

Aboriginal Birth Psychosocial or Physiological safety

**Marie Chamberlain, Kate Barclay, Azar Kariminia
& Alwyn Moyer**

Abstract: The purpose of this paper is to raise awareness and stimulate discussion and research into maternity care options for Aboriginal women living in remote areas of Australia and Canada. These two countries have similar situations in that some communities are so remote that emergency medical care requires the use of aircraft. In addition, both countries have, since the 1970s, adopted policies for the transfer of mothers in late pregnancy to hospitals in urban centres. For many Aboriginal families this policy has been far from ideal. As a result, some Aboriginal women fail to seek early health care when pregnant. In order to counteract this, it is necessary to offer culturally sensitive maternity care that Aboriginal women will accept. The results of an evaluation of a birthing centre in the Canadian Arctic will be presented along with a range of birthing choices for remote area Aboriginal women and their families. Some of these options have already been initiated by some midwives. This paper challenges health service providers to identify the method of maternity health services required by Aboriginal families and provide creative solutions to meet those needs in a safe and cost effective way.

Key words: Aboriginal, pregnancy, birth, Australia, Canada, transfer, birthing centre.
Birth Issues 2001;10(3/4):81-85

Introduction

As in Australia, the policy of transferral of Aboriginal women (Inuit and Indian) for birth in the Canadian Arctic arose because of a decision by the Medical Officer of Health that it was unsafe for women and their babies to give birth in remote communities, away from obstetrically equipped hospitals. A further impetus was a territorial health policy shift towards public health and away from maternal health, resulting in a higher employment of primary health nurses and fewer midwives. There was also a shortage of professional resources for community births and a lack of maternity skills to provide a safe environment for birth.

Remote area Aboriginal women were doubly targeted by the new policy because they had

been identified as being at high risk for adverse physiological birth outcomes. According to the latest statistics, the perinatal mortality rate (PMR) for non-indigenous women and infants in Canada was 7.9 per 1000 with the figure twice as high for Indian and two and a half times higher for Inuit babies.¹

Marie Chamberlain RN CM PhD, is Professor of Midwifery, University of Sydney and the Northern Area Health Service. Kate Barclay BA MA PhD is currently an Associate Lecturer in Japanese Studies at the Institute for International Studies. She was the Research Assistant initially, Azar Kariminia BM MSc is the current Research Assistant, Midwifery Research Centre and Alwyn Moyer BN PhD was the statistician.

Table 1. Aboriginal and non-Aboriginal perinatal deaths 1994-1996.
Rates expressed per 1,000 births

	Aboriginal	Non-Aboriginal
New South Wales	16.3	8.4
Victoria	16.8	10.8
Queensland	24.3	10.6
Western Australia	20.3	9.4
South Australia	25.6	10.2
Northern Territory	27.0	11.5

A similar state exists in Australia for Aboriginal women. In three of the States and the Northern Territory, the PMR for Aboriginal babies was more than twice as high as for non-Aboriginal infants (Table 1). The fetal death rate for Aboriginal mothers was also double that of non-Aboriginal mothers, 13.9 versus 6.7 per 1000 births, with little variation between the three States and the Northern Territory.²

Despite more than two decades of the transferral policy in both countries, the infant death rates remain much worse for Aboriginal than for non-Aboriginal Canadians or Australians.^{1,2} The reasons for this are complex and include psychosocial and physiological factors. One contributing reason could be the criteria used to measure risk when making the decision to transfer.³ Most risk assessment tools have been standardised on mainly white female populations with a physiology somewhat different from indigenous women.³ For example in Canada, Inuit first time mothers were sent out of the community for birth because they have no obstetric history and thus are considered to be at risk of an obstructed birth such as shoulder dystocia. However, results from a community birthing project in Northern Quebec suggest that shoulder dystocia is a rare occurrence for Inuit women. It was also noted that unlike the non-Inuit women under 18 years, adolescent Inuit women produced very healthy babies.²

In Australia, Aboriginal adolescent mothers experience a higher rate of preterm pregnancies than non-Aboriginal mothers in the 20-29 year age group. During the years 1994-1996, almost 1% of Aboriginal mothers were below 15 years with no mothers below that age in the non-indigenous population.¹

This paper will address psychosocial issues that may affect birth outcomes amongst Aboriginal women. For example, in some areas some Aboriginal women forego antenatal care and

delay presenting at a health centre until well established in labour to avoid transferral to another site. Midwives report their antenatal services are often not utilised by Aboriginal women, sometimes because of dissatisfaction with health services and the mainly white, English-speaking staff (personal communication). This also happened in the Canadian Arctic before the introduction of a Birthing Centre.²

Literature Review

There is considerable research indicating high levels of unhappiness and exhaustion among Western women in the first year after birth. This has been attributed to a lack of practical and emotional support, a widely recognised risk factor for postnatal depression.⁴ Williams and Carmichael⁵ investigated the mental health of a cohort sample of parturient women from several different cultures in an economically deprived urban area of Melbourne. They found high rates of depression among Australian-born women who had unstable and/or violent childhoods and/or family life, but the highest rates were among recently immigrated women with minimal English language skills and no support. In other research, refugees are described as being at increased risk of depression because their cultural world is 'decontextualised' and their social support networks weakened.⁶ A sample of Hmong women living in America attributed emotional problems after giving birth to living away from Hmong culture, living as foreigners in American society and having to communicate in an unfamiliar language.⁷ Many minority group women feel discriminated against in mainstream health services. In a study of welfare services for indigenous women suffering violence in Ontario, it was found that not having anyone to communicate with in one's native language exacerbated feelings of loneliness.⁸ Racism was felt in discriminatory attitudes and the cultural ignorance of white staff, as in the ethnocentric structure of services.

The marginalisation felt by some women was so extreme one woman said she would "rather sleep on the street" than go to a white institution."

The causes of adverse outcomes in Aboriginal birth statistics are not simply physiological and therefore physiologically-oriented policies such as transferral have not substantially improved the statistics.

It is important that health services develop less alienating maternity care systems, which include the choice to give birth in the community if it is safe to do so.

Research is needed into why many Aboriginal women do not seek antenatal care, what kinds of antenatal services Aboriginal communities do want and will utilise, and whether such services can be safe, effective and cost efficient. When designing some alternative birthing services for Aboriginal communities in the Far West of New South Wales in 1997, midwives who conducted a literature search found no research on any of the major international maternal health databases.

Evaluation of a birthing centre in Canada's North West Territories (NWT)

By the early 1990s many indigenous women in the Canadian Arctic were requesting more involvement in their births and more choice of where birth should take place. Health professionals supported a birth centre because it could provide the type of culturally sensitive care to Aboriginal women with low risk pregnancies that they wanted.

Two Arctic communities with populations of 1400-1900 were used for the evaluation, one with the birthing centre and one for comparison because the parturient population was demographically similar. The birth centre was based in community A, situated on the Hudson Bay about 250 kilometres by air from Yellowknife NWT, a level 2 hospital and 1000 kilometres by air from Winnipeg, the tertiary referral centre. The comparison community, B, where all women were transferred for birth was 250 miles north east of Community A. Community A was chosen because there was community support, a health centre, a general practitioner and an Aero-Medical Evacuation Service.

The Birthing Centre opened in November 1993 with two midwives. There were no midwives in Community B. The evaluation was conducted in

1995 using a combination of quantitative data on costs and physiological outcomes and qualitative data on people's thoughts and feelings about their maternity care."

Stress associated with leaving the community for birth was the major theme to emerge from interviews with consumers. Mothers were concerned about birthing elsewhere, enforced separation from family, culture and community and the health of children left behind. Some mothers missed the support of partners during childbirth. Two women were homesick while two were bored waiting for the birth. These feelings were aggravated by the difficulties of living in residences with strangers, an unfamiliarly high environmental temperature and unfamiliar food.

One woman in Community B said she suffered depression as a result of having to give up her baby for adoption because no one had warned her how bad she would feel. She was unable to talk to her family or the nurses. Another mother in a tertiary hospital was upset when her baby was taken away before she had seen it or been given an explanation. She was still unclear what the problem was other than 'there was something wrong with the baby's heart'.

The issue of re-integration of mother and newborn into the family after a prolonged absence (average three weeks) was mentioned. One mother said her youngest child did not know her when she returned home. A couple of mothers felt they had to watch their younger children in case they harmed the baby, because they blamed it for taking their mother away. Four mothers transferred from Community A for birth said they felt well prepared because they attended antenatal classes at the birth centre.

Financial stress was incurred by parents when the mother was transferred for birth. Mothers spent money on baby sitters and long distance telephone calls. There was the additional airfare cost if the partner came out and the cost of his time off work. One woman said her husband was unfamiliar with housekeeping and therefore spent more than they could afford on food.

I. Stress

The theme of stress around birth was rarely mentioned by mothers who delivered in the Birthing Centre. They enjoyed having their families and/ or partner with them, found the constant presence of the midwife helpful and were able to birth the way they wanted. Having an Inuit maternity worker present during the

birth to provide explanations in the woman's own language also proved invaluable.

2. Choice

Another theme was the family's lack of choice regarding the place of delivery, the form of delivery and the amount and type of support they wanted during the birth. Parents in Community B felt most health decisions were made by health professionals. In contrast, ten of twelve women in Community A felt they participated in these important decisions. The remaining two women had not been given a choice, one because of hypertension and the other because of the birthing centre's policy of not delivering first pregnancies. Women who delivered out of their community felt they had little choice about moving around and positioning during labour and delivery.

3. Support

The final theme to emerge was the lack of support during labour. Four women said they got little support from hospital nurses during labour, while five mentioned that nurses were not around much or 'not that helpful'. They stated that nurses just 'popped in and out' and did not stay until they were ready to 'push the baby out'. Three mothers felt the hospital nurses had been helpful, and one said they helped calm her. One mother said the nurses and doctors 'only did what they had to do' while two complained of 'doctors coming in at the last minute and telling me to push'. Two others said they had to lie on their backs instead of being able to squat or kneel which they would have preferred as lying down made birth much harder. One mother had engorged breasts and cracked nipples on discharge because she was unable to get assistance with breastfeeding. Upon her return to the community, she went from the plane to the birth centre to get help from the midwife and stated that without this help she would have given up breastfeeding.

For those women who delivered away from home, birth was a traumatic event intensified by feelings of isolation and worry about their families. This was compounded if their partner or a family member was unable to attend the birth. In contrast, three mothers who delivered in the birthing centre and two who delivered out of the community talked about the helpfulness of the midwives on home visits following the birth. One mother thought the midwives were wonderful and would 'like to write to their superiors to tell them'.

In the birthing centre, additional psychosocial support was provided by the Inuit maternity worker. She enabled women to reveal factors

such as sexual abuse, which Inuit women do not usually reveal. She spent a great deal of time on counselling abused women even though this had not initially been part of her role.

The birthing centre project produced many psychosocial benefits including a reduction in family disruption, greater parental satisfaction and greater involvement of fathers with their newborn. These fathers were seen carrying their infants around the community and even bringing them in for baby checks - a new role for Inuit fathers.

The Australian Context

Maternity services which do not follow the traditional pattern of health care have also been established in Australia. The Aboriginal Birthing Project in the Macquarie Area Health Service in western New South Wales, Daruk Aboriginal Medical Service in Mount Druitt (Sydney) and the Aboriginal Maternity Service in Tamworth are three that are well established. Some hospitals have Aboriginal birthing services, or Aboriginal liaison midwives, such as Allison Bush in Sydney, so that even if women leave their communities for birth, they may still obtain more culturally sensitive care. Congress Alukura in Alice Springs provides birthing services for Aboriginal women from Alice Springs and surrounding areas. Kalgoorlie Hospital provides special services for women who come from the Central Desert as well as for women from camps around Kalgoorlie.

In Queensland there are a number of community midwifery programmes, such as Mookai Rosie in Cairns. This programme provides hostel accommodation and support services for indigenous women from Cape York and a community midwifery outreach programme for pregnant Aboriginal women at high risk for health problems. There are also Aboriginal maternity programmes in Cherbourg, Inala and Rockhampton that use midwives and/or Aboriginal maternity workers to provide antenatal and postnatal care to Aboriginal women. A similar programme has recently been created in New South Wales for rural and remote area health services.

These are just a few of the Aboriginal programmes across the country. Unfortunately, they are not replicated in all Aboriginal communities and there is concern that they will not be maintained when funding is withdrawn. Given the present poor Aboriginal infant and perinatal mortality rates, it is imperative that we evaluate all programmes, support the

successful ones and ensure they are implemented by other health services. One way to better health is to ask Aboriginal women what they want and recognise that intolerance of other cultures can not only have a negative effect on birth outcomes but also increase the mother's sense of isolation negatively impacting on future birth practices. Providing a culturally sensitive birthing centre may be one way to encourage Aboriginal women to seek care early and thus reduce the maternal and infant mortality rate.

Conclusion

Evaluation of a Canadian Arctic birthing centre suggests that leaving the community for birth involves emotional and financial costs for many Aboriginal women and their families. Such costs could outweigh any physiological safety gained from being transferred out. Options for community births and other choices in Australia should be explored with remote area Aboriginal communities. Giving birth within the community is what most Aboriginal women want, and at the same time, it could improve birth outcomes and can be cost-effective. Psychosocial health should not be ignored in pursuit of a narrow physiological definition of health, and considering the physiological outcomes of current policies in Canada and Australia, we have little to lose from a more holistic approach.

References

1. Chamberlain M, Moya A, Nair R, Nimrod C, Smith M, England J. Evaluation of the Birthing Project in Rankin Inlet, NWT, Health Canada Report, 1996; NHRDT Grant No. 6606-5519-T.
 2. Day P, Sullivan E A, Lancaster P. Indigenous mothers and their babies, Australia 1994-1996. AIHW Cat. No. PER 9. Sydney: Australian Institute of Health & Welfare National Perinatal Statistics Unit, 1999, Perinatal Statistics Series No. 8.
 3. Carignan G. Pregnancies and births among the Inuit population of Hudson Bay 1989 - 1991. Projet Nord. Community Health Department, University of Laval Hospital Centre, 1993.
 4. Small R, Astbury J, Brown S, Lumley J. Depression after childbirth. Does social context matter? *Medical Journal of Australia* 1994;161(8):473-477.
 5. Williams H, Carmichael A. Depression in mothers in a multi-ethnic urban industrial municipality in Melbourne. Aetiological factors and effects on infants and preschool children. *Journal of Child Psychology & Psychiatry & Allied Disciplines* 1985;26 (2):277-288.
 6. Palinkas LA. Health under stress: Asian and Central American refugees and those left behind. Introduction. *Social Science and Medicine* 1995; 40 (12):1591-1596.
 7. Stewart S, Jambunathan J. Hmong women and postpartum depression. *Health Care for Women International* 1996; 17 (4): 319-330.
 8. Aboriginal Women's Support Program Ltd. A community needs assessment. Submission to the Ontario Ministry of Community and Social Services 1993, April 22nd.
 9. Chamberlain M, Barclay K. Psychosocial costs of transferring indigenous women from their community for birth. *Midwifery* 2000; 16 (2):116-122.
-