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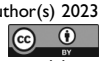

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On the Path to Decolonizing Health Care Services: The Role of Marketing

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Abstract

Despite considerable investment, health outcomes for First Nations people are well below those of the rest of the population in several countries, including Canada, the United States, and Australia. In this article, the authors draw on actor-network theory and the case of Birthing on Country, a successful policy initiative led by First Nations Australians, to explore the decolonization of health services. Using publicly available archival data and the theoretical guidance of actor-network theory, the analysis offers insight into how marketing techniques and technologies can be deployed to achieve improved health outcomes and implement decolonized approaches. The insights provided have theoretical implications for marketing scholarship, social implications for understanding and implementing an agenda of decolonization, and practical implications for health care marketing.

Keywords

decolonization, First Nations, holism, actor-network theory, Indigenous, health marketing

Recent calls have implored the marketing discipline to focus research on outcomes that speak to the grave challenges of our time (Chandy et al. 2021). Among such outcomes, health care and the role marketing plays in shaping consumer behavior is a core concern for developing effective public policy and delivering appropriate health programs.

This is especially significant for vulnerable consumers, particularly First Nations consumers, who, due to ongoing forces of colonialization (Watson 2016), experience inequities in health care markets and disparities in health care outcomes (Baker, Gentry, and Rittenburg 2005). Research shows that health outcomes of First Nations people[1] lag behind the broader population. According to the United Nations, First Nations people "suffer from poorer health, are more likely to experience disability and reduced quality of life and ultimately die younger than their non-indigenous counterparts" (United Nations Department of Economic and Social Affairs Indigenous Peoples 2023). For example, in Australia, the life expectancy of male First Nations people is 8.6 years less than that of the general population, whereas for female First Nations people, it is 7.8 years (National Indigenous Australians Agency 2022b, p. 22). Likewise, the life expectancy of North American Indians and Alaskan Natives is 4.4 years less than that of the general population (Narasimhan and Chandanabhumma 2021, p. 307).

At the same time, other studies show that the health of First Nations people would benefit if a decolonized approach to health care were followed (Hepi et al. 2017; McPhail-Bell et al. 2016; Narasimhan and Chandanabhumma 2021; Stanley et al. 2021). Decolonization is an active resistance to the forces and

[1] In this article we use the accepted term "First Nations" to be inclusive of Indigenous, Aboriginal, Torres Strait Islander, Native, American Indian, First Alaskans, Native Hawaiians, Māori, Metis, and Inuit peoples.

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structures of colonialism that leaves space to recognize and realize the importance of First Nations peoples' knowledge and culture (Dudgeon and Walker 2015; Narasimhan and Chandanabhumma 2021). Importantly, although decolonization is an important worldwide movement for many First Nations people wishing to achieve better health outcomes, there is little guidance on how this might occur (Narasimhan and Chandanabhumma 2021).

Our research aims to address a significant gap in the literature by exploring the following research question: how can marketing be utilized to achieve decolonized health care outcomes? To answer this question, we draw on actor-network theory (ANT) (Callon 1986; Callon and Blackwell 2007; Latour 1987) and its applications in marketing (Adaba and Ayoung 2017; Giesler 2012; Ozuem et al. 2021) to examine the case study of Birthing on Country (BoC). BoC is a policy initiated by the First Nations people of Australia that encourages women to give birth following traditional practices and on their ancestral lands.

Our analysis describes how marketing techniques and technologies were utilized across four phases of ANT to create a successful decolonized health program. Our results show that this process created a strong brand, effective opinion leaders and word of mouth, strong alliances with key public and private actors, and formalized systems, including training. We also document how these marketing approaches were resisted and how this resistance was overcome to decolonize health care for First Nations people.

This article makes several contributions to marketing in the health services sector. First, the study extends the understanding of decolonization within marketing through the lens of ANT and highlights its effectiveness in acknowledging First Nations ontologies (holism). Second, by conceptualizing holism within ANT, this study illustrates how culturally relevant marketing techniques work together with alliances of human actants for the betterment of First Nations consumers. Third, we contribute to practice by demonstrating how marketing can contribute to better health outcomes by developing health practices built on First Nations cultural knowledge and practices. Fourth, our analysis reveals how empowered First Nations people can mobilize marketing to challenge and change mainstream health practices by creating human and nonhuman actants and reshaping health care networks. In this way, our study extends emerging research on decolonization in marketing (Chow, Carrington, and Ozanne 2022; Eckhardt et al. 2021; Varman and Belk 2009, 2012).

The rest of this article is organized as follows. We first introduce ANT as our theoretical framework. Following this, we review the literature on the role of marketing in decolonizing health care practices. Background on our BoC case is then provided, followed by our research approach. Our analysis and findings are then presented, followed by a discussion on the implications of the study, its limitations, and future directions for research.

Actor-Network Theory

Our analysis of the role of marketing in decolonizing health care is informed by ANT, which originated in sociology (e.g., Callon 1986; Latour 1987; Law 1994). ANT is a theoretical framework that challenges traditional sociological perspectives by emphasizing actants[2] and interconnectedness in how social phenomena are constructed (Latour 2007). ANT offers a relational approach to understanding how actor networks emerge and change over time, such as forging alliances, enrolling other actants, and creating connections to achieve specific goals (Latour 1987).

At its core, ANT rejects the notion of fixed social structures and instead views the world as an ongoing, unfinished accomplishment (Latour 1996). Its ontology is relational, whereby actants are treated symmetrically, and humans and nonhuman actants are placed on an equal analytical footing (Law and Singleton 2013, 2014). Through these tenets, ANT captures the complex interactions and interdependencies within social systems (Latour 2007).

Traditionally, sociologists have attributed stability to objectified, structural categories, such as social classes or organizational hierarchies (Callon 1986; Latour 1996, 2007). ANT, in contrast, seeks "to rebuild social theory out of networks" (Latour 1996, p. 369). In this view, the world is seen as a continuously changing space where stability is temporary and inherently fragile. From an ANT perspective, understanding how human and nonhuman actants construct the world is vital (Latour 1996, 2007). ANT's theoretical components revolve around translation: aligning and/or diffusing previously unconnected elements to create new or changed actor networks (Callon 1986; Latour 2007). Following this literature, translation involves four interrelated stages—problematization, interessement, enrollment, and mobilization—each of which is subsequently discussed.

In the *problematization* stage, actants present their conceptions of issues and propose solutions. They highlight the problems they seek to address and indicate their ability to provide solutions through explicit practices. Problematization sets the foundation for the subsequent stages of translation (Callon 1986; Latour 2007).

During the *interessement* stage, the actants define and lock in the roles each will play in solving the defined problem. This stage involves negotiation and allocating roles and responsibilities to the actants in the network (Callon 1986; Latour 2007).

Enrollment follows a successful interessement stage and involves creating alliance networks. In this stage, actants form connections and build agreements around shared interests. Enrollment also strengthens actor networks by stabilizing and cementing the links between actants (Callon 1986; Latour 1987). To describe enrollment "is thus to describe the group of multilateral negotiations, trials of strength and tricks that accompany the interessements and enable them to succeed" (Callon 1986, p. 211). Callon and Blackwell (2007) further suggest that enrollment can occur via multiple paths: physical violence, seduction, transaction, and consent without discussion.

[2] In ANT, the term "actant" is preferred to "agent" because ANT does not draw a sharp distinction between human and nonhuman actors.

Mobilization follows successful enrollment. In this stage, the actants monitor the stability of their various interests and maintain and reinforce the alliances formed during enrollment (Callon 1986; Latour 1987). Mobilization ensures that the actor network remains functional and adaptive to changing circumstances. Creating and evolving an actor network is a compound process that is not always easy, sequential, or linear (Callon 1986; Latour 1987). A successful translation process means that actions converge. However, networks may diverge or collapse even after a successful mobilization stage (Callon 1986; Latour 1987).

Researchers such as Finch and Acha (2008) and Kjellberg and Helgesson (2007) have advocated for greater use of ANT in marketing scholarship. Subsequent adopters Giesler (2012) and Ozuem et al. (2021) argue that ANT can provide a nuanced understanding of all actants and their roles in specific circumstances as well as offer keen insights into the complex relationships among those involved in marketing practices.

Despite its strengths, ANT's flat ontology gives rise to the potential for erasures that do not explicitly acknowledge, a priori, the power structures in place (Steinfield 2022; Todd 2016). We address this possibility directly when mapping the evolution of BoC through an ANT lens by identifying the myriad actants responsible for entrenching colonized health practices. By examining the actor networks involved, we are able to document how power dynamics, individual interests, and alliances have marginalized First Nations birthing practices. More importantly, ANT offers a critical framework for understanding BoC's efforts to decolonize health practices and how the traditional actor networks have been challenged and reconfigured in pursuit of the same. Our analysis allows us to unearth the critical role that marketing techniques and technologies played in that decolonization process. Before this analysis is presented, it is essential to understand the context of health care for First Nations people and their attempts to decolonize it. This discussion also highlights our contributions to marketing knowledge in this area.

Health Care Decolonization

In this section, we provide a definition of decolonization and discuss its importance in health care. We then review the literature to understand how marketing has been used in decolonization, assessing its effectiveness and shortcomings. Finally, this section concludes by emphasizing the importance of a First Nations–centered approach to decolonizing health care.

Decolonizing Health

Waziyatawin and Yellow Bird (2005, p. 2) define decolonization as "the intelligent, calculated, and active resistance to the forces of colonialism that perpetuate the subjugation and/or exploitation of our minds, bodies, and lands, [which is] engaged for the ultimate purpose of overturning the colonial structure and realizing Indigenous liberation." Decolonization for First Nations people is about self-determination, recognition, representation, and, most importantly, reconnection to the land (Chow, Carrington, and Ozanne 2022; Eckhardt et al. 2021). Decolonization means that a relationship of equality replaces the relationship between the colonizer dominating the colonized (Chow, Carrington, and Ozanne 2022; Varman and Belk 2009). Central to the decolonization efforts in Australia is the acknowledgment of the profound damage colonization has inflicted on Indigenous communities and cultures, including invasion, genocide, the banishment of language, and the establishment of missions and reserves in the name of protection (Haebich 2000). Decolonization recognizes that contemporary systems and capitalist ideologies are influenced by prejudiced viewpoints, which strengthen Western superiority, a superiority that heightens racial disparities in the dispersal of wealth and privilege (Banerjee 2021; Burton 2009; Cram, Chilisa, and Mertens 2016). As a result, decolonization aims to redress these systemic power imbalances, critiquing the prevailing dominance of Western modalities and championing the inclusion and affirmation of Indigenous ways of being and doing (Banerjee 2021; Chow, Carrington, and Ozanne 2022; Moreton-Robinson 2015).

In modern-day Australia, First Nations people frequently find themselves engaged in initiatives deeply anchored in prevailing Western "standardizing" methods (Nikidehaghani and Pupovac 2023). Such initiatives often disregard the distinct cultural principles and practices inherent to First Nations communities. The cultures of these communities are characterized as "holistic," highlighting the importance of kinship, community, collective ownership, harmonious existence, and interrelated bonds (Australian Institute of Aboriginal and Torres Strait Islander Studies 2022). Similarly, the First Nations perspective on health care encompasses spiritual and emotional dimensions, addressing the "sociocultural and spiritual risk" typically overlooked in Western models (Kildea et al. 2016, p. 2). This perspective is deeply rooted in ties to family and the wider community, referred to as the "mob" (tribe), and is linked to a particular geographical area known as "country."

However, driven by the forces of colonization, for decades, mainstream policy makers and health care practitioners have failed to adequately consider "the key, distinctive cultural and social determinants that contribute to Aboriginal health and wellbeing" (Dudgeon and Walker 2015, p. 276). First Nations Australians continue to face initiatives based on mainstream Western approaches and practices that often fail to recognize or incorporate their holistic ways of being, knowing, and doing (Zubrzycki, Shipp, and Jones 2017). Health care systems based on Western biomedical approaches that primarily focus on diagnosing and treating individual health issues sharply contrast with First Nations holistic health perspectives that favor community over individual (Gee et al. 2014). Unsurprisingly, Western health care practices built on biomedical values and Western operating principles have led to poorer health outcomes for Australian First Nations people, including higher rates of chronic disease and psychological distress, violence, mental health issues, and substance abuse (Australian Bureau of Statistics 2019). First Nations women are twice as

likely as non–First Nations women to report poor health (Australian Bureau of Statistics 2019).

Therefore, Western health care systems present a potent opportunity for decolonization approaches that are based on First Nations knowledge and that empower First Nations actants. This opportunity calls for reimagining organizational and individual practitioner procedures and practices to address the embedded ontological and epistemic notions in Western-oriented health care systems. By cocreating innovative health care that centers on First Nations perspectives, the relationship between First Nations peoples and the dominant culture health care systems can be transformed in important ways. Marketing can play a key role in this process by not only promoting better health care, but assisting in its decolonization.

Marketing's Role in Decolonizing Health

Marketing and communication scholars have acknowledged the potential of marketing in decolonizing health care (Campbell et al. 2014; Grigg, Waa, and Bradbrook 2008; Hanson, Winberg, and Elliott 2012; McDonald, Cunningham, and Slavin 2015; Wilson et al. 2005). For instance, marketing techniques and technologies have been deployed to address First Nations critical health care concerns, such as antitobacco campaigns (Burgess et al. 2008; Grigg, Waa, and Bradbrook 2008; Wilson et al. 2005), breastfeeding (Wright et al. 1997), and diabetes management (Curtis 2004). Marketing techniques such as events (Jainullabudeen et al. 2015), radio campaigns (Hanson, Winberg, and Elliott 2012; Maksimovic et al. 2015; Verrall and Gray-Donald 2005), and advocacy through lobbying government (D'Abbs and Shaw 2008; Ireland et al. 2011) have also been used in attempts to decolonize health care. In some cases, TV campaigns were developed with First Nations focus groups, experts, and communities. Significant examples are the campaigns "No Germs on Me" to encourage handwashing (McDonald, Cunningham, and Slavin 2015), and "Kicking the habit" (Campbell et al. 2014), "Every cigarette is doing you damage," and "It's about *whãnau*" (Wilson et al. 2005), which focused on smoking cessation. Yet, the behavior change outcomes of these campaigns remain ambiguous (Kubacki and Szablewska 2019).

Several factors complicate the effectiveness of health care marketing campaigns for First Nations communities. These include the challenges of distance for those living in remote and regional areas (Majid and Grier 2010) and poverty (McDonald, Cunningham, and Slavin 2015), making simple changes to health practices (such as handwashing with soap) harder. Low access to television among First Nations people (McDonald, Cunningham, and Slavin 2015) also impedes the distribution of mass media messages. Another central challenge of utilizing marketing to decolonize health care is the deep-seated mistrust. Historically, governments and institutions have marginalized and misrepresented First Nations peoples. Marketing campaigns, especially when spearheaded or funded by these entities, can inadvertently evoke painful memories, leading to skepticism and hesitancy (Bryant et al. 2021; Haynes et al. 2021).

Furthermore, authentic engagement requires steps that go beyond tokenistic consultation. It involves First Nations communities across the intervention process, from ideation to execution (Bachar 2011a; McPhail-Bell et al. 2016). However, many campaigns, despite their best intentions, have either tokenized First Nations involvement or have failed to integrate feedback meaningfully (Burgess et al. 2008; D'Abbs and Shaw 2008; Grier and Kumanyika 2010; Verrall and Gray-Donald 2005). Involving First Nations people in designing and evaluating health care campaigns has been advocated for by the Australian Productivity Commission (2019), highlighting examples of programs led and evaluated by First Nations people as more successful than mainstream attempts.

Another crucial oversight in many marketing initiatives has been the underestimation of the cultural, spiritual, and communal dimensions of First Nations health. Most marketing techniques have not resonated with the lived experiences, values, and aspirations of First Nations communities, instead drawing on standardized reporting and evaluation metrics to demonstrate the success of marketing campaigns (Campbell et al. 2014; Grigg, Waa, and Bradbrook 2008; Hanson, Winberg, and Elliott 2012; McDonald, Cunningham, and Slavin 2015; Wilson et al. 2005). However, these metrics are often quantitative, neglecting the qualitative and holistic impact that is crucial for First Nations communities. Most importantly, a First Nations perspective needs to be designed in any health care program aimed at decolonizing health care for the benefit of these people.

Recognizing a First Nations–Centered Approach

For the decolonization of health care to occur, it must be centered on First Nations notions of holistic experience. In part, this entails a deep commitment to trust-building through the codesign of programs (Bachar 2011b; Grigg, Waa, and Bradbrook 2008; Ireland et al. 2021; Jainullabudeen et al. 2015). Decades of marginalization have led to deep-seated mistrust in health care systems (Haynes et al. 2021). Therefore, any decolonization approach must begin with genuine engagement, open dialogues, and transparent processes. Trust-building is not a one-off activity but a continuous effort that must underpin all interactions (Bachar 2011b; Ireland et al. 2021). Part of building trust is recognizing the traumas and scars of colonization and their transgenerational impact. Marketing health care approaches must be trauma-informed, acknowledging the past, understanding its implications on present health, and working toward healing. For example, using First Nations languages in health care marketing is not just about translation, but about validation and representation. Doing so sends a strong message of respect, inclusion, and understanding (Hanson, Winberg, and Elliott 2012; Ireland et al. 2021). Hence, a First Nations–centered approach necessitates a commitment to its holistic approach as a means to address the "deficit discourses" that led to the marginalization of First Nations patients (Haynes et al. 2021).

In addition to trust, a First Nations approach emphasizes a widespread understanding that everyone has duties toward their community. Consequently, this holistic approach contrasts with the Western focus on individuality (Kildea et al. 2016). In many First Nations cultures, the community's well-being is placed above individual health. This communal orientation, where health is seen in the context of the broader community and environment, necessitates approaches that prioritize collective well-being. It is about seeing health not just as individual journeys but as holistic endeavors, interwoven with the community's social, cultural, and environmental fabric. For health care marketing initiatives to resonate with First Nations communities, they must be cocreated, which involves working hand in hand with communities from the ideation stage to execution and evaluation. The involvement of Elders, who are reservoirs of wisdom, knowledge, and cultural insight, is particularly crucial (Curtis 2004; Hanson, Winberg, and Elliott 2012). Their leadership provides authenticity and cultural grounding to health care programs.

Further, central to First Nations practices are their connections to ancestral lands. For First Nations communities, the idea of "country" carries profound and diverse meanings. It is not merely the physical terrain. Instead, country spans a wide range of things: the earth, rivers, seas, shifting seasons, the air around us, trees, mountains, stones, flora, fauna, food sources, healing elements, ancestral stories, and revered places (Australian Institute of Aboriginal and Torres Strait Islander Studies 2022). It intertwines intricate notions of laws, particular sites, customs, dialects, spiritual convictions, cultural ceremonies, vital provisions, familial connections, and individual identities (Burgess and Morrison 2007). It transcends mere physical space, embodying a comprehensive entity that is rich in cultural, spiritual, and ancestral dimensions. Fundamentally, country offers both a deep sense of belonging and a unique way of life (Victorian Public Sector Commission 2023). It plays a pivotal role in shaping the identities of First Nations people, and their relationships with country are crucial for their overall well-being and the preservation of their cultural legacy (Guerin et al. 2011). Within this context, the ties of First Nations people to country come alive through community interactions, cultural practices, shared knowledge, and artistic expressions (Chow, Carrington, and Ozanne 2022; Victorian Public Sector Commission 2023). This bond is about deeply respecting and focusing on ensuring harmony and stability in the environment. In this way, First Nations talk to country, sing its praises, express concerns for it, and yearn for it (Common Ground 2023).

Taken together, a First Nations–centered approach challenges and pushes against the dominant paradigms to create space for alternative, Indigenous ways of knowing and healing. This involves critically examining existing health care frameworks and being open to restructuring them in ways that center on First Nations knowledge and practices. To underscore the role of marketing in recognizing a First Nations–centered approach, we next provide background on the case of the BoC program.

The Birthing on Country Program

> BoC brings spiritual meaning to the modern world that we live in now. BoC lies deep and wide … deep … and wide … because it stretches from the ancient to the future, and it is for our generation to continue singing … the identity of the Indigenous people of this world. (Kildea, Dennis, and Stapleton 2013, p. 61)

Consistent with the Western approach to health service delivery, First Nations women are expected to deliver babies in hospitals. For years, First Nations women have discussed the challenges and trauma of giving birth in hospitals, including language barriers and disconnection from family, community, culture, and country. For First Nations Australians, traveling to a distant hospital breaks the link between the mother, baby, and the spiritual significance of one's birthplace (Felton-Busch 2009). Family and birth attendants are also absent, and traditional practices cannot be followed, further breaking these links. First Nations Elders feel that a significant cultural risk occurs when not birthing "on country," that is, on their ancestral lands (Kildea and Van Wagner 2012; Wardaguga and Kildea 2005). Importantly, birthing outside of country, often in a major metropolitan center, means that the baby's land and culture are not documented on the birth certificate. Therefore, the baby cannot be recognized as part of a mob (Nation), breaking the First Nations child's bond with the land, culture, and family.

Importantly, traditional birthing practices, which connect First Nations people to the land and recognize their holistic culture (Adams et al. 2018), have been ignored and replaced by reductionist Western medical approaches, which research shows have not been effective. Although Australia has one of the best health care systems in the world, First Nations children are 2.1 times more likely to die during early childhood (Australian Institute of Health and Welfare 2018). This is similar to other countries, such as Canada, where there are 10.9 stillborn births per 1,000 First Nations people (Shapiro et al. 2018), a rate more than double that of the general population at 4.5 per 1,000 (Joseph et al. 2021). In the United States, rates of preterm death are even higher at 13.9 per 1,000 compared with 5.58 for the white (non-Hispanic) population (MacDorman 2011).

For First Nations people residing in the Northern Territory, a state in Australia twice the size of Texas, there are only four main hospitals. This means pregnant women who live outside these four locations must travel an average of more than 312 miles (500 km) to the closest hospital at 38 weeks to give birth. These hospitals are located in urban centers, places not necessarily connected to their culture or country. For many, giving birth in a hospital feels culturally unsafe and hinders their spiritual relationship to the land (Fitzpatrick 1995; Ireland et al. 2011; New South Wales Health Department 2003; Northern Territory Department of Health and Community Services 1992; Senate Community Affairs References Committee 1999).

Consequently, First Nations women and their advocates urged the authorities to allow them to practice BoC, which occurs when a First Nations mother gives birth to her child on the lands of her ancestors (Kildea et al. 2017). For First

Nations people, birthing is broader than labor and delivery in a medical facility (Kildea et al. 2016). It "encompasses culturally safe care for First Nations families during pregnancy and after birth" (HealthcareLink 2019). Traditionally, First Nations midwives with specialist cultural knowledge provide this care (Adams et al. 2018). Hence, BoC refers to maternity services designed by and delivered to First Nations people (Kildea et al. 2016).

Notably, the Australian BoC program drew inspiration and design from an intervention in Canada called the Inuulitsivik Midwifery Service, whereby the Inuit people decolonized birthing practices (Van Wagner et al. 2007, 2012). Research shows that First Nations mothers who had their children on country in local medical centers had better preterm births and intervention outcomes than when they traveled to larger centers (Van Wagner et al. 2012). Despite these outcomes, the program was not widely adopted in Canada, due in part to professional barriers to recognizing First Nations practices and midwives (Van Wagner et al. 2007).

Central to examining BoC from an ANT lens is mapping out the relevant actants. Figure 1 offers a visual representation of BoC's key stakeholders in three successive rings: human actants (inner), nonhuman actants (middle), and First Nations nonhuman actants (outer). Ultimately, the broader movement toward holistically understanding health and well-being is evident in the outer ring of Figure 1. As noted, the land is not just a backdrop; it is an active participant, deeply revered as ancestral territories by these communities. Similarly, water sources, often viewed as sacred, are pivotal in spiritual and cleansing rituals associated with childbirth. The flora and fauna of these regions also play a crucial role in traditional medicines and ceremonies, serving purposes from physical healing to spiritual safeguarding. Furthermore, intangible elements, such as ancestral narratives and the principles of Women's Business (Grandmother's Law), shape childbirth practices and underlying values. Weather conditions, too, have their part to play, influencing the timing and location of birthing practices. These views of First Nations holism mean that the whole is greater than the sum of the parts and that any changes in health practices to benefit First Nations people need to consider the broader aspects of land, culture, and spirituality.

The middle ring of Figure 1 illustrates the nonhuman actants' connections to BoC. These connections include the following: (1) The BoC model itself serves as a guide for the project, influencing the actions and decisions of the human actants involved. (2) Health care facilities and infrastructure play a crucial role in the delivery of health services and influence the experiences of the First Nations mothers and health care providers. (3) Medical equipment and technology enable health care providers to monitor and ensure the health and safety of First Nations mothers and babies. (4) Government policies shape the ways in which the project is implemented and the services are delivered. (5) Educational materials and resources are used to train health care providers and educate First Nations mothers and those who care for the them, influencing their knowledge and understanding of the birthing process. (6) Research data, reports, and evidence influence the decisions made in the project and demonstrate the effectiveness of the BoC model, including the institution. (7) Universities foster research, training, yarning,[3] meeting, negotiation, and discussion. They shaped BoC by providing legitimized evidence for holistic birthing practices and helped brand BoC as an alternative to Western approaches to birthing. (8) Marketing devices assist in disseminating information and facilitating the formation of communities. These nonhuman actants are active contributors to the birthing process.

Finally, the human actants at the center of Figure 1 are individuals or groups that play a significant role in the network of relations. The primary human actants include the following: (1) First Nations mothers are the primary beneficiaries of the project. Their experiences, needs, and preferences significantly shape the implementation of the BoC model. (2) Health care providers include midwives, doctors, nurses, and other health professionals who use their knowledge, skills, and practices to deliver the services and care to the mothers. (3) Researchers and academics contribute to the development and evaluation of the BoC model through research and evidence generation. (4) Community leaders and Elders play a significant role in advocating for the project, ensuring cultural appropriateness, and facilitating community acceptance and participation. (5) Policy makers and government officials influence the project through policy decisions, funding allocation, and regulatory oversight. (6) Family members of the mothers provide support to the mothers and can affect their experiences and outcomes. (7) The broader First Nations community is part of the cultural and social context in which the mothers live and the project is implemented. (8) Non–First Nations allies and supporters play a role in advocating for the project, facilitating resources, and supporting its implementation.

Research Approach

Method

We analyzed the BoC case by qualitatively examining publicly available archival data. Given the program's success in decolonization, our aim was to understand the contribution that marketing played in decolonizing birthing policies and practices for the First Nations people of Australia. Although alternate research methods, such as interviews with First Nations mothers and service providers, would have added more evidence, we chose not to use interviews to avoid any further colonization of this sensitive issue (Hart 2010; Hunter 2006; McPhail-Bell et al. 2016; Smith 2005). The university ethics committee and the First Nations authors on the research team

[3] Yarning is a way of talking that is unique to Indigenous cultures. It is more than just casual conversation; it is a way of building relationships, sharing knowledge, and making decisions. Yarning is based on respect, mutual accountability, and established protocols (Byrne et al. 2021).

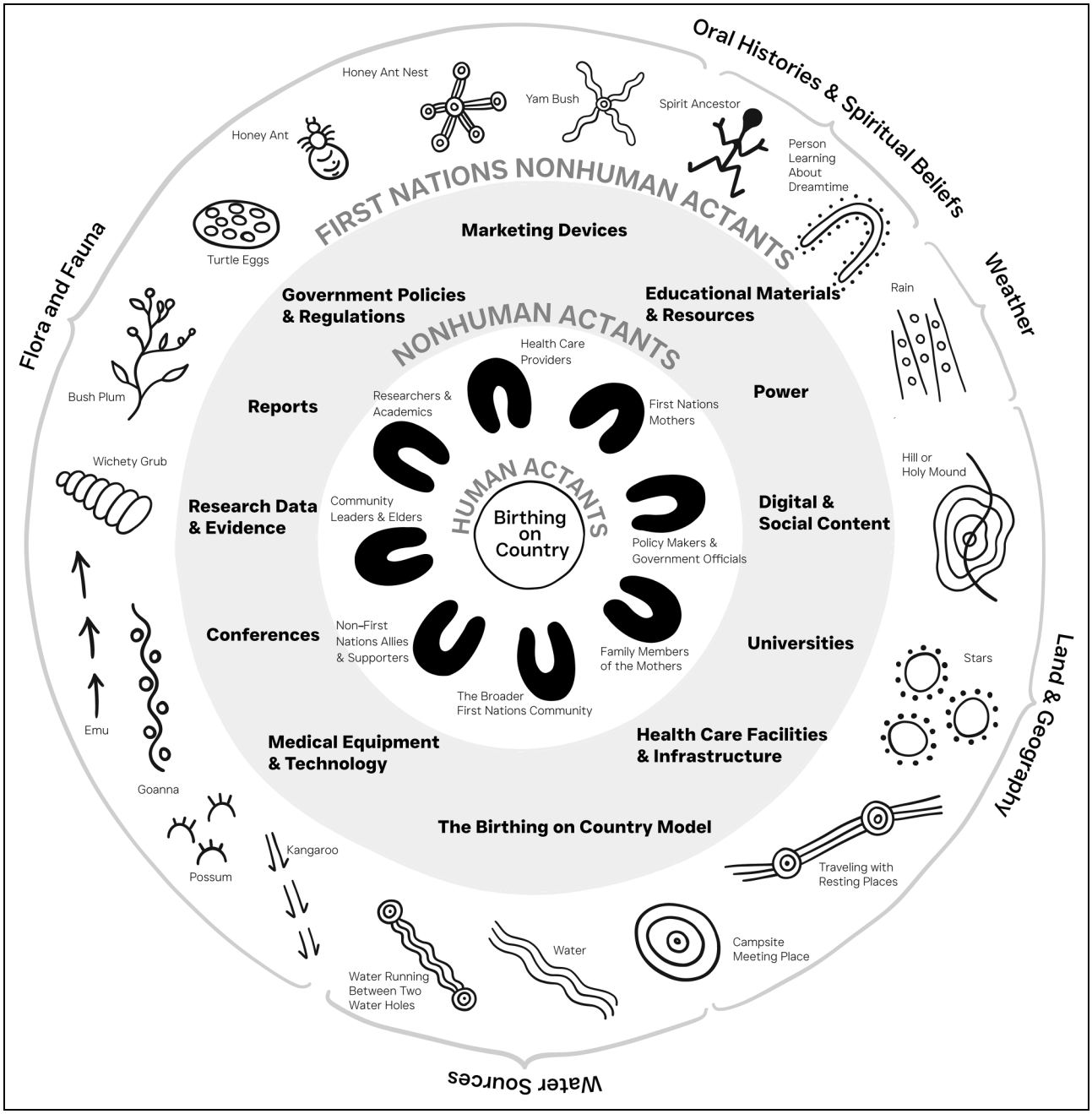

Figure 1. Key Human and Nonhuman Actants in the BoC Program.
Source: Reece George.

further confirmed the wisdom of this decision. Accordingly, we draw on archival evidence to examine how marketing technologies and techniques can be used as decolonizing devices.

Data Collection

A wide variety of data were collected from publicly available sources between 2016 and 2023. Table 1 outlines the data sources and some of the coding examples used in the analysis. Notably, five documentaries, a podcast, and a webinar series that provided testimonies of lived experiences related to BoC and the process of legitimizing the program were examined. We reviewed 96 web pages, 5,987 documentation pages, 19 hours of podcasts and documentaries, and more than 9,300 social media posts and comments.

Data Analysis

We coded the data set according to our theoretical framework and in a way that supported our aim of understanding the

Table 1. Data Coding According to the ANT Stages.

ANT Stage	Data Source	Data Type	Coding Examples
Problematization	Government (federal) Government (Northern Territory) Medical Journal databases Media Government and medical websites BoC website	Government reports Hansards White papers Media releases Medical reports Politician interviews Media documentaries Academic journal articles Web pages	Colonizer perspective: "It is safer for women to relocate them to larger metropolitan hospitals." Decolonizer perspective: "Birth in the communities also contributed to community healing from colonization's effects and rapid social change."
Interessement	Molly Wardaguga Research Centre website BoC website ABC Australia media Journal databases Digital and social media sites Government websites	Lobby and petition documents Testimonials of First Nations mothers Report on birthing outcomes for First Nations people Media, websites, and scholarly literature Social media metrics of the BoC program Examples of promotional material used in the BoC program	Example of decolonized practice: "The team understands us, they want the best for us, they help us, connect to us and we work together to heal from years of hurt."
Enrollment	Molly Wardaguga Research Centre website BoC website ABC Australia media Journal databases Digital and social media sites Government websites Research institute	Independent medical research showing the effectiveness of the program; journal articles Podcasts, documentaries, petition web pages BoC report; medical reports on BoC Molly Wardaguga Research Centre resources Conferences and workshops Digital and social media posts, comments, and user-generated content (testimonials of First Nations communities)	In relation to service delivery, BoC "ensures a spiritual connection to land for Aboriginal mothers, and their babies."
Mobilization	Molly Wardaguga Research Centre website BoC website Digital and social media sites Government websites Medical Grant funding websites Journal databases	Conference and event proceedings "Caring for Mum on Country" Conference and event proceedings for midwives, doulas, service providers, and politicians; related conference blogs Social media posts, comments, and participant content Government reports related to BoC; funding deeds related to BoC; BoC reports related to governance structures Medical reports; journal articles	Ongoing support of the BoC program: The events and workshops "galvanised many advocates to improve maternity services for Indigenous Australians into the future, working together as one community." Governance structure: "a community based and led initiative. The service supports on-site birthing centres and midwifery training in remote communities."

contribution of marketing to decolonizing BoC in Australia. All team members reviewed the complete data set to understand the narrative and determine the significance of each data item. We took notes to capture our interpretations of the data across each stage of the ANT framework: (1) problematization, (2) interessement, (3) enrollment, and (4) mobilization. Table 1 provides examples of our interpretation of data through ANT.

The analysis was undertaken by First Nations and non-Indigenous researchers to ensure a balance between two ways of knowing. Empowering First Nations voices requires specific ethical and research responsibilities. Thus, the quality, suitability, reliability, and representativeness of data were vetted by all the First Nations researchers on the scholarship team. They reflected on the data, findings, and discussion to highlight stories or perspectives that needed heightened attention. However, the final synthesis of insights was the product of the entire authorship team. These findings follow.

Findings

According to Latour (1996), ANT includes multiple actants, both human and nonhuman. Our analysis of the BoC program highlights key actants and their intersection, as detailed previously in Figure 1. In line with the ANT framework, our findings are arranged according to the four stages of the sociology of translation (Callon 1986; Callon and Blackwell 2007; Latour 1987), beginning with problematization, then proceeding through interessement and enrollment, and concluding with mobilization. We recognize the inherent fluidity and complexities involved in the process of translation within the BoC model. Nevertheless, we have opted to present our findings using a stage-based approach, aiming for simplicity and clarity in explanation. Table 2 summarizes our results by highlighting the key strategies and specific marketing actions in each ANT stage.

Table 2. Marketing Actions in the BoC Program Across the ANT Stages.

ANT Stage	General Strategy	Specific Marketing Actants
Problematization	Documenting how a colonized approach created the problem	Government reporting and subsequent policy documents Use of mass media and public relations campaigns Medical reporting and use of visual storytelling
	Arguing for a decolonized approach to birthing	Campaigns for alternative birthing service programs Piloting and reporting Storytelling via media, digital media, academic journals, and official reports
Interessement	Formalizing key actants to drive change	Formalized undocumented practices and formulated training programs Promoting academic, conference, and white paper findings Organizing gatherings among service providers and midwives
	Developing a decolonizing brand and promotional practices	Using local symbols and languages in promotional material Branding, brand differentiation, and positioning Storytelling via workshops Digital and social media posts, podcasts, docuseries
	Establishing alliances to acknowledge the need for change	Public relations: networking and lobbying those in a position of power
Enrollment	Shifting public opinion through BoC ambassadors	Brand ambassadors Thought leadership communicated through a content marketing strategy, including scholarly articles, webcasts, webinars, podcasts, social media posts, and storytelling events on country (e.g., yarning circles with guests) Word of mouth via social media
	Shifting service delivery: enrolling through evidence and thought leadership	Community events Using academic publications to present evidence of the effectiveness in shifting service delivery
	Influencing opinion leaders, influencers, and gatekeepers	Relationship marketing via targeted events with special interest groups (e.g., medical); testimonials, lived experiences, traditional yarning circles, and smoking ceremonies Direct marketing (e.g., email) Petitions
Mobilization	Establishing rules and protocols for mobilizing a decolonized approach to BoC	Showcasing success through marketing events Finalizing and disseminating BoC formal governance structures Engaging in BoC education/training events with all key actants Promoting all the preceding items via journal articles, digital and social media content, and other media

Problematization

We find evidence of problematization due to two general strategies observed in the data. These strategies included documenting how a colonized approach created the problem and arguments for a decolonized approach to birthing. Each of these is next discussed with attention to how specific marketing actants played a role in the process.

Documenting how a colonized approach created the problem. Since the 1960s, the Australian government's approach to managing the problem of poor maternity outcomes for First Nations centered around relocating First Nations women from their land and families to give birth in hospitals. Such colonial solutions were rooted in the discriminatory assumptions that depicted First Nations people as unclean and uncivilized (Kidd 1997). The institutionalization of birthing for First Nations women is thus consistent with a colonized perception of medicine that dismisses more than 60,000 years of traditional practice (such as older women teaching young women about the Grandmother's Law and bonding during their first labor) (Matthias and Morgan 1992). Such institutional solutions aimed at ensuring compliance were legitimized by health experts through the practice of marketing. For instance, drawing on "scientifically sound" practices, statistical information, and graphical representations, government interventions were presented as the best approach to overcoming the problem of high maternal mortality rates for First Nations people (Houston 1989). Further, the mass media official reports (e.g., National Health Strategy Working Party 1996) consistently depicted First Nations people as a difficult market segment in need of management (Kidd 1997).

Despite the colonizers' efforts to manage First Nations mothers, statistics indicated no improvement in outcomes for mothers and babies. For instance, a review of birthing services by the Northern Territory Department of Health and Community Services (1992) indicated that the First Nations perinatal mortality rate continued to be three times more than the non–First Nations rate in that same region. The stillbirth rate in Darwin, the Northern Territory capital, for Aborigines was also two and half times that of non-Aborigines (Matthias and Morgan 1992). These official reports expressed the need to include First Nations birthing practices in Northern Territory's birthing policies, and further to extend this nationally.

Arguing for a decolonized approach to birthing. Callon's (1986, p. 205) notion of the "obligatory passage point" underscores the need to achieve consensus among all human participants in a situation regarding the problem, suggesting that its resolution might require an alternative approach. Obligatory passage points allow actants to set up negotiation spaces that permit a degree of autonomy (Callon 1986). One such point occurred following the report on health disparity by Matthias and Morgan (1992), which offered clear evidence of the aforementioned health disparities. In response, the federal government funded the Northern Territory as a pilot site to investigate the feasibility of establishing a "limited number of new health services in the region" (Burns et al. 1998, p. 133).

The Northern Territory Department of Health and Community Services (1992) also outlined that it was essential to include First Nations people in health care decision making, particularly highlighting the need to recruit First Nations health workers and midwives. However, the government downplayed this recommendation and merely approved funding for establishing birthing centers, outside of hospitals, on First Nations land. Nonetheless, our analysis shows that this was a critical turning point for the BoC movement in resisting colonial birthing practices (Burns et al. 1998).

Shortly after the pilot study was completed, BoC advocates, which included midwives working with First Nations women and academics, initiated a campaign for an Alternative Birthing Services Program (Senate Community Affairs References Committee 1999) that would see birthing done on country and in accordance with a First Nations holistic approach, a policy that eventually became the BoC program. Central to this new campaign was the idea that birthing should offer a more culturally appropriate approach to birthing. In particular, advocacy groups argued that any new program should recognize the critical role of country and should involve the family and community members in the care of the mother and baby.

Multiple actants were vital in progressing the campaign for an Alternative Birthing Services Program. This included researchers from Charles Darwin University (e.g., Sue Kildea), who worked closely with the First Nations Elders and women of Maningrida to publicly share their stories of giving birth and the challenges of traveling to metropolitan cities. For instance, the experiences of one First Nations mother (Deborah) were captured in the Birthing Business in the Bush website (a website developed for First Nations women in the Northern Territory to tell their birthing stories): "I had all of my babies in Darwin, but now I am going to have another one and I don't want to go. I want to do it the bush way. … I haven't got any family in Darwin and there is too much humbug from the drunks who want to take your money. They send you in too early" (Birthing Business in the Bush 2005b). Another First Nations mother of three whose last child was born in Darwin, around 550 kilometers (around 341 miles) southwest of the family's rural Aboriginal home of Galiwin'ku, was quoted via a translator in a public blog post: "The saddest part of leaving her home in East Arnhem Land to give birth to her daughter Judy … was leaving her young kids behind" (HealthcareLink 2019).

Stories were communicated through marketing technology actants like websites, traditional and digital media, academic journals, and official reports. These actants shared cultural practices and how one's place of birth was a critical part of First Nations customs (Birthing Business in the Bush 2005a; Kildea, Dennis, and Stapleton 2013; Kildea and Van Wagner 2012). For example, as documented by Felton-Busch (2009, p. 161), First Nations mothers believe:

> Being born on country connects an Aboriginal person to the land and community in a profoundly cultural way and affords life-long privileges such as hunting and fishing rights and lifelong responsibilities for looking after the country, both land and people. For Aboriginal women, birthing has moved from the personal to the political as governments provide policies about what is 'best' for Aboriginal women and their babies.

As the BoC movement intensified, scientific, health care, and marketing discourses articulated improved health outcomes for mothers and children. For instance, a 1992 Northern Territory Women's Advisory Council report showed a decline in the maternal death rate for women participating in BoC programs (Northern Territory Department of Health and Community Services 1992). Coincidingly, as Kildea et al. (2016, p. 5) argue, "Birth in the communities also contributed to community healing from colonization's effects and rapid social change."

Thus, establishing consensus regarding problematization in the case of BoC required researchers to demonstrate to other actants articulated in Figure 1 that the Western medical approach was not yielding good results. Instead, an alternative decolonized approach was needed to improve health outcomes drastically. Despite this solid first step, Callon (1986) clarifies that obstacles and barriers would arise that would require a collaborative alliance to overcome. This is discussed during the interessement stage.

Interessement

In this stage, actants negotiate and allocate roles and responsibilities to resolve the issues identified in problematization. We find evidence of interessement occurring due to three general strategies. These strategies included formalizing key actants to drive change, developing a decolonizing brand and promotional practices, and establishing alliances to acknowledge the need for change. Each of these is next discussed with attention to how specific marketing actants played a role in the process.

Formalizing key actants to drive change. Central to legitimizing the BoC program were actions initiated by First Nations mothers, midwives, and training institutions focused on traditional birthing practices and universities and their research centers. For example, in 2019, Charles Darwin University launched the Molly Wardaguga Research Centre as a strategic investment to formalize culturally responsive models of care and Indigenous health. These actants formalized undocumented practices and formulated training programs for First Nations

people to assist in BoC practices (see Molly Wardaguga Research Centre 2023a). Documenting practices included identifying traditional spaces to give birth, traditional methods and birthing positions, and roles of midwives, mothers, and other family/community members. Training programs focused on antenatal care, birthing classes, and support groups. These programs provided details on managing specific health risks, engaging in traditional birthing practices (squatting and connecting to land), and training support members in emotional, spiritual, and practical support duties during the birthing process and in postpartum care.

The actants also used academic and scientific discourse to counter colonizer rhetoric. They did so, for example, by producing highly credible journal articles, developing white papers, presenting papers at academic research conferences, and organizing gatherings with service providers and midwives (Molly Wardaguga Research Centre 2023b). These marketing activities helped position birthing as an issue and normalized BoC practices through credible and legitimate sources. Further, by eroding the power of established institutions, counterinstitutions, such as the Molly Wardaguga Research Centre, were given space to challenge the discourse that had historically excluded and misrepresented marginalized communities. These marketing tactics provided a platform for alternative narratives, ideas, and values that helped reshape social norms and create a more inclusive and equitable community of practice based on decolonization.

Developing a decolonized brand and promotional practices. To coincide with the rise of identifying birthing as a community issue and offering First Nations mothers an alternative model for birthing, marketing communications were used to educate people about changes in birthing options. Several important steps were taken. To begin, these materials were developed with First Nations people to enhance the chances of a successful awareness campaign highlighting the need for BoC. Further, marketing and promotional materials were prepared in the local languages of the First Nations people. For example, Ireland et al. (2021, p. 490) used the language of the Yolŋu community in promotional and training materials. By using materials in local languages, those directly impacted by the prevailing birthing practices could evaluate their choices. Most importantly, employing such marketing techniques fostered trust in BoC, which was fast becoming a brand. As a Yolŋu woman states, as reported by Mitchell and Kulas (2021) on their podcast:

> The team understands us, they want what is best for us, they help us, connect us and we work together to heal from years of hurt … they are part of us and we work together to make the land shake.

By drawing on marketing approaches of differentiation (Dickson and Ginter 1987), which attempt to communicate differences in service approaches, BoC was able to identify and highlight the unique attributes of the BoC brand relative to Western approaches to birthing. As stated by Bales (2016), a BoC First Nations spokesperson said in a radio interview:

> A birthing place is … around ceremony, it is about cultural interconnectedness … where we revitalise and renew our traditional practices for mother and babies … we can't do that in a hospital. … It is a humanistic thing … it is a connection to country.

Aside from differentiating the BoC brand, BoC advocates also used the marketing technique of positioning (Dickson and Ginter 1987). This allowed the brand to be seen in a specific way in the minds of consumers by associating values of holism and cultural benefits that made it appealing and relevant to various stakeholder groups, while also reinforcing the need for BoC. The aims of differentiation and positioning were successfully achieved within the First Nations communities, with BoC actants (mothers, midwives, academics, Elders) agreeing that

> the term BoC be retained and that … the term is understood as a metaphor for the best start in life for Aboriginal and Torres Strait Islander babies and their families, an appropriate transition to motherhood and parenting for women, and an integrated, holistic and culturally appropriate model of care for all. (Kildea, Dennis, and Stapleton 2013, p. 8)

The agreement flowed through to First Nations communities (participants and potential participants), with nonhuman actants, such as community-based conferences/workshops, utilized to execute differentiation and positioning strategies further. In one specific workshop in 2013, a participant expressed BoC should be branded as "having family with you, not just the two people they let into the ward" (Kildea, Dennis, and Stapleton 2013, p. 34).

Without an exhaustive marketing budget, it was vital that the BoC brand utilized marketing communication strategies that garnered broad exposure without media buying. Through the use of the marketing approach of storytelling (De Leeuw et al. 2017) to craft compelling brand stories that resonated with audiences and reflected the brand's values, mission, and historical core, the reputation of BoC was improved. For instance, traditional storytelling methods, including yarning sessions at academic conferences and workshops, allowed the story of birthing practices and health care to be embedded into spaces designed for learning and educating multiple actants. In digital spaces, BoC actants utilized social media posts and podcasts to share their stories and experiences. They also collaborated with media entities, such as ABC Australia, to produce docuseries and share stories about the initial successes of the BoC programs. Success in storytelling culminated when BoC advocates' documentary "Djäkamirr: Caretaker of Pregnancy and Birth" won the Indigenous Film Award at the 2021 Fort Smith (Arkansas) International Film Festival in the United States. This further enhanced the aims of establishing consensus around the need to change birthing practices.

This repositioning strategy allowed the BoC program to build a critical mass of early adopters (Ireland et al. 2022). Additionally, putting more success stories in the public domain further normalized the practice (Mitchell and Kulas 2021; Watego 2021), making it more acceptable to the

broader Australian population. Furthermore, by promoting a decolonized agenda, the BoC advocates generated grassroots support and enhanced a national and international brand image that flourished in the media, especially social media. For example, as of January 2023, the hashtag #birthingoncountry had been tweeted 2,167 times and tagged in 1,073 Instagram posts and 1,655 Facebook posts, with many postings by First Nations people.

Establishing alliances to support the need for change. Another critical aspect of the interessement stage was for actants to establish alliances with others who would aid and promote the project (Callon 1986; Maciel and Fischer 2020). This differs from formalizing alliances, a step that occurs in enrollment (Callon 1986). For example, partnerships were initiated with other health practitioners, such as non–First Nations midwives and doctors, who, in turn, began to lobby politicians and medical professionals to expand the BoC program to other regions and states. As a result, governments began to formally acknowledge that they needed to play a part in changing how birthing occurs for First Nations mothers (Daellenbach and Edwards 2010).

Further, this lobbying and petitioning helped challenge the colonized practice of how births are documented in favor of a decolonized approach. More specifically, advocates of the BoC program lobbied politicians. They worked with ABC News to allow birth certificates to state the traditional place of birth rather than a hospital or town (Magick Dennis and Keedle 2019). The authorities acknowledged that the omission of traditional birthplaces built on holism was an issue that required a review and change of practice across the country (Magick Dennis and Keedle 2019).

In the context of the BoC initiative, the phase of interessement encompassed a series of deliberate actions aimed at presenting the program as a secure and empowering endeavor specifically tailored to the needs of First Nations women. Our comprehensive examination reveals that in the instance of BoC, strategic marketing and astute public relations endeavors were employed to engender organic and grassroots support for the initiative. These marketing methodologies effectively served to underscore the imperative for BoC, distinguish and solidify its unique positioning, and accentuate its intrinsic value and significance within First Nations communities and the broader societal milieu.

Furthermore, these calculated marketing efforts were instrumental in swaying the perspectives of critical decision makers across various governmental bodies and medical institutions, thereby cultivating a favorable environment for the successful adoption and implementation of the BoC program. These activities locked in the roles and identities of the actants involved in promoting BoC and presented BoC as a legitimate, scientifically proven approach to birthing and as a culturally appropriate alternative to mainstream birthing practices. Importantly, all major actants acknowledged that colonized birthing practices were not working for First Nations people for many reasons, including power imbalances, misalignment with cultural traditions, and sociocultural factors. The next stage, enrollment, sees these marketing techniques purposed to engage vital strategic alliances with other actants.

Enrollment

We find evidence of enrollment occurring due to three general strategies that formed connections and built agreements around shared interests related to BoC. These included shifting public opinion through BoC ambassadors, shifting service delivery through evidence, and influencing opinion leaders, influencers, and gatekeepers. Each of these is next discussed with attention to how specific marketing actants played a role in the process across specific enrollment strategies involving seduction, transaction, and consent without discussion.

Shifting public opinion through BoC ambassadors. If BoC advocates are to be enrolled, they must first be "willing to anchor themselves" (Callon 1986, p. 211) to the BoC movement. However, Callon (1986) notes that people often sit back and observe before formally enrolling. They are more likely to accept the conclusions drawn by a trusted specialist. This way, consent is obtained without direct negotiation with individuals; instead, support is reached thanks to the influence of a leadership team.

Several key factors substantially contributed to ensuring consent in formally enrolling advocates in decolonizing birthing practices, especially for First Nations communities, midwives, mothers, and Elders. Fundamentally, BoC's use of Molly Wardaguga as a "brand ambassador" gave an authentic, personified representation of the movement. Molly Wardaguga was a Burarra Elder, an Aboriginal midwife, a senior Aboriginal health worker, and a founding member of the Malabam Health Board in Maningrida, Arnhem Land. She was an essential contributor to the Australian discussion on BoC. Her vision was to support women's cultural and birthing aspirations, especially those of women living in remote locations. By naming the BoC institute after her, the movement leveraged her reputation and paid her legacy homage. Using Molly Wardaguga as a figurehead had the added marketing benefit of positioning the institute as a key expert and mediator of knowledge on BoC. In this role, the institute aided in multilateral negotiations with other actants, such as the broader community, governments, and the medical profession.

Shifting public opinion and offering an alternate image of First Nations people was vital in enrolling actants into the BoC program. Mainstreaming a decolonized approach to birthing required repositioning, which is essential to changing perceptions and securing consent (Sheth, Jain, and Ambika 2020). An additional marketing technique used for repositioning was thought leadership (Doherty, Kerrigan, and Belk 2020) via content marketing approaches using owned and earned media (Bowden and Mirzaei 2021). Thought leadership was communicated through the research centers, scholarly articles, documentaries, webinar series, podcasts, newspapers,

social media content, and traditional storytelling events. All these channels offered the public an opportunity to see the wisdom in ancient cultural practices. Scientific and health discourses often supported storytelling; for example, by seducing medical professionals with storytelling, the medical fraternity supported the birthing positions adopted by First Nations mothers (e.g., squatting or leaning against a tree; Kildea and Wardaguga 2009).

Notably, the information, stories, and insights disseminated via digital channels were publicly accessible throughout Australia (Molly Wardaguga Research Centre 2023a; O'Flaherty 2021; Watego 2021). For example, research results on the significance of BoC were repackaged into more accessible messages and disseminated through digital media. This included promoting the evidence gathered by Kildea's team and research stemming from the Molly Wardaguga Research Centre in ABC podcasts, such as "Mums on Country" (Ireland and Maypilama 2023), and the NITV (National Indigenous Television) podcast "Hopes for Birthing Centre at Galiwinku Elcho Island NT" (Ireland and Maypilama 2020). Furthermore, the National Indigenous Radio Service interviewed a First Nations midwife and mother on a program titled "Calls for Action on Indigenous Maternity Care" (Clarke 2016). In this interview, she explained the BoC policy to a national First Nations audience in a way that would secure community buy-in. Such marketing activities helped BoC create a safe space for traditional birthing practices in the community.

As a result, early BoC participants became advocates to increase recognition of the program by promoting its positive outcomes via social media channels, including YouTube, Facebook, and Instagram. Family members posted about their experiences, voicing praise and showcasing the positive experience for mothers, children, and entire family. This included 27 stories of participants' experiences shared on radio, television, online, and in media releases, reaching an estimated 9.6 million people in 2022 (Central Australian Aboriginal Congress, Charles Darwin University, and Molly Wardaguga Research Centre 2022).

In doing so, many early adopters helped decolonize the birthing experience by shifting the dominant maternal and child health narrative from a colonized perspective to one centered on holism. This was further aided by BoC advocates engaging in seduction techniques, which are an enrollment strategy that targets crucial stakeholder actant groups' representatives to foster representative excitement, a sense of shared purpose, and the feeling that they are part of something larger than themselves (Callon 1986). At this stage, seduction techniques occurred through visual displays of joy, happiness, contentment, and holism to influence public adoption of BoC. Such influence was primarily achieved by advocates conversing with their peer group using modes of communication that resonated with them and helped persuade their opinion concerning BoC (Alhidari, Iyer, and Paswan 2015). These early participants also highlighted the importance of community-based care (Kildea et al. 2016), rooted in cultural values and practices, furthering the seduction techniques by highlighting ideal outcomes. In promoting the program's positive results, its participants helped challenge the dominant discourse that often marginalizes the voices of First Nations communities.

Shifting service delivery: enrolling through evidence. Transactional strategies—a type of enrollment—are ways marketing actants attempt to persuade others to participate in a specific program, centered around building trust and relationships between actants involved in the process of enrollment (Callon 1986). In this regard, ongoing community investment was one of the keys to the program's success. BoC programs allowed family members to attend this most sacred event, with partners being able to participate using traditional fire healing techniques (Kildea and Wardaguga 2009). This connection between the father and the child–mother dyad differs significantly from hospital births, especially since men often did not attend the birth for financial reasons, inaccessibility, or the need to look after other children. As the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives CEO Janine Mohamed (cited in Dragon 2019) reports, "Birthing on Country models of care provide integrated, holistic and culturally safe and respectful care for the 'best start to life' for Aboriginal and Torres Strait Islander families and their communities." This change in delivery "ensures a spiritual connection to land for Aboriginal mothers and their babies" (Dragon 2019).

To facilitate enrollment, evidence was also collected regarding the service delivery costs. These data assisted BoC advocates in using transaction and seduction techniques to enroll governments and medical providers into the BoC program. Further, with a mix of health, financial, and marketing discourses (Gao et al. 2023; Kildea et al. 2021, 2017), BoC advocates were able to position BoC in a manner that convinced institutions to formalize their role in the BoC movement. For example, the research showed that the program reduced costs per birth by an average of AUD 5,283 (approximately USD 3,540) due to lower preterm birth rates and reduced transportation costs to regional hospitals for mothers (Gao et al. 2023). Hence, presenting a clear financial advantage to a decolonized approach to birth for First Nations peoples convinced governments to consider further investing in future BoC programs and initiatives (National Indigenous Australians Agency 2022a).

Influencing opinion leaders, influencers, and gatekeepers. The BoC movement drew on seduction techniques to positively influence key opinion leaders, influencers, and gatekeepers. Relationship marketing is critical in swaying key stakeholders (Wiener, Flaherty, and Wiener 2022). For this reason, advocates ran workshops and special events for medical professionals, politicians, service providers, and medical authorities to humanize BoC. Advocates forwarded their case for further investment in the BoC program. They showcased research findings, testimonials, and lived experiences as insights into the program.

This relationship marketing "established wide community and service support to urgently redesign the maternity system in North-East Arnhem Land" (Ireland et al. 2022, p. 7). While some of these techniques do not appear to be a decolonized

approach, advocates did use traditional customs and practices, including yarning circles and smoking ceremonies at events, conferences, and workshops to set the tone and emphasize the cultural significance of the BoC program.

Advocates of the program also used direct marketing techniques to spread targeted information to gatekeepers, for example, sharing with policy makers the statistics on decreased infant mortality rates, improved social outcomes, and lower levels of domestic violence among the communities that had adopted BoC. Through these discussions, these advocates demonstrated to key stakeholders that BoC had reduced costs and improved social/health outcomes and should be a legitimate option for women in rural and remote areas (see Molly Wardaguga Research Centre 2023b). In doing so, they reaffirmed their position as thought leaders and experts. Additionally, lobbying techniques, such as online petitions, were used (Walker 2016). This, combined with email marketing, helped those attempting to sway opinion to create a direct line of communication with decision makers.

At this point, we have established how core ambassadors and advocates engaged in multilateral negotiations with key actants, identifying and confirming their roles and willingness to participate in BoC-related activities. All actants aligned with the brand used a variety of marketing techniques and technologies to enhance the visibility, credibility, and legitimacy of the BoC program through transactional activities and, most importantly, by using seduction strategies to influence those who had the means to invest and support the brand over the long term.

Mobilization

In this section, we find evidence of mobilization through establishment of rules and protocols for instituting a decolonized approach to BoC. We next discuss how the specific marketing actants played a role in the process.

The First Nations communities were mobilized through a range of action research projects, such as Caring for Mum on Country (Molly Wardaguga Research Centre 2023b), which worked in collaboration with the Yolŋu women in Arnhem Land (Ireland et al. 2021). In these instances, academic researchers, doulas, midwives, and First Nations mothers were transformed into what Callon (1986, p. 218) calls "graphic representations." Thus, these actants were transported from the land into easily transportable, reproducible, and diffusible sheets of paper (Callon 1986; Kildea et al. 2021). While this may sound callous or dehumanizing, it allows for storytelling and other marketing techniques to showcase success to broader audiences. It also helped ensure the ongoing commitment of a wide range of silent actants in medicine, government, health service institutions, the general public, and the First Nations communities.

Another key to the success of mobilizing the program was to establish formal governance structures that helped ensure that all actants were represented and that decisions were made collaboratively and in the project's best interests. These structures also provided a mechanism for ongoing interaction with the actants involved in the project, as all would know their responsibilities and the commitments they had made to ensure the viability of this new birthing approach. Significantly, this framework respected First Nations knowledge and incorporated traditional practices. It empowered First Nations women to decide the location and conditions of their birthing journey. The framework also involved a training and education protocol, service characteristics, and policies and procedures for monitoring and evaluation. Consequently, this framework would come to form the basis of all research projects undertaken by the actants, including those funded by government agencies, such as the Australian National Health and Medical Research Council (NHMRC) partnership, the Institute for Urban Indigenous Health, the Aboriginal and Torres Strait Islander Community Health Service Brisbane, and the Mater Mothers' Hospital.

In 2019, following the success of the BoC program in improving the health outcomes for First Nations mothers and their babies (Kildea et al. 2021), the Council of Australian Governments Health Council (2019) recommended that the BoC model be adopted as one of the core elements of the national strategic directions for Australian maternity services.

Groups like the Molly Wardaguga Research Centre announced national conferences on BoC to align representatives' and their constituents' attitudes, behaviors, and ongoing practices. Workshops and special events for health workers, policy makers, and potential funding agents were another essential aspect of stabilizing BoC in the mobilization stage. These events provided an opportunity to engage with health practitioners and to promote the value of BoC. Such events also provided an opportunity to address any concerns or questions that health practitioners may have had about the BoC approach. Importantly, they "galvanised many advocates to improve maternity services for Indigenous Australians" (Charles Darwin University 2022).

In addition to engagement and communication, ongoing education and training were critical to the mobilization stage. This education and training helped promote cultural competence and sensitivity on the part of mainstream health services and assisted in scaling the program. It also helped ensure that health care practitioners would provide culturally appropriate care to First Nations mothers and babies. Last, education worked to ensure the sustainability of community-led birthing programs by ensuring that health practitioners could and would provide ongoing support and guidance to First Nations mothers and families.

The BoC focal actants, through multiple settings such as community workshops, ABC interviews, and journal articles, highlighted the importance of funding for the successful mobilization of the program. Presented with scientific data that demonstrated the program's success from medical and healing perspectives (e.g., Ireland et al. 2021; Kildea et al. 2021), the Australian government acknowledged the need for financial support. Several agencies demonstrated a long-term commitment to BoC at this stage by providing ongoing funding via NHMRC grants and federal and territory budget allocations.

These allocations included successive financing of nearly $57 million (in AUD) over several decades for researchers, building culturally safe medical centers on First Nations country, First Nations service providers, medical practitioners, First Nations community organizations, and other aligned organizations. For example, NHMRC grants were secured across multiple years in the following amounts: $1,090,701 in 2013, $1,297,911 in 2014, and $1,496,532 in 2015. More recently, a $5.5 million investment was awarded through the NHMRC Partnership Project scheme in 2021, $15 million in national funding became available in November 2021, and $15.3 million was awarded from the Department of Health and Aged Care Queensland and Northern Territory in 2022. Also, in 2022, the Department of Health and Aged Care provided $5.9 million for research in the Northern Territory and Queensland and over $11 million at the national level.

This substantial investment in the BoC program demonstrates that institutions once part of the colonizer power regime had become staunch supporters and advocates. These institutions recognized the importance of decolonizing health care and promoting First Nations–led models of care. This support from funding agencies has contributed to building a sustainable framework for BoC and has created opportunities for the program to expand its reach and impact. Further, it demonstrates a growing commitment to reconciliation and recognizing First Nations knowledge and practices in the broader health care system.

Discussion

Implications for Marketing Theory

The study extends the use of ANT in marketing (Bajde 2013; Giesler 2012; Ozuem et al. 2021) by examining the usefulness of ANT as an approach to decolonize health care practices. A key challenge in any decolonizing approach is abstaining from standard marketing techniques to avoid reinforcing colonialism in communications and branding (Ger 2018; Varman and Belk 2009). Our study shows that visual storytelling and medical reporting were influential in problematizing the colonized health approach. Further, storytelling via media, the use of digital media, and campaigns for alternative birthing services reinforced arguments for a decolonized approach. The interessement stage was typified by more personalized campaigns of building alliances, networking, branding, and service design. Enrollment was facilitated by utilizing an array of marketing actants such as brand ambassadors, thought leadership, community events, petitions, and relationship marketing techniques, followed with direct marketing designed to get buy-in from all human actants. Finally, BoC was mobilized and successfully implemented by holding marketing events such as conferences, finalizing and disseminating BoC governance structures, and engaging with all key human actants in BoC education/training events.

We also recognize First Nations knowledge as a critical component of theory building for investigating issues concerning First Nations consumers, advancing this perspective from decolonization research in marketing in general (Belk and Groves 1999; Chow, Carrington, and Ozanne 2022; Eckhardt et al. 2021) to that in health care. Importantly, our ANT theorization underscores a critical understanding of the need for the continuous negotiation and reconfiguration of actant networks in implementing decolonization within health care. This encompasses acknowledging elements of First Nations health care practices.

Importantly, such an approach expands transformative research and cocreation in health marketing (Dahl, Peltier, and Milne 2018; Davey and Grönroos 2019; Frow, McColl-Kennedy, and Payne 2016; Mai and Wang 2019; Verleye et al. 2017) by incorporating holism within health care (Gee and Walsemann 2009; McGuffog et al. 2023). This is done by moving beyond considering the individual lived experiences of First Nations people as vulnerable consumers (Beatson et al. 2020; Boenigk et al. 2021) to assess the broader impacts of actants and networks. This use of the ANT framework with connected marketing approaches also holds much promise as a means of understanding power and facilitating change in health markets and systems (Donovan, Hampson, and Connolly 2018; Ozuem et al. 2021) thus improving outcomes for First Nations people. Our conceptual framework (see Figure 1), for example, provides an opportunity to closely examine the network of human and nonhuman mechanisms through which colonization has been entrenched and sustained.

We also believe our theoretical framework helps map the holistic perspective of First Nations people (Banerjee 2021; McPhail-Bell et al. 2016; Wright et al. 1997) and how this must be addressed in any positive health change (Gee et al. 2014; McGuffog et al. 2023) to overturn barriers of colonial structures in health services (Silberner 2021; Tsey and Every 2000).

Implications for Marketing Practice

Although there is yet to be a clear consensus among researchers and practitioners about the role of marketing in decolonizing health care, there is a growing recognition that health care systems and research practices need to be decolonized if we are to address the health inequities suffered by First Nations and other marginalized populations. This healing process may require several steps. For example, our case study clarifies that including First Nations knowledge and worldviews in current health marketing practices is essential. Further, and relatedly, it may mean encouraging First Nations people to participate in health care marketing practice. From our analysis, marketing can play a critical role in this process across all stages of the change process.

As noted, there is an understanding of the problem for health care marketers when working with First Nations people. What needs to be improved is how to implement change successfully. Our article makes an essential contribution to practice by demonstrating that not only does a holistic approach to First Nations health care need to be followed, but for decolonization to be

successful and beneficial, there must be alliances for change across different parties (researchers, health practitioners, government, and First Nations people). In the BoC case study, these alliances occurred over several years with the strategic use of marketing interventions at each stage of the ANT process.

This article thus provides a template for future practice. Table 2 shows that crucial roles for marketing in decolonizing health care appear at each stage of the ANT process. Notably, the case study illustrates that this process takes time. Still, significant change is possible if a systematic approach is used and targeted marketing interventions are used strategically. For social marketers seeking more extensive fundamental changes to health care, the ANT approach with matched marketing activities outlined in this article may provide a change plan.

Implications for Marginalized Groups

This study provides implications for First Nations people who wish to engage in decolonization. First Nations people can leverage marketing techniques and technologies to create access to help establish and legitimize decolonized health care services. To that end, marketing can be used to communicate the problem, promote the program, and design service delivery in a consistent fashion. Additionally, marketing practices might be used to advocate for developing infrastructure that supports such health care services. In the case of BoC initiatives, this includes birthing centers funded by government and placed on First Nations land, culturally appropriate facilities, and community-led health care services.

Another critical lesson for First Nations people is that they need a network of allies. First Nations people must build relationships and partnerships with parties who share their goals of decolonizing birthing practices. This includes engaging with researchers, policy makers, health care professionals, and community organizations to develop collaborative strategies, share knowledge, and advocate for change. This article shows that universities and research institutes could present an argument with the same underlying rationale of "healing," but using the same discourses as the colonizer (scientific and health care). This partnership allowed authentic representation and an ability to navigate a system designed to suppress, marginalize, and dehumanize. Without these alliances, there would only be pockets of decolonization scattered across the country.

Further, ANT could be used to understand how markets are shaped, particularly how actants influence markets (Hawa, Baker, and Plewa 2020). This may be a handy tool for studies that seek to shape markets for a better world. With its focus on how technical artifacts influence systems of knowledge and practice, ANT may also be useful for understanding other aspects of health care marketing, including vaccine access (Malhame et al. 2019) and widespread adoption of blood pressure monitors and scales (Williams et al. 2020). Importantly, ANT not only explains this process, but may also help ensure positive change occurs.

Lastly, the ANT framework may help change medical practices in other areas. While reviews of health policies and the need to identify areas of decolonization are welcome (Herzog et al. 2021; Mackean et al. 2019; Mokuau et al. 2016), they do not plot a systematic way forward as ANT does. Combined with complementary marketing techniques, this robust theoretical framework can make marketing a critical catalyst for the social and technical change needed to decolonize and improve health care. Our research shows that marketing approaches applied judiciously at each stage of the change process identified in the ANT framework offer essential opportunities for a decolonized approach to health care.

Limitations and Directions for Future Research

This study primarily focuses on maternal health for First Nations Australian women, leading to potential contextual variations such that our findings may not be generalizable to broader populations or other health concerns. Given the context of decolonizing health care, there is a risk that researchers from a dominant culture may inadvertently project their cultural assumptions onto the data, leading to bias in interpretation. To avoid this problem, our team comprised several First Nations researchers.

Research with First Nations peoples requires deep relational partnerships toward codesign and coimplementation. Decolonization involves more than just addressing justice issues caused by historical marginalization; it requires a holistic, Indigenous theoretical and methodological approach. Any study or intervention in this space must carefully consider issues of consent, representation, and the potential for causing harm. This led us to use sources that spoke of the lived experiences of First Nations people rather than undertaking interviews. However, mixed methods (qualitative and quantitative) may be needed to explore and understand this complex topic fully. The challenges faced by potentially vulnerable groups, such as First Nations people, deserve the attention of marketing researchers to build more robust conceptual and methodological perspectives.

Conclusion

This article shows that a decolonization agenda is possible in health care and that marketing techniques and technologies, historically used to reinforce colonial structures, can resist colonization and enact positive change for First Nations peoples. Our article focuses on one case study, BoC. It offers evidence that marketing can play a role in the decolonization process for a critical health care service for the betterment of First Nations peoples. Hopefully, these processes and findings can be scaled to benefit other marginalized groups in society.

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