






**Remote Aboriginal Birthing:
the role of research in
improving systems**

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Background

- We know there are problems of poor health in Aboriginal women in far greater proportion than the rest of the population
- Also that there are poorer maternal death outcomes and infant outcomes
- Aboriginal women repeatedly request different types of service



Paper will

- Describe how research can make a difference quickly and efficiently
- Proposes that different approaches to research can help rapid improvements
- Draws on an NT example to demonstrate results
- Describes a process that uses research strategically


Problems of persistent poor outcomes

- Health services were poorly informed about how current models work and their 'product'
- Evidence was lacking or not used
- Priorities therefore distorted
- Resources were limited
- System is/was not balanced across the groups that should influence this
- Women/families themselves had no say
- Acute care models dominated



Research as a strategy for improvement

- Strategy is to become partners with policy makers, clinicians and in this case 'elders'
- Then researchers can work with and inform colleagues and community by:
 1. generating knowledge
 2. use data as advocacy for 'patients'
 3. defining problems
 4. using evidence to address a range of risks
 5. using data to help with redesigning services
 6. evaluating service redesign



Researchers can help by

1. generating knowledge about the system
2. integrating evidence into improvement
3. working alongside women/families



Researchers can help by

- 4. working with health professionals and policy makers
- 5. assisting with redesigning services using new knowledge and evidence



An illustration of what I mean

Circles that overlap and reinforce each other to provide good quality services



How do conventional researchers fit??

- 1. generating knowledge about system **YES**
- 2. addressing the risks identified with evidence **NO**
- 3. assisting with redesign or new services based on new knowledge **NO**



A participatory approach works with people

- Involves end users and recipients from day 1
- Shares data 'along the way'
- Works with end users and recipients of care to explain/interpret/makes sense of findings
- Assists with application of findings
- Can evaluate or assist with modifications along the way
- Does not preclude other techniques



Some of our Advisory Group 'in town'



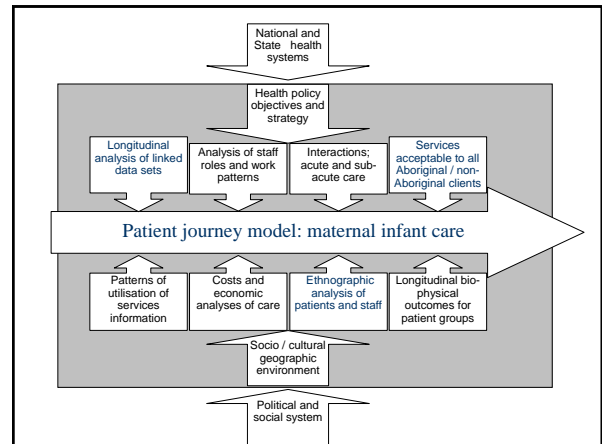
Some of our Advisory Group 'in the bush'





Data generating knowledge -NHMRC and ARC studies

- Ethnographic (n=20 women/families) post doc
- 120 hours of observation; remote and hospital
- 67 interviews with staff
- Case audit data (n=750 records over 3 years)PhD
- Research honours student data; 33 detailed analyses of out of hospital births- records and interviews
- Epidemiological analyses 2nd PhD
- Costing data 2nd post doc/junior researcher



Case study exposing different view of risk

- Case study from one of our research sites; where we met a woman and nurse at the plane as the woman was flown out in tears
 - Normal pregnancy
 - 2 normal births previously
 - 3rd evacuation this pregnancy
 - Coerced onto plane
 - 2 small children at home
 - Husband who drinks



Knowledge generation

- Staff see no irony /tragedy nor ethical dilemma
- Despite local DMO, adequate clinic and midwives on staff; woman evacuated to hospital for a third time
- System remains unchallenged by this without knowledge,
 - Necessity of hospital birth
 - 10% of women doing the same thing from one large site
 - Costs of repeated transport
 - Risks to other children and family safety and well being
 - Distress caused
 - Time wasted, nurse said she spent most of the day getting this organised



Detail from honours student work

- In comparison to the rest of the Northern Territory and Australia, women in this community have more babies born outside of a hospital setting (0.7%).
- During 2003-2007, between 6.1-13.2% (32 out of 342) babies were born in one of our research communities and not in hospital
- 2 of these were under 36 weeks and 1 was 36 weeks
- From 2000-2002 only 2% of all births in the NT happened outside of hospital {Stewart, 2005}.
- Nationally only 0.7% of all births happen outside of hospital {Laws, 2006}.

Ireland. S. Honours thesis; Charles Darwin University



Why does this happen-honours student work

- Interviews with women who gave birth in their community showed they were
 - Unhappy with prior hospital experience
 - Almost all women who had babies before
 - Cultural insensitivity
 - They saw greater risks flying out than staying home

Outcomes

- Thesis complete
- 1st class honours awarded
- presented at 2 Advisory Committee meetings
- informed new model of care and training program
- 3 papers going off for publication
- Feedback loop to women completed
- 2 conference presentations

Another example of problems with system from our data

- Young multip – previous history of miscarriage, petrol sniffer, partner drinks excessively
- ‘Evacuated’ to Darwin to hostel for weekly checks at 30 weeks – staff concerned about possible prem birth
- Partner takes woman into ‘long grass’ – staff unable to communicate or contact her
- Her risk has increased – she could have stayed in her community and been evacuated later or in labour

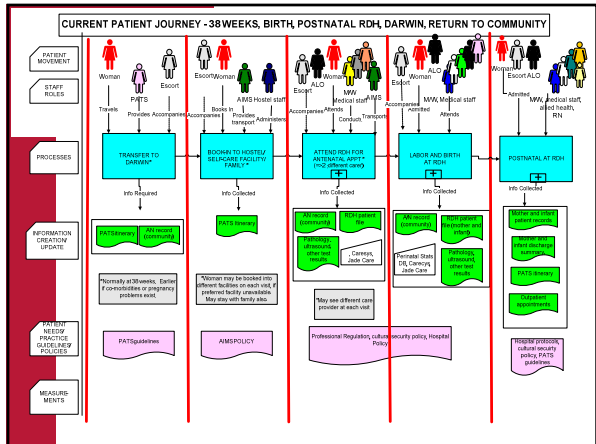
Summary of some other PhD student findings

- Antenatal care starts too late and is inadequate
- Major discontinuities in care which increases risk
- Birth without family or even language support in many cases
- Flown home day 2
- Problematic discharge summaries
 - may or may not arrive at the clinic, default problem in electronic record leads to inaccuracies
- No further routine post natal care

Sarah Bar-Zeev PhD work in progress

Integrating findings across different studies

- Sub studies published separately
- Synthesis on overarching narratives or stories
- ‘Mapped’ and shared with end users



Integrating with other evidence

- Researchers also work with the ‘literature’
- **This shows in countries that do better with Indigenous birthing there is**
- Intense efforts and success in training Indigenous midwives in other countries
- Local birthing for well women and excellent partnerships with tertiary services and providers who constitute a ‘circle of care’
- Review of risks and accommodation of social risk as well as physical risk in decisions



Evacuation necessary for safety?

- If one is convinced that a large hospital is the safest place for all births then this is a reasonable belief

However

- Evidence from Australia does not support this
- Evidence from Western countries Canada, New Zealand and other places contradicts the NT position



Is it Indigenous populations that need evacuation?

Perhaps this is related to poor basic health and social conditions?

No- not if you look at research conducted with

- Indigenous Canadians
- Malaysia
- Sri Lanka



International evidence from healthy and wealthy populations

- Shows home birth is actually safer than hospital birth in the North America, Holland and Canada
- That C/S provided at considerably higher rates is associated with higher risks for mother and infant



Paradoxes in mainstream Australia

Fact

- The healthiest and wealthiest women have worst morbidity outcomes in Australia
- Small rural units are closing despite good outcomes
- Continuity of care models have best outcomes, but remain exceptional in Australia

Perception

- Private hospital care is the best care and cost/amount paid is the best guide to quality
- You are always better off giving birth in a large hospital and need an obstetrician and anaesthetist standing by
- Acute care models of specialist led service delivery are superior



Not surprising that similar paradoxes exist in Indigenous maternity care

Perception

- Evacuation improves safety for all women
- All Aboriginal women are less healthy or require obstetric care
- Evacuation reduces all risk
- Women will comply with the requirement for evacuation
- Aboriginal women are satisfied with services

Fact

- Evacuation is necessary for women with obstetric or medical problems;
- Conservative estimate of around 60% are fully fit and suitable for local birth
- Evacuation increases social/emotional risks and needs weighing against biophysical risks of remaining home
- Early findings from study show around 10% of remote women avoiding or minimising pregnancy or birth care



How has research helped changes in NT

Two years into a 5 year project

- Discharge processes
- Midwifery Group Practice
- Designated midwife role
- Doula
- Indicators
- Feeding into service redesign governance models
- DWD



Slide 28

k2

kylie.davis, 29/01/2009



Research as a strategy has

1. Generated knowledge of performance of current systems
2. Identified and defined problems in delivery care
3. Used our own and others evidence to address a range of risks
4. Is using data to help with redesigning services
5. Will revisit baseline data to evaluate service redesign



Conclusion

- Aboriginal birthing in remote Australia made progress but 'stalled' around 15 years ago
- If 1 in 10 women in a small sample avoid current services
- We have increased biophysical risks while immeasurably and inequitably increased social and emotional risk.
- In too few places in Australia we have rethought acute care models for remote or rural women
- We have few 'circles of care' or partnership between acute care, remote staff and community that puts the woman and family at the centre



Conclusion

- There are too few research partnerships that mutually support researchers, clinicians and policy and vice versa in current systems
- There are too few research techniques or strategies that engage the end users actively



Our research has shown

- Too little psychosocial care is provided for the most disadvantaged Australians
- Their biophysical care is inadequate and poorer quality than other Australian women receive or would accept
- **But** it has also helped find system improvements and works with those making change
- Participatory evaluation can continue to make a difference

