational and management continuity), information sharing between health services (informational continuity) and nurse led care coordination. The care coordinator assists with scheduling multiple visits to the hospital whilst at the same time to reducing travel requirements, locating relevant medical records, providing choice in appointments closer to home or telehealth, planning discharge and providing health and social support to families. Outreach care includes nursing, paediatric and social work follow up care as close to the home as possible.

Evaluation of this program has revealed important reductions in the number of hospital admissions, emergency department presentations, non-attendance of hospital appointments and reduced mean length of stay among Aboriginal and Torres Strait Islander children compared with those using the hospital services prior to the implementation of the program[49]. Notably, while these outcomes are important processes of care, evaluations of future programs or initiatives need to include a focus on health and wellbeing outcomes for the child and their family.

An important outcome of the AACC program has been the strengthening of relationships between Aboriginal and Torres Strait Islander families and mainstream hospital services. Further evaluation has revealed families utilising the program are generally more satisfied with their experiences of hospital admissions and discharge, as well as follow up appointments, than those families who have not accessed the program[40]. Aspects of the program particularly valued by families include the care-coordinator nurse checking in with them during hospital visits and admissions, helping to identify relevant support services, and advocating for the family to both hospital departments and external health services.

The provision of a dedicated nurse led care coordination role was a central element of this program, and while promising, there has been little additional formal evaluation of the implementation of this type of role for improving Aboriginal and Torres Strait Islander child health outcomes. Families also identified Aboriginal and Torres Strait Islander health workers in the program as a critical support mechanism, providing firsthand knowledge and understanding of cultural obligations, as well as supporting a culturally responsive hospital environment.

In other jurisdictions, formal partnerships between children's hospitals and ACCHOs have been used as a key strategy to build relationships with the local Aboriginal and Torres Strait Islander community and improve the cultural responsiveness of hospital systems (e.g. the Wadja Aboriginal Family Place within the Royal Children's Hospital, Melbourne which is linked to the

Victorian Aboriginal Health Service). The Early Assessment and Referral Links (EARL) project in Victoria is another example of the benefits of investment in relationship building to improve maternal and child health services for Aboriginal and Torres Strait Islander families [49]. This is facilitated through monthly planning meetings between maternity and allied health services, the local ACCHOS, and local government agencies including child protection services, held predominantly at the ACCHOs to build community visibility of these services. The planning meetings involve discussion of clients (with their consent), case management including 'streamlined referrals' to local services to provide a 'wrap-around' service for the child, as well as sharing of knowledge about Aboriginal and Torres Strait Islander child-rearing practices. Participating agencies are self-funded to attend the planning meetings.

Early evaluation of this project has indicated increased engagement among Aboriginal and Torres Strait Islander families with maternal and child health services, increased referrals to allied health services and increased breastfeeding and immunisation rates[50]. There was also an increase in referrals to child protection services across the pilot program, but importantly, an overall reduction in out-of-home care for children following implementation.

The provision of outreach services in remote and regional communities has been evaluated as a strategy to increase access to ear, nose, and throat specialist care to address the high burden of otitis media among Aboriginal and Torres Strait Islander children. Available evidence indicates improved access to care[51]. Despite these small improvements, the quality of evidence to support implementation of outreach ear, nose and throat specialist care is generally low, with poor coordination, inconsistent involvement of local ACCHOs and lack of availability of a specialist noted as major impediments to the sustainability of this approach.

Across the literature there remains a lack of detailed information about other strategies to improve aspects of care coordination including information sharing. In the case of children with a disability, although not formally evaluated, suggested strategies for improving coordination of and culturally responsive care[43,44] include:

- Having standardised processes to identify needs for specific conditions and how to connect to relevant services, such as care plans.
- Promoting a stronger role for specialist disability support in ACCHOs and Aboriginal and Torres Strait Islander health worker positions.
- Use of case conferencing and other formal communication channels between the education and health sectors.
- Cross-sector networking and committees to share information and supports available.
- Promoting a shared goal and vision for the family between providers and the family.

- Provision of cultural mentorship of mainstream service providers, including specific resourcing for mentorship within service provision.
- Having requirements for organisations to demonstrate how they are working with relevant organisations such as ACCHOs (e.g., as a requirement for funding).
- Cross-sector governance to promote education and training providers to collaborate across sectors.

While these strategies have not been evaluated, they have relevance to improving coordination of care not only for children with disability, but also those with complex social needs.

Participation in quality improvement activities

There is clear evidence emerging from the primary health sector that participation in regular continuous quality improvement activities can increase the coverage of child health checks in regional and remote areas and improve the follow up of identified health problems[52]. The key strategies employed by services have generally focussed on aspects of relational and informational continuity including community engagement activities, audit and feedback against indicators related to processes of care and the establishment of recall and reminder systems. There is now a need to extend this to quality improvement strategies beyond the individual health service that target coordination of care across the primary and tertiary care sectors including specialist follow up care, as well as assessment of responsiveness to family needs[53].

Family-centred parenting programs and support initiatives for Aboriginal and Torres Strait Islander families, with a culturally responsive workforce

Early parenting programs provide an important opportunity to strengthen the connection between families and the health system and thus improve health and social outcomes. While there has been widespread roll out of mainstream structured parenting programs that have been adapted for Aboriginal and Torres Strait Islander families, such as the Australian Nurse-Family Partnership Program (ANFPP), there has been very little published evaluation of health and developmental outcomes for Aboriginal and Torres Strait Islander families participating in these programs nor the extent to which they assist with access to and coordination of care for children. Further, rigorous data on the extent to which Aboriginal and Torres Strait Islander families are engaging with the ANFPP is lacking. Nevertheless, there is some evidence that programs may reduce contact with the child protection system. Evidence from one community site for the ANFPP suggests involvement in the program when implemented by the local ACCHO reduced contact with the child protection system, particularly among families with younger and first-time mothers[54]. Ongoing evaluation of this model is occurring[55]. Positive effects on child protection notifications were also found in a small evaluation of an adapted version of the Triple P Parenting program[56].

There is also very little evidence about the impact of parenting programs developed specifically for Aboriginal and Torres Strait Islander families. Emerging evidence suggests that such programs may increase parenting confidence and reduce risk behaviours among Aboriginal and Torres Strait Islander children (as reviewed by Mildon & Polimeni 2012[57]). A key aspect of these programs has been a focus on building trusting relationships between health providers and families and thus building relational continuity. Strategies to achieve this have including the provision of care centred around the needs of the whole family including cultural and social needs, exchanging knowledge through yarning, a focus on family strengths, flexibility and Aboriginal and Torres Strait Islander health care provider led or peer led[58,59]. Measures of success reported in existing studies include sustained engagement of families throughout the program, including those with complex needs. Critical factors underpinning the success of these programs included investment in building the Aboriginal and Torres Strait Islander workforce and supporting this workforce with access to clinical support and the sharing of information and knowledge between health workers, midwives, and nurses to help problem solve and improve quality of care provided[58,59].

The engagement of Aboriginal and Torres Strait Islander families in less formal programs such as supported playgroups can improve access to and engagement with child health and community services and build awareness of child developmental issues among parents and the wider community. While there are relatively few evaluations of playgroups specifically for Aboriginal and Torres Strait Islander families, there is some evidence that participation in supported playgroups is associated with higher parental engagement in home learning activities, improved measures of child vocabulary and improved parenting confidence in Aboriginal and Torres Strait Islander families[60,61]. The key feature of existing playgroups for Aboriginal and Torres Strait Islander families is a focus on relationship development between staff and parents and through wider community engagement, again, highlighting the importance of relational continuity, being culturally responsive and building trust in health and social systems as a pathway to sustained engagement. Important learnings from these groups indicate that engagement can be enhanced by moving away from use of language regarding ‘parenting skills’ to instead using child health and development language to address longstanding mistrust and concerns about judgement of parenting skills.

Embedding family-centred care across the health system

The provision of family centred care is recognised as a core feature of providing culturally responsive care for Aboriginal and Torres Strait Islander children and families, as outlined in policy documents such as the National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families[62]. Key features of family centred approaches include: a focus on strengths and strengthening protective factors, addressing the needs of the whole family, promoting family choice and control over service responses, and the development of collaborative relationships between families and professionals.

While there are many examples of family centred care initiatives being implemented in the Aboriginal and Torres Strait Islander primary health care sector with emerging evidence of benefit in terms of access to and satisfaction with care (reviewed by McCalman et al[63]), there has been very little attention paid to understanding ways to practically embed family centred care in hospital and mainstream settings. Nevertheless, several key framework documents[1,63] provide broad direction on system enablers to support culturally responsive and family centred care including:

- A culturally respectful and non-discriminatory health system.
- Service provision that is flexible to respond to the needs of the family, that identifies and supports the strengths of the family rather than focuses on deficits and allows extended consultation times to build trust and enable providers to work with the whole family.
- Access to care based on proportionate universalism.
- Commitment to health equity and addressing the social determinants of health.
- Evidence-based practice informed by research and the experience of Aboriginal and Torres Strait Islander families.
- Supporting the cultural safety and development of the Aboriginal and Torres Strait Islander workforce and the cultural competence of the broader workforce at all levels of governance and service delivery.
- Aboriginal and Torres Strait Islander leadership and participation in design, development, implementation, delivery and evaluation of health services.
- Supportive Government policy and funding, including flexibility in funding mechanisms, and joint accountability and funding continuity across the service system to promote interagency and intergovernmental collaboration and coordination.

SUMMARY OF SYSTEM ENABLERS AND BARRIERS OPTIMISING ABORIGINAL AND TORRES STRAIT ISLANDER CHILD HEALTH AND WELLBEING

Enablers	Barriers

Aboriginal and Torres Strait Islander governance of Aboriginal and Torres Strait Islander specific services[62,64]	Fragmented care in silos resulting in families receiving care from multiple service providers with different priorities[41,43,44,48]
Aboriginal and Torres Strait Islander workforce that is supported with access to clinical expertise in a culturally safe environment[58,59,62,65]	Long wait lists resulting in delayed assessment of developmental issues (such as autism, developmental delay and fetal alcohol spectrum disorder) and access to treatment[40,42]
Cultural safety frameworks implemented and assessed in mainstream settings[40,62]	Financial barriers to access associated with transport and the requirement for multiple specialist services; high mobility of some Aboriginal and Torres Strait Islander families resulting in presentation to multiple services, without having a regular primary care provider[40,41,49]
Formal partnerships between hospital services and ACCHOS and other primary care providers, with clear demarcation of roles and responsibilities of each[40,50]	Lack of appropriate referral pathways as well as overlap, repetition and inefficiency in the referral process[41]
Investment in relationship development between services (workshops, regional planning meetings, co-design approaches) and building relationships with families[49,50,58]	Lack of information sharing between professions and services[43]
Designated care coordination roles, care planning and reminder systems[40] which are not reliant on text messaging alone as are	Services models not aligned or resourced to address the complex needs of some Aboriginal and Torres Strait Islander families and limited support for fathers[66,67]

problematic when families have no credit or change phone numbers.	
Engagement of clinicians and community-based services in the development of referral pathways, resourcing of clinical registers where appropriate	Lack of recognition of Aboriginal and Torres Strait Islander parenting practices in service models[47,50,57]
Provision of outreach clinics in the community and telehealth specialist care[40,51,68]	Lack of coordinated governance across the disability care sector[42,43]
Building the capacity of the ACCHO sector and Aboriginal and Torres Strait Islander health workers to deliver disability services	Lack of prioritisation of child health at a leadership level[69]
Participation in and resourcing of quality improvement initiatives designed to improve outcomes for Aboriginal and Torres Strait Islander families[52,53]	Lack of Aboriginal and Torres Strait Islander workforce in mainstream services, and high turn-over of staff in the early childhood sector[43]
Including appropriate communication strategies to build community awareness of child developmental issues[62]	Mistrust and concerns surrounding inappropriate child protection notifications by staff working in mainstream settings[40]
	Differential access to care across urban and remote settings[52]

AIM 3: To describe successful systems level approaches for improving the health of Aboriginal and Torres Strait Islander families that could be applied to promoting a healthy birthweight, a healthy start to life and the health and wellbeing of Aboriginal and Torres Strait Islander children.

To illustrate potential system level initiatives that may be relevant for strengthening the systems to promote a healthy start to life and Aboriginal and Torres Strait Islander child health and wellbeing, we present examples of successful international and local approaches that incorporate elements of systems redesign.

Institute for Urban Indigenous Health systems approach to care

The Institute for Urban Indigenous Health (IUIH) is an ACCHO that aims to provide continuity between primary, tertiary and community care for Aboriginal and Torres Strait Islander families in Southeast Queensland. This occurs by bringing together a network of ACCHOs to plan and coordinate service delivery with mainstream care in the region. In January 2021, IUIH released an evaluation of the services, completed by Deloitte, which included cases studies of three programs related to eye care (Cataract Pathway), referral planning (IUIH Connect) and the Birthing in Our Community program (BiOC) (described in Rapid Review 1). It included a discussion of the critical success factors to the IUIH model of service delivery and their transferability to other settings[70].

Key features of the three programs described included provision of 'wrap-around services' from a hospital to community interface linking acute care with culturally responsive primary health care and social care services. The common critical enabling factors for this model were: (a) relationships and governance operationalised as shared clinical, corporate and cultural governance across acute and primary care settings; shared models of care; partnerships with private hospitals to enable a bulk billed approach to elective surgeries at a reduced price; (b) providing a single point of care for clients in a trusted, culturally secure location; (c) joined up referral pathways in and out of acute care based on strong leadership and a commitment to a network approach with other health and referral services in the region; shared data and technology infrastructure; and (d) a dedicated workforce for coordination, operationalised as care coordinators, and having staff work across hospital and community based sites and outreach workers to assess patients who need support with care coordination. The programs have all showed important improvements in clinical outcomes including a reduction in patients failing to attend for cataract surgery, an increase in referrals for care from the hospital and community services, and in the case of the BiOC program, greater utilisation of antenatal care and a reduction in preterm birth among Aboriginal and Torres Strait Islander women, women of Aboriginal children and children.

Other important aspects of the IUIH approach include the centralised governance function of IUIH over a network of ACCHOs in the region, reflecting shared values, trust and relationships across these organisations. This regional approach provides greater 'purchasing power' through pooling of network wide funds and subcontracting arrangements to deliver savings across the network. Funding has been optimised by adopting a 'profit for purpose model' involving the generation of income from a wide range of sources including the Medical Benefits Schedule, non-government funding sources such as the Fred Hollows Foundation, self-generated income, as well as support from Queensland Health and other government organisations for IUIH infrastructure and some service provision. Profits are reinvested to provide a flexible pool of funding. The strong relationships built by IUIH with the acute sector reflect relationships built over the last 10 years demonstrating a long-term commitment to providing integrated care; yet the evaluation revealed a need to continue to work on and strengthen these relationships to reduce fragmentation of care. These findings demonstrate a successful model for Aboriginal and Torres Strait Islander led coordination of care based on an integration of care at a regional level across primary and acute settings.

Successful implementation strategies used to support integrated care of complex comorbidity

A recent publication by Looman et al[71] analysed and summarised the key mechanisms and successful implementation strategies used to support the delivery of integrated care for individuals with complex comorbidities, based on in-depth evaluations of 17 integrated care programs in Europe. A key goal of these programs was to reduce fragmentation of care across acute, primary and home care settings. Programs were selected based on criteria that involved a clear definition of integrated care for multi-morbidities, were innovative in the country's context, had outcome data, and provided care to at least 100 people. Following the analysis of program findings, the authors identified strategies across the key areas of service delivery, leadership and governance, workforce, financing, technology, information and research, as well as an overarching mechanism. The key strategies and approaches synthesis in these broad areas are listed in the table below:

Broad area	**Mechanisms/strategy**
Service delivery	1. Focus on incremental change in the system rather than 'disruptive innovation' approaches to allow relationships to be developed and address barriers in a stepwise approach 2. Allow flexibility in service delivery whilst still maintaining standardisation of roles and responsibilities of staff and organisations and formal relationships between organisations
Leadership and governance	3. Adopt collaborative governance by engaging all relevant stakeholders

	4. Distribute leadership across different levels of the health and social care system through management boards with equitable numbers of positions for key stakeholders
Workforce	5. Invest in creating a team culture with demarcation and recognition of individual roles 6. Development of new roles and competencies for integrated care including care coordinators or case managers
Financing	7. Secure long-term funding and adopt innovative payments to overcome fragmentation (e.g. pooled budgets, shared-savings/loss-agreements, incentivise integration)
Technology	8. Strengthen access to digital technologies to support communication and collaboration including shared information systems
Information and research	9. Invest in systemic collection of information and continuous quality improvement processes to provide feedback and monitoring of programs
Overarching mechanisms	10. Engage in alignment work that address micro, meso and macro-levels of integration including macro-level policies concerning financing, culture and technical systems

This summary highlights the importance of a broad range of strategies to improve health care and outcomes for individuals with complex needs, including strategies at all levels of the health system, targeting improved leadership and governance, a competent workforce, effective information systems and sustainable funding. The summary also points to the need for incremental approaches to achieve sustained improvements in the quality of health care systems.

Child FIRST intervention

The US-based Child FIRST intervention[72] was developed to reduce fragmentation of early childhood services, provide a ‘system of care’ for vulnerable families with a child up to 36 months of age, decrease psychosocial stress within important individuals in the child’s life and to promote child wellbeing. The goal was to deliver a coordinated, family focused approach, with flexibility to offer the spectrum and intensity of services based on individual family needs. Key features of this system of care approach include provision of support by a multidisciplinary team including clinical and social support and a care coordinator/ manager, a focus on relationship building and trust with families, delivery of therapeutic psychosocial support in the home with the intensity of support tailored to the needs of the family members, a focus on recognising and reinforcing strengths, offering flexibility at all times including when appointments were missed, and the development of a plan to deliver broad, integrated supports and community based services for all family members, which reflected family priorities, strengths, culture and needs.

Following implementation with 157 families with complex needs, families accessing this service had significantly higher engagement with services than those offered standard care, reported lower levels of parenting stress, had substantially less child protection service involvement and the children have improved language and externalising symptom scores. Key features of this approach include a dedicated focus on mental health outcomes and reducing distress among parents, and the flexibility to offers services to 'wrap-around the whole family', at varying levels of intensity and in the home environment.

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Appendix B Aboriginal Families Study - Child health data

Child health issues experienced by school age Aboriginal and Torres Strait Islander children in South Australia

Background

This brief report has been prepared by the Aboriginal Families Study based on data collected in wave 2 follow-up of Aboriginal and Torres Strait Islander families living in urban, regional, and remote areas of SA.

The Aboriginal Families Study is a prospective cohort of 344 Aboriginal and Torres Strait Islander children and their mothers and carers. Families recruited to the study are Aboriginal and Torres Strait Islander families that had a baby in SA between July 2011 and June 2013. Around one quarter of all Aboriginal and Torres Strait Islander mothers who had a baby in SA during this period were recruited to the study. Mothers completed a questionnaire about their own health and their baby's health when the study children were around 4-10 months of age. Wave 2 follow-up of the cohort was undertaken when the children were in early primary school (mean age = 6.5 years).

The study - funded by the National Health and Medical Research Council - is being conducted by the Intergenerational Health group at Murdoch Children's Research Institute (MCRI) in partnership with the Aboriginal Health Council of South Australia (AHCSA) and the South Australian Health and Medical Research Institute (SAHMRI). Further information about the study is available on our study website (https://www.strongerfutures.org.au/aboriginal-families-study) or by contacting the lead investigator (stephanie.brown@mcri.edu.au).

The study is guided by an Aboriginal Advisory Group auspiced by the AHCSA. The Advisory Group was established in 2007 and has met 5-6 times a year since this time to guide community engagement, co-design, and conduct of the study and interpretation of study findings. The Aboriginal Advisory Group has approved release of these preliminary data for the purpose of informing the Closing the Gap Aboriginal and Torres Strait Islander Continuity of Care protocol (pregnancy to age 5).

About the families taking part

Of the 344 families recruited to the study, 251 (72%) have taken part in wave 2 follow-up. Postcodes were used to classify families as living in a major city, inner regional, outer regional, remote, or very remote area using the Australian Bureau of Statistics Remoteness Structure - a measure of relative access to services. These have been combined into urban, regional, and remote for the purpose of this report.

Just under half of the study children (113, 45%) were living in Adelaide at the time of wave 2 follow-up, 91 (36%) were living in regional areas and 47 (19%) were living in remote areas of SA (see Tables 1a and 1b). Over 90% of study children were living with their mother, and 9.6% were living with a carer (often a family member). The mean age of the study children at follow-up was 6.5 years (range 5-9 years of age).

A majority (65%) of the children living with their mother were in households where two or more adults were living in the household, and just over a third (34%) were in households with no other adults apart from their mother. It was common for mothers to be caring for three or more children. Almost half (49%) of mothers were not in a relationship at the time of follow-up. Overall, 58% of mothers had three or more children: 52% in Adelaide, 59% in regional areas and 79% in remote communities. Most mothers (77.5%) had a health care concession card, and very few had private health insurance (11.5%). One third of mothers (and study children living with them) had moved house three or more times in the 5 years prior to wave 2 follow-up.

Table 1a. Socio-demographic characteristics of mothers and carers of study children aged 5-9 years

	Total (n = 251)	**Urban (n=113)**	**Regional (n=91)**	**Remote (n=47)**	Test of statistical significance
	n (%)	n (%)	n (%)	n (%)	
Mothers' and carers' characteristics					
Age at wave 2 follow-up					
Mothers (n=227, Mean, SD)	32.3 (5.7)*	31.6 (5.2)	32.7 (6.3)	33.3 (5.3)	p=0.192
Carers (n=24, Mean SD)	50.4 (13.4)*	47.3 (13.9)	51.8 (15.8)	52.4 (6.4)	p=0.738
20-24 years	12 (4.8)	5 (4.4)	6 (6.6)	1 (2.1)	p=0.088
25-29 years	82 (32.7)	47 (41.6)	26 (28.6)	9 (19.1)	
30-34 years	77 (30.7)	31 (27.4)	27 (29.7)	19 (40.4)	
≥ 35 years	80 (31.9)	30 (26.5)	32 (35.2)	18 (38.3)	
Aboriginal and/or Torres Strait Islander (mothers and carers)					
Aboriginal	221 (88.0)	100 (88.5)	76 (83.5)	45 (95.7)	p=0.596
Torres Strait Islander	2(0.8)	1 (0.9)	1 (1.1)	0	
Aboriginal and Torres Strait Islander	2 (0.8)	1 (0.9)	1 (1.1)	0	
Not Aboriginal/Torres Strait Islander	26 (10.4)	11 (9.7)	13 (14.3)	2 (4.3)	
Mothers' characteristics					
Adults living with mother					
None	86 (34.8)	39 (35.1)	37 (41.1)	10 (21.7)	p=0.017

One	119 (48.2)	55 (49.5)	43 (47.8)	21 (45.7)	
Two or more	42 (17.0)	17 (15.3)	10 (11.1)	15 (32.6)	
Relationship status					
Living with partner	93 (41.2)	44 (42.3)	31 (38.8)	18 (42.9)	p=0.701
In relationship, not living with partner	22 (9.7)	10 (9.6)	6 (7.5)	6 (14.3)	
Not in relationship with partner	111 (49.1)	50 (48.1)	43 (53.8)	18 (42.9)	
Children living with mother					
None	8 (3.2)	5 (4.4)	3 (3.4)	0	p=0.188
1 – 2	95 (38.3)	49 (43.4)	33 (37.1)	13 (28.3)	
3 – 10	145 (58.5)	59 (52.2)	53 (59.6)	33 (71.7)	
Moved house (past 5years)					
None	49 (22.0)	22 (21.4)	13 (16.7)	14 (33.3)	p=0.075
1–2 times	102 (45.7)	41 (39.8)	42 (53.8)	19 (45.2)	
3 or more times	72 (32.3)	40 (38.8)	23 (29.5)	9 (21.4)	
Health care concession card					
Yes	176 (77.5)	81 (77.1)	62 (77.5)	33 (78.6)	p=0.983
No	51 (22.5)	24 (22.9)	18 (22.5)	9 (21.4)	
Private Health Insurance					
Yes	26 (11.5)	19 (18.1)	5 (6.3)	2 (4.8)	p=0.014
No	201 (88.5)	86 (81.9)	75 (93.8)	40 (95.2)	
Paid employment					
Yes	78 (34.5)	38 (36.5)	22 (27.5)	18 (42.9)	p=0.200

No	148 (65.5)	66 (63.5)	58 (72.5)	24 (57.1)	
Currently studying					
Yes	37 (16.3)	20 (19.0)	9 (11.3)	8 (19.0)	p=0.315
No	190 (83.7)	85 (81.0)	71 (88.8)	34 (81.0)	
Highest education					
Year 10 or less	117 (52.5)	48 (46.6)	44 (55.7)	25 (61.0)	p=0.228
Completed Year 12	34 (15.2)	15 (14.6)	15 (19.0)	4 (9.8)	
Diploma/Certificate/Degree	72 (32.3)	40 (38.8)	20 (25.3)	12 (29.3)	

Notes: M = Mean; SD = Standard Deviation; *mean age difference between mothers and carers was 18.2 years (p < 0.001)

Table 1b. Socio-demographic characteristics of study children aged 5-9 years

	Total (n = 251)	**Urban (n=113)**	**Regional (n=91)**	**Remote (n=47)**	Test of statistical significance
	n (%)	n (%)	n (%)	n (%)	
Study children's characteristics					
Child age: M (SD)	6.5 (1.0)	6.5 (1.0)	6.4 (1.0)	6.8 (.96)	p = 0.143
Child age categories					
5-6 years	139 (55.4)	65 (57.5)	54 (59.3)	20 (42.6)	p = 0.141
7-9 years	112 (44.6)	48 (42.5)	37 (40.7)	27 (57.4)	
Child Gender					
Male	139 (55.4)	66 (58.4)	49 (53.8)	24 (51.1)	p = 0.651
Female	112 (44.6)	47 (41.6)	42 (46.2)	23 (48.9)	
Child's biological father					
Aboriginal	180 (73.8)	77 (68.8)	62 (72.9)	41 (87.2)	p = 0.332
Torres Strait Islander	3 (1.2)	2 (1.8)	1 (1.2)	0	
Aboriginal and Torres Strait Islander	5 (2.0)	3 (2.7)	1 (1.2)	1 (1.2)	

Not Aboriginal/Torres Strait Islander	56 (23.0)	30 (26.8)	21 (24.7)	5 (10.6)	

Notes: M = Mean; SD = Standard Deviation

Health and wellbeing of study children

Health issues experienced by the study children, identified by the mother or carer, or by a doctor, are shown in Table 2 and Figure 1.

The most common health issues mothers or carers reported that their children experienced in the 12 months prior to wave 2 follow-up were:

- ear health issues (e.g. infections) (27.1%)
- dental problems (26.4%)
- allergy/eczema (21.9%)
- anxiety (19.5%)
- asthma/chronic cough (19.2%)
- sleep problems (13.5%)

Other health issues experienced by the study children include: vision/eye problems (13.1%), hearing problems (10.0%), skin infections (11.8%) and injuries (9.7%).

One in four children (23.9%) experienced one or more developmental and/or emotional and behavioural difficulties that had been diagnosed by medical practitioners. These included:

- learning difficulties (15.7% of children)
- speech problems (15.7% of children)
- attention difficulties (6.8% of children)
- emotional and/or behavioural difficulties (8.5% of children)
- attention difficulties (6.8% of children)
- developmental difficulties (6.8% of children)
- autism (6.4% of children)
- disability (4.3% of children).

We note that these estimates do not include any conditions children were experiencing which had not yet been diagnosed by a medical practitioner. Thus, findings are likely to understate the true prevalence of these conditions, especially for families where there are barriers to accessing services. All findings should be considered with these limitations in mind.

We have stratified these data according to whether the study children were living in urban, regional or remote areas of SA at the time of follow-up. In Table 2, we have reported the odds of children living in regional and remote areas experiencing each health issue compared with children living in Adelaide. Values above one indicate higher odds and greater likelihood of experiencing individual health issues and odds below one indicate lesser likelihood. Odds ratios are shown with 95% confidence intervals. When the confidence interval crosses one, this indicates that differences may have occurred by chance. In Figure 2, we present the same data in graphical format. The error bars on these graphs represent the 95% confidence interval around the estimate of prevalence. The true estimate may lie anywhere between this range. While we recognise there might not be full recognition of the health issues children experience, the results show that these health issues are experienced at high rates by children living in urban, regional and remote areas of SA. Notably, it is evident that the prevalence of ear health issues is high both among children living in Adelaide (31.2%) and children living in remote communities (34.8%).

The relatively small numbers once data are stratified in this way requires some caution in the interpretation of odds ratios and 95% confidence intervals. It is possible that some effects that failed to reach statistical significance reflect real differences. For example, the higher prevalence of perforated ear-drums among children living in remote communities (9.5%) compared with children living in urban communities (1.9%) and higher proportion of children in remote communities experiencing hearing difficulties (18.2% versus 8.7% in Adelaide) are likely to be a real effects. Allergies, eczema and skin infections also appear to be more common in remote communities. However, overall it is evident that high rates of health issues are experienced by children living in Adelaide as well as those living in remote areas of SA.

Table 2. Child health problems in previous 12 months (at age 5-9 years)

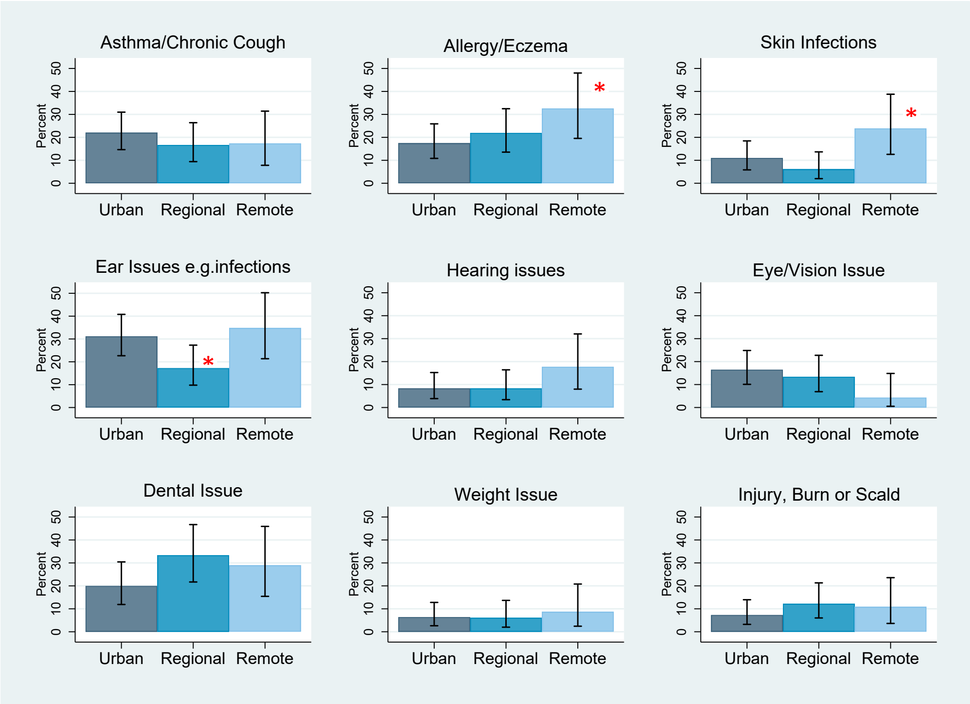
	Total (n = 251)	**Urban (n=113)**	**Regional (n=91)**
	n (%)	n (%)	n (%)
Identified by mother or carer			
Asthma/chronic cough	46 (19.2)	24 (22.0)	14 (16.7)
OR (95% CI)		*1.0 (ref)*	*0.7 (0.3 - 1.5)*
Allergy/Eczema	52 (21.9)	19 (17.4)	18 (22.0)
OR (95% CI)		*1.0 (ref)*	*1.3 (0.6 - 2.7)*
Skin infections	28 (11.8)	12 (11.0)	5 (6.1)
OR (95% CI)		*1.0 (ref)*	*0.5 (0.2 – 0.9)*
Ear health issues (e.g. infections)	64 (27.1)	34 (31.2)	14 (17.3)
OR (95% CI)		*1.0 (ref)*	***0.5* (0.2 - 0.9)***
Ear ache	57 (24.4)	30 (27.8)	13 (16.0)
OR (95% CI)		*1.0 (ref)*	*0.5 (0.2 – 1.0)*
Glue ear/fluid	17 (7.5)	10 (9.6)	1 (1.3)
OR (95% CI)		*1.0 (ref)*	***0.1* (0.0 – 1.0)***
Perforated ear drum	8 (3.6)	2 (1.9)	2 (2.5)
OR (95% CI)		*1.0 (ref)*	*1.3 (0.2 – 9.6)*
Runny ears	16 (7.1)	7 (6.7)	5 (6.3)
OR (95% CI)		*1.0 (ref)*	*0.9 (0.3 – 3.0)*
Hearing problems	24 (10.5)	9 (8.7)	7 (8.6)
OR (95% CI)		*1.0 (ref)*	*1.0 (0.4 - 2.8)*
Dental/oral health (e.g., decay)	47 (26.4)	16 (20.0)	20 (33.0)
OR (95% CI)		*1.0 (ref)*	*2.0 (0.9 - 4.3)*
Eye/vision issues	31 (13.1)	18 (16.5)	11 (13.4)
OR (95% CI)		*1.0 (ref)*	*0.8 (0.3 - 1.8)*
Sleep concerns	32 (13.5)	15 (13.8)	11 (13.4)
OR (95% CI)		*1.0 (ref)*	*0.9 (0.4-2.2)*
Anxiety	46 (19.5)	25 (22.9)	15 (18.3)
OR (95% CI)		*1.0 (ref)*	*0.7 (0.4-1.5)*

Injuries (e.g., burn, injury)	23 (9.7)		8 (7.3)	10 (12.2)	5 (10.9)
OR (95% CI)			*1.0 (ref)*	*1.8 (0.7 – 4.7)*	*1.5 (0.5 - 5.0)*
Doctor identified					
Speech problem	37 (15.7)		16 (14.7)	15 (19.0)	6 (12.8)
OR (95% CI)			*1.0 (ref)*	*1.4 (0.6 - 3.0)*	*0.9 (0.3 - 2.3)*
Autism	*15 (6.4)*		6 (5.5)	6 (7.6)	3 (6.4)
OR (95% CI)		*1.0 (ref)*	*1.4 (0.4- 4.5)*	*1.1 (0.3- 4.9)*	
Attention issues (e.g., ADHD)	16 (6.8)	6 (5.5)	8 (10.1)	2 (4.3)	
OR (95% CI)		*1.0 (ref)*	*1.9 (0.6- 5.8)*	*0.8 (0.1- 3.9)*	
Learning difficulty	37 (15.7)	16 (14.7)	15 (19.0)	6 (12.8)	
OR (95% CI)		*1.0 (ref)*	*1.4 (0.6 – 3.0)*	*0.9 (0.3 - 2.3)*	
Emotion/behavioural issues	20 (8.5)	10 (9.2)	6 (7.6)	4 (8.5)	
OR (95% CI)		*1.0 (ref)*	*0.8 (0.3 - 2.3)*	*0.9 (0.3 - 3.1)*	
Developmental issues	16 (6.8)	9 (8.3)	4 (5.1)	3 (6.4)	
OR (95% CI)		*1.0 (ref)*	*0.6 (0.2 - 2.0)*	*0.8 (0.2 - 2.9)*	
Disability	10 (4.3)	2 (1.8)	5 (6.3)	3 (6.4)	
OR (95% CI)		*1.0 (ref)*	*3.6 (0.7 - 19.1)*	*3.6 (0.6 - 22.6)*	
Any of the above	60 (23.9)	28 (24.8)	23 (25.3)	9 (19.1)	
OR (95% CI)		*1.0 (ref)*	*1.0 (0.5 – 1.9)*	*0.7 (0.3 - 1.7)*	

Notes: OR = Odds Ratio; 95% CI = 95% confidence intervals; $^{*}p < 0.05$

Figure 1. Child health problems in past 12 months by region child was living in at time of follow up

Child diet



Mothers/carers participating in follow-up were asked to report on fruit and vegetable consumption, and consumption of sugary drinks, fish meals and snack foods (see Tables 3-7). Mothers/carers (n=251) reported that their children consumed a mean of 2.5 serves of vegetables, two serves of fruit, and two serves of snack foods on the previous day, with little variation between geographical locations. They reported that 75% of children consumed at least one serve of vegetables, and 85% of children consumed at least one serve of fruit on the previous day.

Mothers/carers reported that just over half of children (52%) did not consume soft drinks on the previous day. Children's soft drink consumption on the previous day was lower in urban areas (4% consumed 3 or more soft drinks; mean 0.8 serves a day) than in remote areas (14% consumed 3 or more soft drinks per day; 1.3 serves a day).

Mean fish consumption by children was 0.6 meals in the past week, with a third of children (34%) consuming fish in the past week. There was slightly higher consumption in urban areas compared with regional or remote areas.

Take away meals were consumed 1.6 times a week by children, with little variation between regions. Just over half (58%) the children had consumed one or two takeaway meals, and a further 19% had consumed three or more takeaway meals, in the past week, with no clear variation between regions.

Just over a third of children (36%) were overweight or obese, with no clear variation between regions (See Table 8).

Table 3. Mother or carer reported child nutrition and diet by urban, rural and remote areas (continuous)

	Total N = 251	Urban N = 113	Regional N = 91	Remote N = 47	Test of statistical

Domains	**Descriptive statistics: Mean (SD)**				**significance***
(yesterday)					
Vegetables	2.52 (1.98)	2.63 (2.08)	2.26 (1.67)	2.64 (2.25)	p = 0.428
Fruits	1.87 (1.40)	1.91 (1.43)	1.73 (1.48)	2.04 (1.17)	p = 0.461
Soft drinks	0.81 (1.12)	0.54 (0.87)	0.95 (1.22)	1.26 (1.34)	**p = 0.006**
Snack foods	2.11 (1.54)	2.19 (1.41)	2.00 (1.78)	2.14 (1.37)	p = 0.696
(past week)					
Fish meals	0.56 (0.97)	0.71 (1.11)	0.42 (0.76)	0.48 (0.92)	p = 0.143
Take away meals	1.57 (1.35)	1.52 (1.48)	1.59 (1.21)	1.67 (1.30)	p = 0.822

Notes: Test of statistical significance* analysis of variance anova

Table 4. Mother or carer reported child nutrition and diet by urban, rural and remote areas

	Total N = 251	**Urban N = 113**	**Regional N = 91**	**Remote N = 47**	**Test of statistical significance**
Domains	Descriptive statistics: Median				
(yesterday)					
Vegetables	3	3	2	2.5	p = 0.428
Fruits	2	2	2	2	p = 0.461
Soft drinks	0	0	0.5	1	p = 0.006
Snack foods	2	2	2	2	p = 0.698
(past week)					
Fish meals	0	0	0	0	p = 0.143
Take away meals	1	1	2	1	p = 0.822

Table 5. Mother or carer reported child nutrition and diet (continuous with details)

	Descriptive Statistics				
Domains	**Mean**	**SD**	**Min**	**Max**	**Median**
(yesterday)					
Vegetables	2.52	1.98	0	9	3
Fruits	1.87	1.40	0	9	2
Soft drinks	.81	1.12	0	6	0
Snack foods	2.11	1.54	0	8	2
(past week)					
Fish meals	.56	.97	0	7	0
Take away meals	1.57	1.35	0	8	1

Table 6. Mother or carer reported child nutrition and diet (ordinal)

	N = 251 n (%)					
	Yesterday				Past Week	
How many	**Vegetables**	**Fruits**	**Soft drinks**	**Snack food**	**Fish meals**	**Take away**
0	56 (24.7)	35 (15.4)	117 (51.5)	24 (10.5)	148 (65.8)	51 (22.4)
1	19 (8.5)	54 (23.8)	67 (29.5)	63 (27.5)	44 (19.6)	71 (31.1)
2	34 (15.2)	88 (38.8)	24 (10.6)	68 (29.7)	24 (10.7)	62 (27.2)
3	45 (20.1)	25 (11.0)	11 (4.8)	42 (18.3)	5 (2.2)	23 (10.1)
4	35 (15.6)	13 (5.7)	4 (1.8)	16 (7.0)	3 (1.3)	17 (7.5)
5	24 (10.7)	8 (3.5)	3 (1.3)	8 (3.5)	1 (0.4)	2 (0.9)
6	5 (2.2)	2 (0.9)	1 (0.4)	4 (1.7)	-	1 (0.4)
7	5 (2.2)	1 (0.4)	-	4 (1.7)	-	1 (0.4)
9	2 (0.9)	1 (0.4)	-	-	-	

Table 7. Mother or carer reported child nutrition and diet by urban, rural and remote areas (categorical)

	Total N = 251	**Urban N = 113**	**Regional N = 91**	**Remote N = 47**	**Test of statistical significance***
Domains	n (%)	n (%)	n (%)	n (%)	
(yesterday)					
Vegetables					

None	56 (24.7)	27 (25.2)	18 (23.1)	11 (26.2)	
One or two	55 (24.2)	21 (19.6)	24 (30.8)	10 (23.8)	
Three and more	116 (51.1)	59 (55.1)	36 (46.2)	21 (50.0)	p= 0.529
Fruits					
None	35 (15.4)	14 (13.0)	18 (23.1)	3 (7.1)	
One or two	142 (62.3)	68 (63.0)	47 (60.3)	27 (64.3)	
Three and more	51 (22.4)	26 (24.1)	13 (16.7)	12 (28.6)	p= 0.118
Soft drinks					
None	118 (51.8)	66 (61.1)	39 (50.0)	13 (31.0)	
One or two	91 (39.9)	38 (35.2)	30 (38.5)	23 (54.8)	
Three and more	19 (8.3)	4 (3.7)	9 (11.5)	6 (14.3)	**p= 0.008**
Snack food					
None	24 (10.5)	8 (7.4)	13 (16.7)	3 (7.0)	
One or two	131 (57.2)	60 (55.6)	44 (56.4)	27 (62.8)	
Three and more	74 (32.3)	40 (37.0)	21 (26.9)	13 (30.2)	p= 0.190
(past week)					
Fish meals					
None	148 (65.8)	61 (58.1)	57 (73.1)	30 (71.4)	
One or two	68 (30.2)	38 (36.2)	20 (25.6)	10 (23.8)	
Three and more	9 (4.0)	6 (5.7)	1 (1.3)	2 (4.8)	p= 0.171
Take away meals					
None	51 (22.4)	29 (27.1)	15 (19.2)	7 (16.3)	
One or two	133 (58.3)	57 (53.3)	50 (64.1)	26 (60.5)	
Three and more	44 (19.3)	21 (19.6)	13 (16.7)	10 (23.3)	p= 0.446

Notes: Test of statistical significance* chi squared

Table 8. Child BMI by urban, rural, and remote residential areas (n=184)#

	Total N = 184	**Urban N = 89**	**Regional N = 55**	**Remote N = 40**	**Test of statistical significance***
	n (%)	n (%)	n (%)	n (%)	

Child BMI					
Average weight	113 (64.2)	58 (69.0)	34 (65.4)	21 (52.5)	
Over-weight / obese	63 (35.8)	26 (31.0)	18 (34.6)	19 (47.5)	p= 0.195

Notes: Test of statistical significance* chi squared**;** **#** Data only available for children who completed child activity based assessments

Use of health services

Primary health care

We also asked mothers and carers of the study children to report on contacts that they had with general practitioners, child health nurses, Aboriginal and Torres Strait Islander health workers and dentist/dental nurses with regard to the study children's health in the 12 months prior to wave 2 follow-up.

As with the data reported in Table 2 and Figure 1, we have stratified these data according to whether the study children were living in urban, regional and remote areas of SA at the time of follow-up. In Table 9 we report odds ratios and 95% confidence intervals for the odds of children having seen health professionals in the previous 12 months comparing children living in regional and remote areas with children living in Adelaide. In Figure 2 we display some of these data graphically.

The majority of the study children had seen a GP at least once in the previous 12 months:

- 80.7% in Adelaide
- 75.6% in regional areas, and
- 86.7% in remote communities.

A third of children in Adelaide and regional areas had seen a child health nurse, compared with 74.5% in remote communities where access is likely to have been via a local Aboriginal health service.

Similarly, around a third (32.4%) of children in Adelaide, and a slightly higher proportion in regional areas (46.3%) had seen an Aboriginal and Torres Strait Islander health worker, compared with 80.9% in remote communities.

Half of children in Adelaide (51.0%) had seen a dentist or dental nurse in the previous 12 months, compared with 46.0% in regional areas and 59.5% in remote communities. Of the children experiencing tooth decay or other dental health problems, more than one in three had not seen a dentist or dental health nurse in the previous 12 months: 37.5% of children living in Adelaide, 44.4% of children living in regional areas and 40% of children living in remote communities.

Specialist and allied health care

Mothers and carers were also asked to report on whether the study children had seen a paediatrician and a range of allied health professionals in the previous 12 months (see Table 9).

Around one in three children had seen a paediatrician in the previous 12 months:

- 29.4% in Adelaide
- 28.0% in regional areas
- 40.4% in remote communities.

Reflecting the high prevalence of ear health issues:

- 12.8% of children in Adelaide, 9% in regional areas and 19.1% in remote areas had seen an ear, nose and throat (ENT) specialist

- 32.1% of children in Adelaide, 30.5% in regional areas and 48.9% in remote areas had been assessed by an audiologist
- 21.1% of children in Adelaide, 34.1% in regional areas and 27.7% in remote areas had seen a speech pathologist.

Looking solely at the children experiencing ear health issues in the previous 12 months (27% of children overall),

- 38% of children in Adelaide, 43% in regional areas and 56% in remote communities had seen a paediatrician in the previous 12 months
- 29% of children in Adelaide, 36% in regional areas and 44% in remote communities had seen an ear, nose and throat specialist in the previous 12 months
- 38% of children in Adelaide, 50% in regional areas and 63% in remote communities had been assessed by an audiologist in the previous 12 months
- 38% of children in Adelaide, 43% in regional areas and 38% in remote communities has seen a speech therapist at least once in the previous 12 months.

Around one in three children living in Adelaide (30.3%) or regional areas (35.4%) had seen an optometrist, and one in five in remote communities (23.4%).

Overall, around one in seven children had seen a psychologist or counsellor in the previous 12 months:

- 17.4% in Adelaide
- 12.2% in regional areas
- 17.0% in remote communities.

Looking solely at the children with identified (i.e. medically diagnosed) emotional and/or behavioural issues (8.6% of children),

- 53% of children living in Adelaide, 78% in regional areas and 80% in remote communities had seen a paediatrician at least once in the previous 12 months
- 35% of children living in Adelaide, 44% in regional areas and 40% in remote communities had seen a psychologist or counsellor at least once in the previous 12 months.

Finally, around one in ten children had seen a physiotherapist in the previous 12 months:

- 11% in Adelaide
- 11% in regional areas
- 17% in remote communities.

Tertiary health care

We also inquired about children's visits to hospital in the 12 months prior to wave 2 follow-up (see Table 9).

Of the children living in Adelaide:

- 17% had visited an Emergency Department
- 9% had been admitted to hospital
- 16% had visited a hospital outpatients department.

Of the children living in regional areas:

- 22% had visited an Emergency Department
- 12% had been admitted to hospital
- 16% had visited a hospital outpatients department.

Of the children living in remote areas:

- 28% had visited an Emergency Department

- 15% had been admitted to hospital
- 15% had visited a hospital outpatients department.

Overall, the results suggest comparable rates of accessing primary health care or specialist and allied health care comparing children living in regional and remote areas with children living in Adelaide.

Three exceptions to this overall pattern were that child health nurses, Aboriginal and Torres Strait Islander Health Workers and audiology were accessed by a higher proportion of families in remote communities.

Of note, not all children experiencing individual health problems, such as oral health issues, ear health issues or emotional and behavioural difficulties appear to have had access to appropriate primary, specialist and allied health care. There are significant gaps in children's access to dental health care, and while not all children with ear health issues may require specialist involvement, audiology or referral to a speech pathologist, it does appear that some children may not be receiving adequate follow-up or referral across urban, regional and remote areas of SA. Similarly, a large proportion of children with medically diagnosed emotional and behavioural difficulties had not seen a psychologist or counsellor in the previous 12 months.

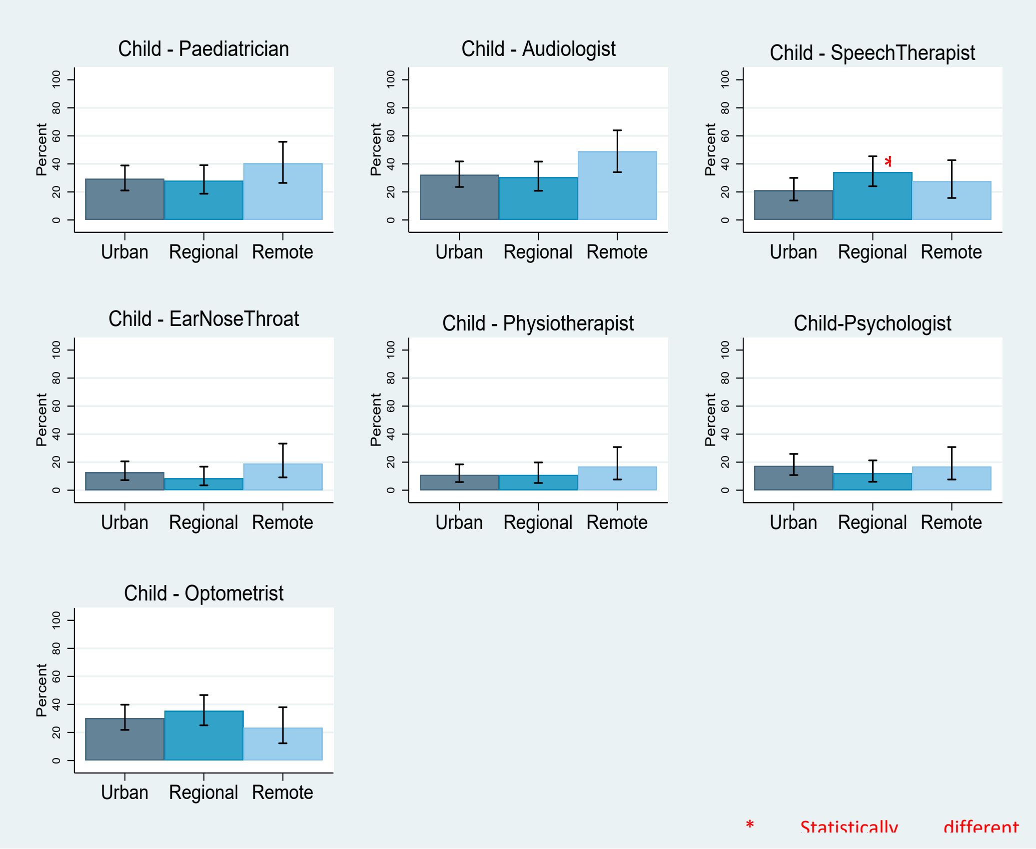
Table 9. Health service utilisation by study children in previous 12 months (at 5-9 years of age)

	Urban	**Regional**	**Remote**
	(n=113)	**(n=91)**	**(n=47)**
	n (%)	n (%)	n (%)
Primary Health care			
General Practitioner	88 (80.7)	62 (75.6)	39 (86.7)
OR (95% CI)	*1.0 (ref)*	*0.7 (0.4 - 1.5)*	*1.6 (0.6 – 4.1)*
Child Health Nurse	38 (35.2)	27 (32.9)	35 (74.5)
OR (95% CI)	*1.0 (ref)*	*0.9 (0.5 - 1.7)*	***5.4*********(2.5 – 11.6)***
Aboriginal Health Worker	35 (32.4)	38 (46.3)	38 (80.9)
OR (95% CI)	*1.0 (ref)*	*1.8 (1.0 - 3.3)*	***8.8*********(3.8 - 20.2)***
Dentist/dental nurse	53 (51.0)	36 (45.0)	25 (59.5)
OR (95% CI)	*1.0 (ref)*	*0.8 (0.4 – 1.4)*	*1.4 (0.7 – 2.9)*
Specialist and Allied Health care			
Audiologist	35 (32.1)	25 (30.5)	23 (48.9)
OR (95% CI)	*1.0 (ref)*	*0.9 (0.5 - 1.7)*	***2.0*******(1.0 - 4.1)***
Optometrist	33 (30.3)	29 (35.4)	11 (23.4)
OR (95% CI)	*1.0 (ref)*	*1.3 (0.7 - 2.3)*	*0.7 (0.3 - 1.5)*
Physiotherapist	12 (11.0)	9 (11.0)	8 (17.0)
OR (95% CI)	*1.0 (ref)*	*1.0 (0.4 - 2.5)*	*1.7 (0.6 - 4.4)*
Speech therapist	23 (21.1)	28 (34.1)	13 (27.7)
OR (95% CI)	*1.0 (ref)*	*1.9***(1.0 - 3.7)*	*1.4 (0.7 - 3.1)*
Psychologist/counsellor	19 (17.4)	10 (12.2)	8 (17.0)
OR (95% CI)	*1.0 (ref)*	*0.7 (0.3 - 1.5)*	*1.0 (0.4 - 2.4)*
Paediatrician	32 (29.4)	23 (28.0)	19 (40.4)
OR (95% CI)	*1.0 (ref)*	*0.9 (0.5 - 1.8)*	*1.6 (0.8 - 3.3)*

Ear nose & throat specialist	14 (12.8)	7 (8.5)	9 (19.1)
OR (95% CI)	*1.0 (ref)*	*0.6 (0.2 - 1.6)*	*1.6 (0.6 - 4.0)*
Tertiary Health care			
Emergency Department	18 (16.5)	18 (22.0)	13 (27.7)
OR (95% CI)	*1.0 (ref)*	*1.4 (0.7 - 2.9)*	*1.9 (0.9 - 4.4)*
Hospital admission	10 (9.3)	10 (12.0)	7 (15.2)
OR (95% CI)	*1.0 (ref)*	*1.3 (0.5 - 3.4)*	*1.7 (0.6 - 4.9)*
Hospital outpatient clinic	17 (16.0)	13 (15.7)	7 (15.2)
OR (95% CI)	*1.0 (ref)*	*1.0 (0.4 - 2.1)*	*0.9 (0.4 - 2.4)*

Notes: OR = Odds Ratio; 95% CI = 95% confidence intervals; * *p* < 0.05, ** *p* < 0.01, *** *p* < 0.001

Figure 2. Health care utilisation: study children in past 12 months at time of follow up (5-9 years)



Children’s mental health and social and emotional wellbeing

There are no culturally validated measures of Aboriginal and Torres Strait Islander children’s mental health and social and emotional wellbeing that are age appropriate for 5–9-year-old children.

Mothers and carers of the study children were asked to complete a standardised 25-item measure of children’s emotions and behaviours, called the Strengths and Difficulties Questionnaire (SDQ). The SDQ includes subscales designed to assess emotional problems, conduct problems, hyperactivity, peer relationship problems and prosocial skills. The subscales for emotional problems, conduct problems, hyperactivity, and peer relationship problems are summed to assess the total difficulties score.

The SDQ was selected for inclusion in the Aboriginal Families Study as it has been used previously in a number of studies involving Aboriginal and Torres Strait Islander children, including the West Australian Aboriginal Child Health Survey (WAACHS) and the Longitudinal Study of Indigenous Children (LSIC). The WAACHS identified higher prevalence of social and emotional difficulties among Aboriginal children (aged 4-17 years) compared to non-Aboriginal children (24% versus 15%).

The overall distribution of the SDQ total difficulties scores for children in the Aboriginal Families Study cohort are shown in Table 10 (below).

Table 10. Overall distribution of total difficulties scores on the Strengths and Difficulties Questionnaire (n=232)

SDQ total difficulties score	Number	%
Close to average (0-13)	161	69.4
Slightly raised (14-16)	26	11.2
High (17-19)	21	9.0
Very high (20-40)	24	10.3

Almost one in five children (19.3%) were scored by their mother or carer in the high/very high range indicating that the children were experiencing significant emotional and/or behavioural difficulties. A further 11.2% of children had slightly raised scores suggesting that they may be at risk of social and emotional difficulties.

In order to assess the extent to which children experiencing emotional and/or behavioural difficulties had received clinical support in the previous 12 months, we looked at what mothers and carers had told us about children’s contacts with specialist and allied health services.

Figure 3 reports the children’s contact with specialist paediatricians and psychologists/counsellors in the previous 12 months by their score on the SDQ for the total sample. The figure shows that while many children have had contact with a paediatrician and/or a psychologist, almost one in three children (14/45, 31.8%) with scores in the high to very high range on the SDQ had not been seen a paediatrician or psychologist in the previous 12 months.

We also looked carefully at the children whose mothers/carers said that they had been diagnosed by a medical or other health practitioner with developmental conditions (e.g. autism, attention problems, learning difficulties, speech or language difficulties or emotional/behavioural problems). These children accounted for just over half of the children who scored in the high to very high range (24/45, 53.3%), shown in Figure 4. The children who scored in the high to very high range without a diagnosis of a developmental concern being given (21/45 46.7%) may reflect those for whom support is in place but a diagnosis has not yet been reached, as well as barriers in provision of care. It is vital to understand these patterns further to ensure emotional/behavioural problems are fully recognised and comprehensively supported with families.

Figure 3: Specialist clinical support by a paediatrician or psychologist/counsellor in the last 12 months by score on the Strengths and Difficulties Scale (n=232)

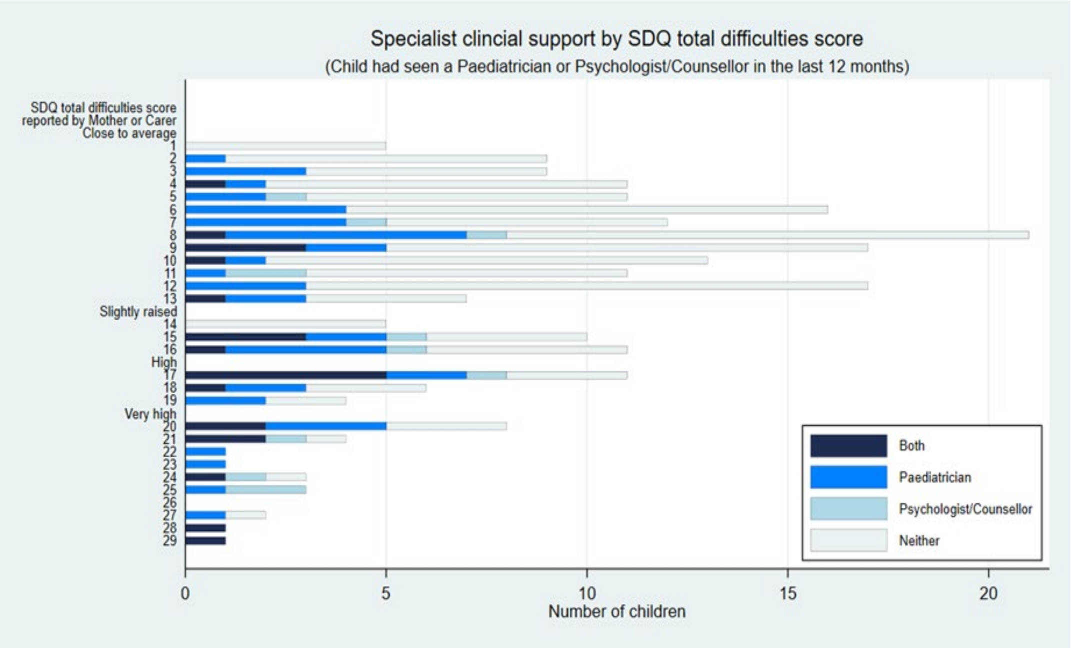
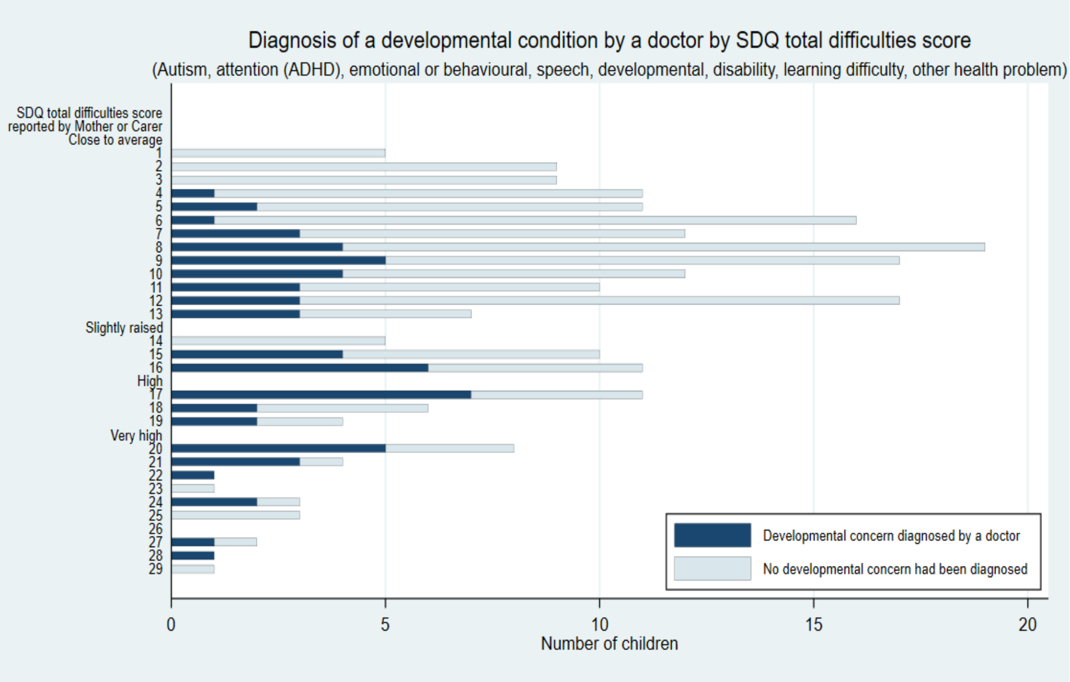


Figure 4: Diagnosis of a developmental condition, emotional/behavioural difficulty, learning or other developmental problem by score on the Strengths and Difficulties Scale (n=232)



When we look specifically at the 24 children scoring in the high to very high range on the SDQ with a diagnosed developmental condition or other emotional/behavioural or learning difficulty, the majority had received some specialist support in the preceding 12 months (Table 11). While half (12/24 50.0%) had seen both a paediatrician and psychologist/counsellor, a third had seen a paediatrician only (8/24 33.3%), and in one case a psychologist or counsellor only (1/24 4.2%). Most concerningly (3/24 12.5%) had not received support in the last 12 months from either a paediatrician, psychologist or counsellor.

Table 11. Specialist support where children scored in the high to very high range on the SDQ total difficulties score and had a diagnosed developmental condition, emotional/behavioural or learning difficulty (n=24)

In the last 12 months child has seen:	Number	%
Both a paediatrician and psychologist/counsellor	12	50.0
A paediatrician	8	33.3
A psychologist/counsellor	1	4.2
Neither	3	12.5

In summary, while many families with children experiencing difficulties are accessing specialist services, it appears that around one in ten children affected had not had recent support (in the past year) from a specialist paediatrician or psychologist. These data are a strong indication that some children may not have access to the support that they need to achieve optimal social and emotional wellbeing.

Unfortunately, the data do not permit us to assess the extent to which families accessing primary health care services, specialist and allied health care received culturally appropriate support matched to their specific context and needs. However, the proportion of children with diagnosed developmental difficulties and/or high to very high scores on the SDQ who had not had contact with a specialist paediatrician and/or psychologist in the previous 12 months highlight the importance of strengthening the recognition, referral and follow-up of Aboriginal and Torres Strait Islander children in this age group.

Appendix C Consultation participants

Role	**Organisation/Agency**
Midwife	Nganampa Health, APY Lands
Outreach Midwife	Nganampa Health, APY Lands
Community Health Nurse/ Midwife	Nganampa Health, APY Lands
Child Health Nurse	Nganampa Health, APY Lands
Child Health Nurse and Paediatric Liaison	Nganampa Health, APY Lands
Smoking Coordinator and Specialist Paediatric Visit Assistant	Nganampa Health, APY Lands
Mental Health Nurse	Nganampa Health, APY Lands
GP (Ernabella)	Nganampa Health, APY Lands
GP (Mimili & Indulkana)	Nganampa Health, APY Lands
GP (Amata)	Nganampa Health, APY Lands
Eye Health Coordinator	Nganampa Health, APY Lands
Ear Health Coordinator	Nganampa Health, APY Lands
Cardiac Program Coordinator	Nganampa Health, APY Lands
Director	Port Augusta Children's Centre (Department of Education)
Occupational Therapist (OT)	Port Augusta Children's Centre (Department of Education)
Manager	Aboriginal Family Support Services, Port Augusta
Associate Clinical Services Co-ordinator	Anangu Bibi Birthing Program, Port Augusta
Aboriginal Cultural Child and Family Support Consultant	Child and Family Health Services (PTA)
Clinic Program Manager	Pika Wiya Health Service
GP	Pika Wiya Health Service
Women's Health Team	Pika Wiya Health Service
Child Health Team (and respiratory clinic)	Pika Wiya Health Service
Team Leader	Connected Beginnings Program (PTA)
Aboriginal Community Development Worker	Connected Beginnings Program (PTA)

Aboriginal Community Development Worker	Connected Beginnings Program (PTA)
Aboriginal Community Development Worker	Connected Beginnings Program (PTA)
Aboriginal Liaison Project Officer	SA Dental (metro & regional)
Aboriginal Liaison Project Officer	SA Dental (metro & regional)
Clinic team	Aboriginal Family Birthing Program (Port Lincoln)
Clinic team	EFN-LHN (Port Lincoln)
Clinic team	Port Lincoln Hospital Child Development Unit
Clinic team	PLH Allied Health services (Port Lincoln)
Clinic team	AFSS (Port Lincoln)
Clinic team	Port Lincoln Health Service Aboriginal Health
Caseworker	DHS Safer Families (Port Lincoln)
Education worker	Kirton Pt Child Care Centre (Port Lincoln)
Caseworker	Centacare (Port Lincoln)
Education worker	Port Lincoln Children's Centre
Yadu staff	Yadu Health Aboriginal Corporation -
External professional stakeholders	Ceduna
Consumers for Aboriginal Birthing x6	Ceduna
Chief Executive Officer	Nunyara Aboriginal Health Service Inc
General Practitioner	Nunyara Aboriginal Health Service Inc
Visiting Specialist	Nunyara Aboriginal Health Service Inc
Patient Journey Coordinator	Nunyara Aboriginal Health Service Inc

Service Users	Nunyara
Professional Stakeholders	Mount Gambier
Health Service - Staff	Tullawon
External Stakeholders	Tullawon Health Service
Project Officer	Aboriginal Health, Department for Health and Wellbeing, SA Health
Principal Advisor – Aboriginal Workforce	Workforce Strategy – Workforce Services
Manager	Department for Health and Wellbeing
Midwife	Yarrow Place Rape & Sexual Assault Service
Midwife	AN Care, LMH, NALHN
Team Leader Young Parents Program	Youth and Women's Safety Wellbeing Divion (YWSWD), Metropolitan Youth Health (MYH)
Midwife Consultant	Women's and Babies Division
Coordinator	Safety and Quality
Manager	Aboriginal Health, Department for Health and Wellbeing, SA Health
Project Officer	Aboriginal Health, Department for Health and Wellbeing, SA Health
Clinic team	MFM
Manager	Aboriginal Liaison Unit – Women's & Children's Hospital
AHP	Watto Purrunna
Executive Lead	Allied Health, Complex, Sub-Acute and Spiritual Care
Clinician	WCHN
Midwife x2	Aboriginal Family Birthing Program, WCHN
Acting Midwifery and Nursing Director	Safety and Quality WCHN
Midwifery Education Facilitator	Women's and Babies' Division
AMIC x2	Aboriginal Family Birthing Program, WCHN
Senior Nurse	NICU/SCBU, WCHN

Director Aboriginal Health	Women's and Children's Health Network
Clinic staff	WCHN
Deputy Director North	Child and Family Health Service
Youth Director	Family & Wellbeing
General Manager	Community, Primary and Population Health, WCHN
Clinic staff	CAMHS
Clinical Midwife	Midwifery Group Practice
Nurse	WCHN
Manager Strategic Partnerships	Aboriginal Health Division, WCHN
Manager, Strategic Operations - Hospital	Aboriginal Health Division, WCHN
Nurse/Midwife Unit Manager	Aboriginal Family Birthing Program, WCHN
Midwifery Director	Policy, Workforce, Best Practice, Models of Care, SA Health
Senior Aboriginal Maternal and Infant Care Worker	Regional
Clinic team	Regional
Clinic team	Regional
Midwife	Regional
Director, Aboriginal Health,	EFNLHN
Neonatal Unit	WCHN
Strong Mums, Strong Kids	Nunkuwarrin Yunti
Acting Advanced Midwife	RSS Office
Consumer group	Nunkuwarrin Yunti
A/Advanced Midwife Manager	Maternity & Neonatal Services Rural Support Service Acting Executive Office Maternal Services Committee
Nurse Practitioner	WCHN, CAMHS, Mental Health Expertise
Aboriginal Clinical Health Worker Young Parents Program	Youth and Women’s Safety Wellbeing Divion (YWSWD), Metropolitan Youth Health (MYH)
Aboriginal Clinical Health Worker,	YWSWD, MYH

Team Leader of My Place team	Yarrow Place
Nursing Director	Women's and Children's Local Health Network
Executive Director	Aboriginal Health, NALHN
Manager	Aboriginal Services, CaFHS
Education EYCD Children’s Centre	Regional
CEO	Aboriginal Health Council of SA Ltd.
Digital Project Lead	Aboriginal Health Council of SA Ltd.
Project Officer	Aboriginal Health Council of SA Ltd.
Manager	Aboriginal Health Council of SA Ltd.
Staff	Aboriginal Health Council of SA Ltd.
Medical	Aboriginal Health Council of SA Ltd.
Staff	Maralinga
Health Manager	Oak Valley
Clinic team	Moorundi
Clinic staff	Moorundi
Riverland stakeholders & community	Moorundi
Victor Harbour stakeholders and community	Moorundi
Murray Bridge stakeholders and community	Moorundi
Meningie/ Raukkan stakeholders and community	Moorundi
CEO	Nunyara
Clinic Staff	Nunyara
Clinic	Nganampa Health
Community	Nganampa Health
Staff	Nganampa Health
CEO	Pangula Mannamurna
Clinic Team Leader, RN/Midwife,	Pangula Mannamurna
Senior Aboriginal Health Practitioner, AMIC Officer,	Pangula Mannamurna
Community	Pangula Mannamurna
Clinic staff	Pika Wiya

Senior Manager Client Services,	PLAHS
RN/Midwife	PLAHS
Clinic staff	PLAHS
Family Home visiting worker	PLAHS
Counsellor	PLAHS
Program and Services general manager	Tullawon
Family maternal health team leader	Tullawon
RAN	Tullawon
Aboriginal Health Worker	Tullawon
CEO	Tullawon
CEO	Umoona Tjutaku Health Service
Staff	Umoona Tjutaku Health Service
Community members	Umoona Tjutaku Health Service
Stakeholders	Umoona Tjutaku Health Service
CEO	Yadu
Clinic staff	Yadu
AHP Child Health / AMIC	Yadu
AHW	Yadu
Practice Coordinator	Yadu
Clinic staff	Nunkuwarrin Yunti
CEO	Nunkuwarrin Yunti
Executive	Nunkuwarrin Yunti
Chief Executive Officer	WCHN
Interim Chief Operations Officer	WCHN
Senior Exec	WCHN
Early Childhood Programs	Education
Pillar one with AC	Education
Early childhood leader	Education
Early years advisor, Aboriginal early childhood strategy	Education
State Manager, SA/NT Faculty	RACGP
Chair, Council Member	RACGP
GP meeting	RACGP
Clinicians	RFDS Adelaide
Community Midwife	RFDS Port Augusta
Coordinator	Country PHN
Project officer	Country PHN

Senior Manager	Country PHN
CEO	Adelaide PHN
Manager	Adelaide PHN
Executive Manager	Adelaide PHN
Director Aboriginal Health	Yorke and Northern Local Health Network
Executive	Dept Human Services
Executive	SA Health
Telehealth Manager	WCHN
State-wide Telerehabilitation Program Manager	SA Health
Digital unit	SA Health
Nursing Leads	WCHN
Manager, Digital Health & Systems Integration	Country SA PHN
Acting PATS Manager	SA Health
Director	EFNLHN
Planning meeting	EFNLHN
Professor	Telethon Kids Institute
SA Health Chief Child Protection Officer	Child Protection & Policy Unit | Department for Health & Wellbeing
Clinical Director	Women's & Babies Division
CoP members meeting	SA Maternal Neonatal Gynaecology Community of Practice
CoP members meeting	SA Child and Adolescent Community of Practice
Executive	NALHN
Senior Manager	NALHN
State Manager SA	AHPRA
Senior staff	Australian Nursing & Midwifery Federation
Federal Professional Officer	Australian Nursing & Midwifery Federation
Senior staff	Australian College of Midwives -SA division
Co-Chair Vulnerable Families	Dept Premier & Cabinet -Aboriginal Affairs & Reconciliation
Vulnerable Families Priority working group	SA intergovernmental team

Commissioner	Aboriginal Children and Young People
Manager, Aboriginal Housing Strategy	Housing SA
Principal Project Officer, Aboriginal Housing Strategy	Housing SA
Senior Executive	SA Ambulance Service
Senior case worker	Relationships Australia
Case workers	General and Child Family Assessment & Referral Network Service (CFARNS)
Director	Office of the Early Years
Senior Manager	Office of the Early Years
Case workers	Safer Families - Pathways service & CFARNS
Manager	Intensive Family Services - MGO contracting
Case workers	Strengthening links
Consumer Consultations Bungala	Pika Wiya
Attendance was twenty-nine people of eight men, twenty-one women and seven of those women were expecting a baby.	Port Augusta (Pika Wiya Consumer Consultations)
9 clients attended in the age groups ranging from 26 to 60+	Connected Beginnings Program (Pika Wiya Consumer Consultations)
	Roxby Downs/Andamooka (Pika Wiya Consumer Consultations)
8 men participating and 9 women participating	Quorn (Pika Wiya Consumer Consultations)
Community Midwife	Strong Mums Solid Kids (SMSK)
Aboriginal Health Worker, Maternal Health	Strong Mums Solid Kids (SMSK)
Aboriginal Health Worker, Child Health	Strong Mums Solid Kids (SMSK)
Administration Officer	Australian Nurse Family Partnership Program (ANFPP)
Aboriginal Family Partnership Worker	Australian Nurse Family Partnership Program (ANFPP)
Aboriginal Family Partnership Worker	Australian Nurse Family Partnership Program (ANFPP)

Aboriginal Family Partnership Worker	Australian Nurse Family Partnership Program (ANFPP)
Men's Aboriginal Family Partnership Worker	Australian Nurse Family Partnership Program (ANFPP)
Acting Team Manager & Narrative Therapist Counsellor	Paanthi, Social Emotional Well Being (SEWB)
Narrative Therapist	Paanthi, Social Emotional Well Being (SEWB)
Narrative Counsellor	Paanthi, Social Emotional Well Being (SEWB)
Case Worker	Harm Minimisation Team (HMT)
Case Manager	Harm Minimisation Team (HMT)
Social Health Case Work - Child and Youth	Towilla Purruttiappendi (TP)
Social Health Case Worker	Towilla Purruttiappendi (TP)
Case Manager	Redress Support Services (TP)
Team Manager	Link-Up SA
Principal Project Officer	Aboriginal Affairs and Reconciliation, Department of the Premier and Cabinet Co-Chair, Aboriginal Affairs Executive Committee, “Building Capacity in Vulnerable Families”
Director	DCP, Aboriginal Practice Directorate, Service Delivery and Practice
Senior Aboriginal staff meeting 12 staff	DCP, Aboriginal Practice Directorate, Service Delivery and Practice
Manager of Operations	SALHN, Aboriginal Health Services
Clinical Manager	SALHN, Aboriginal Health Services, Aboriginal Family Clinic
Aboriginal Cultural Consultant Lead	WCHN, Child and Family Health Services
Midwife	WCHN, MY Health, Metropolitan Youth Health, Youth and Women's Safety and Wellbeing Division
Manager & Midwife	NALHN, Lyell McEwin Hospital, Northern Aboriginal Birthing Program

Community Development Coordinator	DHS Safer Families, Kaurna Plains Children's Centre
Aboriginal Social Worker	Safer Family Services, Department of Human Services, North East team
Nutritionist/Researcher	SAHMRI
Middle Manager	Nunkuwarrin Yunti, Community Health Promotion Education
Nurse Supervisor	Nunkuwarrin Yunti, Australian Nurse Family Partnership Program
Middle Manager	Nunkuwarrin Yunti, Women Children and Family Health
Team Manager, SMSK	Nunkuwarrin Yunti, SMSK
Chief Executive Officer	Aboriginal Family Support Services
Chief Executive Officer	Nunga Mi:Minar Incorporated; Northern Regional Aboriginal Family Violence Service
Senior Aboriginal Project Officer	Department of Human Services, EIRD Strategic Policy and Reform (by survey response)
Middle Manager	Nunkuwarrin Yunti, Quality Safety and Reporting
Middle Manager	Nunkuwarrin Yunti Women Children and Family Health
Middle Manager	Nunkuwarrin Yunti, Primary Care Services
Aboriginal Health Worker	Nunkuwarrin Yunti, Primary Care Services
Senior Medical Officer	Nunkuwarrin Yunti, Primary Care Services
Middle Manager	Nunkuwarrin Yunti Women Children and Family Health
Director	Anglicare, Aboriginal Services
Principal Aboriginal Consultant	Anglicare, Children, Youth and Families
Social Innovator, Families and Cultural Connections	The Australian Centre for Social Innovation
Manager, Child and Family Early Intervention Services	RASA (& Western CFARN/CFSN)
Practice Manager	Relationships Australia SA, Family Led Decision Making

Acting Director, Aboriginal Health	Central Adelaide Local Health Network
Manager, Strategic Partnerships and Research Translation, Aboriginal Health	Northern Adelaide Local Health Network
Executive Manager, Specialist Services	Lutheran Care
Aboriginal Cultural Practitioner	Anglicare
Youth Facilitator	CREATE Foundation
Middle Manager	Nunkuwarrin Yunti Women Children and Family Health
Director	Dept Human Services

Social Worker	Dept Human Services
Physiotherapist	1Stop Health.
Site Manager	Centacare Limestone Coast
Community Mental Health Practitioner	Mind Australia
Crime Prevention Officer	SAPOL
Women’s Health Nurse and Midwife	SA Health and Pangula Mannamurna
Acting NUM of Maternity Paediatric Unit	Limestone Coast Local Health Network
Physiotherapist	Country Health Connect
2IC	Goodstart Early learning
O&G consultant	LSCHN- Mount Gambier Hospital
Director	Dept Treasury & Finance
Senior Officers Group Aboriginal Health	SA Health
CEO Forum – ACCHOs	AHCSA
National Manager	National Quality and Safety Health Standards
Nursing Executive	SALHN
Director	SALHN
Chairperson	AMA - SA
CEO	AMA - SA
Speech Pathologist	Solid Foundations
Office of the Chief Nurse	SA Health