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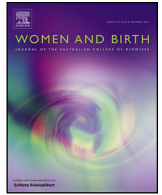

ORIGINAL RESEARCH – QUALITATIVE

Models of midwifery care for Indigenous women and babies: A meta-synthesis

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ABSTRACT

Issue: Indigenous women in many countries experience a lack of access to culturally appropriate midwifery services. A number of models of care have been established to provide services to women. Research has examined some services, but there has not been a synthesis of qualitative studies of the models of care to help guide practice development and innovations.
Aim: To undertake a review of qualitative studies of midwifery models of care for Indigenous women and babies evaluating the different types of services available and the experiences of women and midwives.
Methods: A meta-synthesis was undertaken to examine all relevant qualitative studies. The literature search was limited to English-language published literature from 2000–2014. Nine qualitative studies met the inclusion criteria and literature appraisal – six from Australia and three from Canada. These articles were analysed for coding and theme development.
Findings: The major themes were valuing continuity of care, managing structural issues, having negative experiences with mainstream services and recognising success.
Discussion: The most positive experiences for women were found with the services that provided continuity of care, had strong community links and were controlled by Indigenous communities. Overall, the experience of the midwifery services for Indigenous women was valuable. Despite this, there were still barriers preventing the provision of intrapartum midwifery care in remote areas.
Conclusion: The expansion of midwifery models of care for Indigenous women and babies could be beneficial in order to improve cultural safety, experiences and outcomes in relation to pregnancy and birth.

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Summary of Relevance:

Problem or Issue

- The outcomes for babies of Indigenous women are poorer than those of non-Indigenous women, with smaller birth weight, more preterm births and a higher infant mortality ratio.
- Individual studies have analysed models of midwifery care for Indigenous women and babies, but there has not been a synthesis of the findings.

What is Already Known

- Models of midwifery care have been established for Indigenous women and babies in many countries.
- Individual qualitative and quantitative studies have favourably analysed the experiences of these services.

What this Paper Adds

- A synthesis of qualitative research on the topic has enabled a richer description of the opinions and experiences of midwives and women who have used the services.
- The most positive feedback came from the services that provided continuity of care and that were community controlled.

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1. Introduction

This study was primarily based in Australia but aimed to draw on experiences from other English-speaking countries, specifically Canada, New Zealand (NZ) and the United States of America (USA). It is recognised that there are hundreds of Aboriginal and Torres Strait Islander nations across Australia with different languages, traditions and culture. When referring to Indigenous Australians, this is inclusive of all Aboriginal and Torres Strait Islander peoples. Similarly, Indigenous people in Canada are not a homogenous group. The studies incorporated in this meta-synthesis relate to both Inuit and First Nations peoples in Canada. The reason to analyse the experience of Indigenous women and babies across different countries is not to categorise them as a homogenous group; it is because they have a common experience of a history of disadvantage, exclusion and isolation from mainstream society. This has led to poorer health outcomes and is an international phenomenon.[1]

In Australia, the maternal mortality ratio (MMR) for Indigenous women from 2008–12 was more than double the non-Indigenous rate at 13.8 compared to 6.6 deaths per 100,000 women giving birth.[2] A higher proportion of Indigenous women smoke in their pregnancies, have smaller babies and preterm births.[3,4] Babies of Indigenous women have a neonatal mortality rate of 18 compared to 9 per 1000 live births of non-Indigenous women.[4]

The main reasons for the poorer outcomes include the high rates of social, environmental and economic disadvantage amongst Indigenous women, potentially leading to lack of access to primary health care services such as antenatal care. The cultural responsiveness of antenatal clinics has also been a factor in Indigenous women not accessing care.[5–8] Indigenous Australian women have lower attendance for antenatal care than non-Indigenous; 15% of Indigenous women attended less than five antenatal consultations in comparison to 5% of non-Indigenous women.[4]

In addition, a higher proportion of Indigenous women live in remote areas contributing to challenges and complexities of maternity care.[4] The health care policy in most Australian states and territories dictates that women living in remote communities need to be relocated to a regional centre at 36–38 weeks gestation to await labour and birth.[9] The evacuation policy became routine in the 1990s across the Northern Territory. Women often travel alone to the regional centres – resulting in a lonely and isolated birth experience as they could not afford to have their families travel with them.[10] Women's stress was often compounded by having to leave older children at home in the care of others.[10] They were also unable to undertake any of the traditional birthing ceremonies being alone and away from their families and communities.[9] The evacuation policy results in a significant lack of cultural safety for Indigenous women living in remote and rural areas.

1.1. Models of midwifery care

Midwifery-led continuity of care of care models are beneficial to all women,[11] but given the poorer outcomes for Indigenous women and babies in many countries, prioritising continuity of care services for Indigenous women could be beneficial. The systematic review of midwife-led continuity models of care, including 15 trials and 17,674 women, concluded that this model should be offered to all women with low risk pregnancies. Women receiving care in midwife-led models were more likely to know the midwife who cared for them in labour, have a spontaneous vaginal birth, were less likely to have an instrumental birth, use analgesia or anaesthesia, experience preterm birth or lose their baby before 24 weeks gestation.[11]

Due to the poorer outcomes for babies of Indigenous women and other risk factors, it has been recognised in Australia that the development of models of midwifery care for Indigenous women and babies was urgently needed.[3] This was identified by the Australian National Maternity Services Plan that set out a five year vision from 2010–2015 to provide maternity care close to where people live in order to improve outcomes for Indigenous women and babies.[12] The models developed have been based on midwifery-led care. Similar models have been established in other countries such as Canada, the world-renowned example being the Inuulitsivik Health Centre operating three birth centres in the remote region of Nunavik. It has been in existence for almost three decades, Inuit midwives have been trained to run the centres and it has provided safe and culturally competent care while returning birth to remote communities.[13,14]

A literature review was conducted by Kildea and Van Wagner,[15] primarily using the term 'birthing on country', to analyse the models that existed in Australia, Canada, NZ and the USA. Such models were defined as community-based and governed, developed by and/or with Indigenous people and incorporating traditional practice. These culturally competent models would have a connection with land and country, have a holistic approach to health care, would value Indigenous and non-Indigenous ways of knowing and learning and be able to assess risks and competently provide services. Despite some limitations of the studies, the conclusion was that 'birthing on country' models of care would most likely be of benefit to, and improve outcomes for, Indigenous mothers and babies. It was suggested that these models of care were appropriate for Indigenous communities living in remote, rural and urban areas.[15] The literature review conducted by Kildea and Van Wagner was not a meta-synthesis, which is a rigorous search and synthesis of qualitative studies.[16]

Quantitative research has also analysed models of midwifery care for Indigenous women and babies. The services analysed had reduced smoking rates,[17,18] reduced preterm birth rates and improved birth weights.[19–22] Cost effectiveness was demonstrated in one service[23] and another estimated a modest cost to the health care system.[6]

While small studies have been conducted to analyse the experiences of women and midwives in the models of care, there has not yet been a synthesis. Therefore, it was considered important to undertake a review of models of midwifery care for Indigenous women and babies to help guide practice development and innovations. The aim of this study was to examine qualitative research relating to the different types of midwifery models of care for Indigenous women that were available, and the experiences of women and midwives.

2. Methods

2.1. Design

A meta-synthesis of qualitative research was conducted using the approach outlined by Noblit and Hare.[24] A meta-synthesis is a rigorous search of qualitative studies on a particular topic. The purpose of a meta-synthesis is distinct from a quantitative systematic review in that it is searching for explanation of a particular phenomenon, rather than providing empirical evidence in relation to methods and procedure. A meta-synthesis has an interpretive intent with the purpose of obtaining a richer understanding of the topic under scrutiny to gain an insight that is greater than the sum of its parts.[16,24] Qualitative research aims to search for meaning of phenomena, therefore it is more concerned with idiomatic (meaningful) interpretations rather than semantic (literal).[24,25] Idiomatic interpretation was applied rather than

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