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Paperbark and pinard: A historical account of maternity care in one remote Australian Aboriginal town

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ABSTRACT

Background and aim: Maternity care in remote areas of the Australian Northern Territory is restricted to antenatal and postnatal care only, with women routinely evacuated to give birth in hospital. Using one remote Aboriginal community as a case study, our aim with this research was to document and explore the major changes to the provision of remote maternity care over the period spanning pre-European colonisation to 1996.

Methods: Our research methods included historical ethnographic fieldwork (2007–2013); interviews with Aboriginal women, Aboriginal health workers, religious and non-religious non-Aboriginal health workers and past residents; and archival review of historical documents.

Findings: We identified four distinct eras of maternity care. Maternity care staffed by nuns who were trained in nursing and midwifery serviced childbirth in the local community. Support for community childbirth was incrementally withdrawn over a period, until the government eventually assumed responsibility for all health care.

Conclusions: The introduction of Western maternity care colonised Aboriginal birth practices and midwifery practice. Historical population statistics suggest that access to local Western maternity care may have contributed to a significant population increase. Despite population growth and higher demand for maternity services, local maternity services declined significantly. The rationale for removing childbirth services from the community was never explicitly addressed in any known written policy directive. Declining maternity services led to the de-skilling of many Aboriginal health workers and the significant community loss of future career pathways for Aboriginal midwives. This has contributed to the current status quo, with very few female Aboriginal health workers actively providing remote maternity care.

1. Introduction

In Australia's Northern Territory, Indigenous women account for 36% of all mothers. Of these women, the majority (64%) live in rural and remote areas, unlike the majority of non-Indigenous mothers, who live in urban areas (95%).[1] Aboriginal women in remote areas are the least likely of all Australian women to have choice and control over their pregnancy care, choice of care provider or planned place of birth.[2] Currently, remote maternity services recommend the routine evacuation of all pregnant women into regional areas to give birth in hospital, with only antenatal and postnatal care offered in the woman's home town.[3] Prior to the regional centralisation of maternity services, Aboriginal women in some communities elected to give birth in their community-based health clinic. These clinics were closely aligned to contemporary definitions of a primary maternity unit[4]; maternity care was provided by midwives and Aboriginal health workers without on-site obstetrical, anaesthetic, laboratory or paediatric support.

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It has been demonstrated in other parts of the world that primary maternity units can provide equitable and accessible maternity care to women with low-risk pregnancies[4] and also culturally safe and empowering maternity care to women from an all-risk Indigenous population, without compromising safety.[5,6] In the absence of clear evidence demonstrating an improvement in perinatal outcomes from the centralisation of maternity services,[2,7] the re-introduction of primary maternity health services to support childbirth in select remote Aboriginal communities has been suggested as one way of addressing Aboriginal maternal and infant health inequity. It has also been proposed as a way of satisfying the long-standing requests of Aboriginal women to give birth on their ancestral home country.[7–10] Despite this, there is a dearth of literature that historically contextualises changes to remote maternity services in the Northern Territory. Historical perspectives on maternity care are important because by gaining a deeper understanding of the past, clinicians, researchers and policy makers can better manage and respond to the challenges that can occur when developing and maintaining midwifery-led maternity services.[4] Our purpose with this paper is to historically contextualise the changes to maternity care in remote areas of the Northern Territory. To do so, we use as a case study the maternity health care experiences of women and health practitioners in one remote Aboriginal township from pre-colonisation to 1996.

2. Research site

The research site is a remote Northern Territory Aboriginal township named *Saint Fiacre* (pseudonym). Aboriginal people have lived in this area for hundreds of generations, representing many thousands of years of continuous occupation. In the years preceding the establishment of a religious mission, people in the area experienced vicarious contact with Europeans via an Aboriginal trade route supplying foreign substances: tea, tobacco, sugar, cloth and metal. Ceremonial and trade travellers visiting the nearby colonial capital had been exposed to the English language and, over time, a few returned home with the ability to comprehend and speak the new tongue. In the early 1930s, as the pressure of colonisation increased, neighbouring tribes began to disintegrate, posing a threat to the tribal lands of others and leading to widespread conflict, disarray and fear.[11] The encroaching colonisation weakened the people in the *Saint Fiacre* region; their social reality and order was unravelling at the edges.

In the mid-1930s, the Catholic Missionaries of the Sacred Heart established *Saint Fiacre* as a mission at a temporary coastal location until some years later when it moved to a permanent inland site. There was no hostility recorded towards the all-male missionaries, whose supply of foreign goods such as tea and tobacco were openly welcomed. The mission catered for Aboriginal people who belonged to the area's 23 clan groups and represented several separate languages. The people organised themselves socially into a complex kinship network with associated ceremonial obligations and broadly divided themselves into the 'saltwater' and 'freshwater' people. The permanent site of the mission was on the traditional lands of one clan, which resulted in gradual linguistic intimidation and assimilation until one Aboriginal language came into dominance. With inadequate supplies and resources to support the whole population, the mission ran a rotating roster, whereby groups of people belonging to the same clan took turns to work and receive rations from the mission. When not in attendance at the mission, they returned to their clan estates and lived as they had done so before the mission started. Nuns from the Catholic order Daughters of Our Lady of the Sacred Heart were employed briefly in the months prior to the Second World War but were evacuated due to wartime concerns about their safety. The nuns returned immediately after the war and contributed to the mission community by providing, among other services, mainstream biomedical health care and Western education.

Today *Saint Fiacre* remains one of the largest and most remote Aboriginal towns in the Northern Territory. The urban referral centre is approximately a one-hour flight away, and the community remains inaccessible by road during the wet monsoon season. A community health centre, financed and run by government, services the health needs of the town. Despite the existence of a purpose-designed childbirth room in the health centre, no planned births occur there.

3. Gaining permission

Working with permission from and in partnership with Aboriginal women, this research forms part of a doctoral study investigating women's health. Ethical approval for the research project was granted by Charles Darwin University and the Menzies School of Health Research Ethics Committee with a subcommittee dealing specifically with Aboriginal research (Application #HR-10–1429). Letters of written support were obtained from the community. A local reference group comprising senior women community leaders, Aboriginal health workers and other interested individuals oversaw the overarching project. The local reference group provided support, advice and direction throughout the research process, including with the research objectives and methodologies.

Mrs. Concepta Wulili Narjic has been the cultural mentor for the project, providing leadership and advice on all aspects of Aboriginal research methodology and recruitment. Several Aboriginal research assistants who live permanently in the community were recruited, trained and paid to assist with data collection. Due to the sensitive topic of reproduction, they requested anonymity; however, Mrs. Narjic is comfortable about being publicly identified and has given permission.

4. Methods and participants

This historical ethnographic study, completed during a six-year (2007–2013) relationship with the community, involved iterative cycles of data collection. Research rigour was ensured by collaboration with Aboriginal women, prolonged community engagement, triangulation of research methods and participant validation.[12(pp23–29)] Data collection methods included ethnographic fieldwork in the community; community observation and participation; field site visits to buildings and places of historical significance; written field notes; and semi-structured interviews with retired Aboriginal and non-Aboriginal health professionals. During the semi-structured interviews, the interviewees used a theme guide to elicit the health workers' recollections of scope of practice, clinical experiences and training. We also conducted an archival review of collections held at the local community museum, Northern Territory; Daughters of Our Lady of the Sacred Heart Convent, Kensington, New South Wales; and the Australian Institute of Aboriginal and Torres Strait Islander Studies, Canberra, Australian Capital Territory.

Non-Aboriginal participants were identified via archival material and word-of-mouth suggestions offered to the first author, who then approached potential participants to seek their participation. They were given written information, and consent to an interview (in-person, phone or email) was sought and gained. Only one participant declined to be interviewed due to her poor health and advancing age.

Aboriginal participants were recruited by the fifth author with the assistance of the Aboriginal research assistants and the local reference group, who used the 'message stick' sampling technique to verbally invite potential Aboriginal participants to the research. This method has been successfully used in previous research in a