Birthing on Country

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The Midwifery Research Unit is a joint initiative between Australian Catholic University and Mater Medical Research Institute.
Acknowledgement to Country
Where we are coming from.....
Close the Gap

• “It is inconceivable that a country as wealthy as Australia cannot solve a health crisis affecting less than 3% of its population” Close the Gap Report

– 10,183 mothers and their babies.
National Maternity Services Plan

• Action 1.4
  – Increase access for women and their family members in remote Australia to high-quality maternity care

• Action 2.2
  – Develop and expand culturally competent maternity care for Aboriginal and Torres Strait Islander people

National Maternity Services Plan

• Action 2.2.3
  – Development and implement a national evidenced based Birthing on Country service delivery model

• Action 3.2
  – Develop and support an Aboriginal and Torres Strait Islander maternity workforce
    • Health workers / Cert IV Maternal Infant Health /AMIC workers
    • Midwives
    • Doctors
Birthing on Country L/R

Evidence based strategies

- Very little high quality evidence
- Small numbers
- Short term evaluations
- Evidence is building
“…should be understood as a metaphor for the best start in life for Aboriginal and Torres Strait Islander babies and their families because it provides an integrated, holistic and culturally appropriate model of care; not only bio-physical outcomes … it’s much, much broader than just the labour and delivery … (it) deals with socio-cultural and spiritual risk that is not dealt with in the current systems.”

Birthing on Country Workshop Report
Birthing on country

• “…It is important that the Birthing on Country project move from being aspirational to actual.

• The Birthing on Country agenda relates to system-wide reform and is perceived as an important opportunity in ‘closing the gap’ between Indigenous and non-Indigenous health and quality of life outcomes.”

  – Birthing on Country Workshop Report
Evidence based strategies

- Continuity of carer
- Community based / controlled
- Outreach / home visiting
- Flexibility
- Indigenous staff
- Culturally appropriate
- Working in partnership
  - AHWs and midwives
  - Agencies
- Community development

(Herceg, 2005)
Evidence supports a different approach

• It's not business as usual
  – Eg. BMid workforce, midwives no longer nurses
  – Eligible midwives in private models
    • ‘If I could outsource all of my midwifery services I would do it in a flash’ Rural DON

• We must not try and reopen service in the same way we did in the past

• If establishing Level 3 ensure a Level 2 is embedded and enabled if needed
  – E.g. Mareeba
Evidence that we should change the way midwives work

– Cochrane review
  • 13 RCTs; n=16,242 women
  • Reduced: interventions in birth and preterm birth rates, with women reporting increased satisfaction and sustained breastfeeding

– COSMOS – Low Risk
  • Reduced CS

– M@NGO - All risk
  • Reduced: Inductions, elect CS, PPH, LOS, Cost
  • Clinically significant – reduction in CS, PPH, Increased Breastfeeding 6 weeks & 6 months

Why?

Midwifery care

Culture of confidence in normal birth

Healthy women, babies

Intact perineum

Spontaneous birth

Birth as close to home and family as possible

Risk in perspective

Spontaneous labour

Pain as part of childbirth

Cascade of Normal

Dr Vicky Van Wagner
Canada
We have examples

• Urban models
  – Birthing in our Community
    • IUIH, ATSICHS, Mater
  – Ngarama
  – Townsville Mums & Bubs

• Rural models
  – Mareeba
Models for women flying in from remote
  – Darwin
Primary Maternity Services in Australia: A Framework for Implementation, 2008

- Includes antenatal, birthing and postnatal care for women with low-risk pregnancies
  - Level 11 Services
  - Primary Maternity Units
  - Birthing Centres

- Endorsed by all State and Territory Ministers
The Evidence

Primary Maternity Units
Birth Centres
Free standing units
Level 11 Units

Safe for mother and baby
Benefits for the mother

Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study

Birthplace in England Collaborative Group
New Zealand - Primary units

- 51/58 units in rural or remote settings
  - 31 are > 1 hour from tertiary services
  - Weather a problem – services continue
  - Culturally secure services
    - 23% of Maori women birth in primary units
- Primary maternity unit: 16.25% birth
  - Low transfer rate (10%) due to good risk screening

Hunter, M., et al., Do low risk women actually birth in their planned place of birth and does ethnicity influence women's choices of birthplace?
Some of the fears

– Mothers and babies will die
– We will be blamed
– No-one really wants to birth in communities anymore – it is only the old ladies
– All the women with risk factors will stay
– There are too many women with risk factors anyway
We can learn from others
“I can understand that some of you may think that birth in remote areas is dangerous. And we have made it clear what it means for our women to birth in our communities. And you must know that a life without meaning is much more dangerous.”

Jusapie Padlayat
Elder, Chair of Inuulitsivik Health Board
Bringing birth back

- Builds capacity in the community
- Restores skills and pride
- Builds family and community relationship
- Inter-generational support and learning
- Respect for traditional knowledge
- Promotes healthy behaviours
- Supports self determination
- Integration of traditional and western medicine
“to bring birth back to the communities is to bring back life . . .”

Puvurnituq elder
1988
We can do it …

Birthing on country

Birthing Services Ahead