‘Birthing in the bush’ overseas: models that work

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In 2012, 24.8% of birthing mothers in Australia’s Northern Territory (NT) came from rural or remote communities.[1] At present, the only birthing services in the NT are in the four major cities and towns. Thus, in 2012, around one in four women preparing for the birth of her child was expected to leave her home, family and community in order to birth her baby in a setting with skilled maternity carers and appropriate resources at hand.

Leaving her community is not without risk; the emotional, cultural, spiritual, social, financial and physical risks that may ensue in this arrangement are well documented in many studies, reports and research articles (for example, see Kildea & Van Wagner[2]). For many families, there are also the complexities and challenges of negotiating a dominant colonial health care system. However, women and their families must juggle these risks with the risks of planning to birth in a remote setting: a setting with varied access to skilled maternity carers, appropriate resources and huge geographical barriers to emergency care if required.

If birthing services are to be safe, and sustainable in the remote setting, there are many barriers to be overcome. The oft-quoted ‘tyranny of distance’, inclement weather and its impact on road or air access, variable and transient population sizes and birth rates, shifting government or organisational structures and funding, and the difficulty of recruiting and retaining skilled maternity carers are all factors that affect the planning, organisation and quality of maternity care. Despite this, and in the face of similar barriers and complexities, there are many services in rural and remote communities around the world providing safe maternity and birthing care.

In 2014 the author spent three months travelling through Scotland, Nunavik (in far Northern Canada) and Aotearoa/New Zealand visiting successful birthing services in remote communities, as part of a Peter Mitchell Churchill Fellowship. The aim was to observe the ways these birthing services are successful and sustain themselves.

Most of the birthing centres visited are geographically closer to tertiary referral centres than some remote communities in Australia. However, the travel time or overall time of transfer was often comparable, particularly when factoring in weather or road conditions. Furthermore, these birthing services work in very similar contexts to many rural and remote communities in Australia, with similar rates of disease and disadvantage, and similar barriers and complexities that are inherent to health service provision in the remote setting. Each of these communities has developed their own unique and appropriate solutions to these barriers. In all successful services visited, however, there were four noticeable commonalities repeatedly identified:

- community support and drive, and a belief in the importance and precedence of women’s choice
- confident and skilled maternity carers
- good communication and respectful relationships within the maternity care team
- service flexibility and reflexivity, with supportive, maternity-care focused management.

This presentation will discuss these four elements, and share some examples of how birthing services can work in remote communities.

Community support and drive, and a belief in the importance and precedence of choice

> You can’t have a community where the biggest event is death. There is a beginning and an ending to life. We need to know both. (Elder, Puvirnituq[3])

In every remote birthing service visited, the sense of community ownership and pride in their birthing services played a significant role in the development and the maintenance of the service. Every

woman, midwife and manager met expressed a strong sense of the right to birth in their community. As people spoke of their work to retain, revitalise or sustain their birthing service, their pride and resolve was obvious.

In Montrose, Scotland, the birthing service was once on the brink of closure. Falling birth rates prompted the plan to re-direct funds and resources, and close the birth centre. The community and the midwives rallied. Their campaign focused on creating a maternity service that would provide women with the care that they wanted in labour and birth. Consequently today, more than 54% of all births in the region (including those identified as 'high risk' and referred to the nearest tertiary hospital) are now at the Montrose maternity unit, 70% of them water births.[4]

There could not be a birthing service in a remote community if it was not wanted by the community. It therefore follows that birthing services need to consider and respond to what the community wants, if they are to be sustainable. In addition to, and following from this community support, is an underlying belief held by maternity carers, women and community members alike, in the importance and precedence of women's and the community's prerogative to choose where their babies are born.

The very existence of the birthing services in Nunavik is evidence of the power of community support and the importance placed on women birthing in their community, surrounded by their families. These services were built from scratch, in a context very similar to that currently experienced by women living in rural and remote Australia. Another example of the power of this belief in women's choice is found in the Scottish *NHS Highland Midwifery Guidelines: Planned Homebirth* policy[5], which states that:

> The decision of where to give birth should always be made by the woman and family with sufficient time to make an informed decision regarding their intended place of birth. The woman should be given appropriate, accessible and evidenced information and be fully involved in the decision making process (Maternity Services Action Group, Scottish Government 2010).
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> …If the midwife is aware of any risk factors which would impact on the suitability of the woman for Homebirth she should refer the woman to a Consultant Obstetrician. Although the midwife, supervisor of midwives, obstetrician and/or the GP [General Practitioner] may feel that Homebirth is not appropriate, the woman still has the right to choose Homebirth and midwifery care and support must be provided (NMC 2004).

This policy is upheld across Scotland, including across the rural and 'remote' communities. For example, in the Wester Ross region of Scotland, on a good day it takes an average of two hours to drive the often single track road to the nearest tertiary referral hospital, in Inverness. Some homes in the region are accessible only by boat or by foot; the region is relatively sparsely populated. There are around 50–60 babies born to families living in the 3 500 square km region each year. Of these, 2–5 births will happen at home, in the community. The remainder of these births will happen in nearby birth centres or hospitals; women make the decision to either relocate there close to the time of their birth, or take a chance and drive there once labour begins. Given the underlying community and health service culture, it is simply part of their role that maternity carers work to support this relatively small group of women in their birth choices. To allow for this, the maternity care providers in the region work together closely to ensure women are able to access the maternity care that they want, when they need it. Three midwives cover the entire region for antenatal, postnatal, labour and birth care; the remaining out-of-hours care is covered by five general practitioners (GPs, who have obstetric training) on a rotating "on call" roster. When a homebirth is planned, or in the advent of an unplanned birth in the community, midwives also work closely with the local ambulance services. To keep their individual skills up to date and their team communication and relationships strong, obstetric emergency training for GPs and ambulance staff is run by the midwives twice a year. .

While informed consent and decision making must include very clear discussion of the possible outcomes of any choice or event, often a pregnant woman and her family have already considered these possibilities themselves. Midwives working in remote birthing services reflected that many women know at their first antenatal visit where they want to birth. For some, this might be the regional hospital as this is where she feels safer, or perhaps this is where other women in her family have birthed their babies. Women living in remote communities are acutely aware of the barriers and risks

entailed in birthing in a remote community, and will choose the maternity care that they feel is safest for them and their baby.

Confident and skilled maternity carers

The second stand-out element of successful birthing services in remote communities was their dedication to training and maintaining a confident, skilled workforce of maternity carers. Without exception, midwives and managers acknowledged the unique skill set required to work safely and sustainably in these settings. Many times, midwives explained the difference of practicing in a remote birthing service where you 'can't just push a button' to call for help; 'you are the help'. In Canada, Vicki Van Wagner, a midwife and academic, explained that when working in these isolated settings, 'you need a homebirth midwife who is comfortable in the hospital'. Meaning, maternity carers must be confident to practice relatively independently and comfortably with women, while also having the necessary skills to pre-empt, identify and respond to obstetric emergencies. Similarly, another midwife and academic in Aotearoa, Jean Patterson, emphasised, 'we need to have midwives who are comfortable to keep it safe to birth, so that women can get on with the business of birthing'.

In both Nunavik and Aotearoa, training models for midwives have been developed in order for students to remain in their community, a strategy increasingly employed to strengthen the rural and remote workforce. In contrast, midwifery managers in Scotland voiced their concerns that midwifery training is now only available in the major cities of Glasgow and Edinburgh; they fear the impact that this may have on their local workforce and birthing services in the future.

Aside from the aforementioned community support, another key to the success and sustainability of birthing services in Nunavik is the way in which student midwives are recruited, supported and trained. As the community worked to establish their own birthing service, they simultaneously identified that they wanted Inuit women to be the maternity carers who assisted their women in birth. To this end, they enlisted the help of midwives from outside the region to assist in the development of a locally based training program, specifically designed to focus on the skills required in their remote setting. As this program developed over the years, it is now predominantly local Inuit midwives teaching local midwifery students as part of a recognised training program.

Students work closely with the midwives, gradually taking on more responsibility and independence in practice as they and their midwifery colleagues feel comfortable. Training is generally completed in four or five years; in this time, they will be the second midwife at around 40 births and the primary midwife for at least 60 births. Once they have achieved competency in all the required skills, and feel confident in themselves and their practice, they are ready to be evaluated. After successful completion of oral, written and practical exams, the students can then apply to be registered as midwives.

Students and midwives all agreed that a significant factor in the sustainability of their service is the ability for students to stay in their community, with their families and colleagues, during training. Student midwives in Nunavik have the option of doing much of their practical and clinical learning in their own language, at their own pace, with space and flexibility to take time for family, cultural and personal responsibilities. Traditional ways of learning which focus on oral and hands-on approaches are respected. The students however, like all midwives, learn to read and interpret pathology and radiology results, appropriately document their clinical practice, to access and read current evidence and research, and to integrate this into their practice.

This success stands in stark contrast to the experience of other remote Canadian communities. Where student midwives are required to leave their communities for training (in written English or French), there has been a very high dropout rate. Indeed, many of the midwives and managers working in remote communities emphasised the importance of 'growing our own' workforce as a key factor in ensuring the sustainability of their birthing service.

Good communication and respectful relationships within the maternity care team

The third element that was commonly acknowledged as key to the success and sustainability of birthing services in remote communities was a purposeful emphasis on maintaining strong relationships and clear communication between **all** members of the maternity care team. Midwives

and managers felt that easy and clear communication between all involved in obstetric care—midwives, GPs, obstetricians, paramedics, administrative staff, emergency service volunteers, and tertiary referral centre personnel alike—enhanced the ability to work well as a team, and helped them to feel safer in their practice. Each of these birthing services has clearly identified referral and consultation strategies.

In the context of rural and remote communities, it makes sense to utilise tele-health capabilities to assist in referrals and consultations, professional education, team building and communication. For example, in Scotland, the rural maternity services have regular videoconference meetings and education sessions with the practitioners in the tertiary centres they refer to; videoconferencing seems as commonplace as making a phone call. Similarly, in Nunavik, video- and teleconferencing is used regularly for the midwives and student midwives to attend planned education sessions. In addition, teleconferencing is used to hold their routine 36-week review of all pregnant women in the community. At this review, the woman, the midwives and local doctors all discuss her health and plans for her labour and birth; everyone understands the plan of care, the reasons behind it, and their role in it.

Critical incident debriefing was also often emphasised as an important part of supporting each member of the maternity care team, growing together and sustaining health professionals in what may often be challenging situations. Many services also had very clear structures around mentoring and supervision. In Scotland, supervision is a mandatory part of being registered for midwifery practice and there are set coordinators who travel around the regions supporting midwives to attend and/or provide supervision. In each of the remote birthing services, the midwives were quick to acknowledge the invaluable support of their midwifery, medical, and other colleagues as one of the reasons their work was sustainable, and safe.

Service flexibility and reflexivity, with supportive midwifery management

> Because of where we are, there needs to be space allowed for creativity… that goes for the services, professional boundaries, and the education… (Lissie Sakiagak, Student midwife, Salluit[6])

Finally, midwives working in remote birthing services spoke of the value of having supportive managers and a workplace culture that understands their role as midwives, as well as the remote community context. They identified the value of a midwifery (or maternity-care focused) management structure, which intrinsically appreciates the realities in which they work, and is able to facilitate the flexibility and reflexivity that supports and sustains them in their roles.

“You need to be able to be flexible” was something acknowledged time and time again. The ability to ‘go with the flow’, and accept and adapt to changing conditions, barriers or complexities was cited as one of the keys to sustaining remote maternity and birthing services. Midwifery managers spoke of the importance of a ‘robust infrastructure’ when working in remote communities.

For example, midwifery managers in Scotland explained how flexibility in the arrangement of midwifery positions can assist in the recruitment and retention of staff. A common strategy is to ‘split’ full time midwifery positions. This strategy serves many purposes; not only can a part-time position help make remote practice more sustainable (by allowing time off-call and the opportunity to attend other commitments), but it also means more midwives are retained and available in the community, contributing to a more resilient and responsive workforce.

In Aotearoa, maternity care is provided by Lead Maternity Carers (LMCs; qualified doctors or midwives), who work either independently or in practices in a continuity of care model. In recognition of the challenges faced by LMCs working in less populated, more remote communities, an innovative program was designed to support and sustain them in their practice. The Rural Midwifery Recruitment and Retention Service (RMRRS) was established ‘to support the retention of midwives practicing rurally as Lead Maternity Carers and the recruitment of midwives to join or set up practices in rural areas that are experiencing a shortage’.[7] It is a joint venture between the New Zealand College of Midwives and the Midwifery and Maternity Providers Organisation, and is funded by the Ministry of Health. Many midwives working in rural areas of Aotearoa expressed how the RMRRS has been of assistance to them in sustaining their practice.

The RMRRS assists rural midwives with:

- a locum service to allow midwives working in rural areas to take their entitled nine days of annual leave per year, as well as an additional five days 'emergency locum cover'
- a mentoring scheme
- collecting data to assist the long term planning and sustainability of rural maternity services
- advocacy in the form of identifying areas of need or workforce shortages
- grants to assist midwives planning to move to a rural community where there is an identified need for more LMCs
- a point-of-call and source of networking and communication by connecting LMCs, district health board staff, hospital and obstetric staff.

While the manifestations of service flexibility, reflexivity and supportive maternity-care focused management varied between the birthing services visited, this element nevertheless appeared to be key to the success and sustainability of these birthing services in remote communities.

Conclusion

While this presentation has outlined four elements that were noted to play a key role in the success and sustainability of birthing services in remote communities, it is also obvious that these elements all feed into and support each other.

There is increasing evidence that demonstrates the positive impact that remote birthing services have on maternal, infant and community health. This cannot be discussed in depth here, but a good example is found in the research of Van Wagner et al[8] as they reviewed the outcomes of the Nunavik maternity services from 2000–2007. In these communities, there are high rates of poor health and complicating factors that pre-dispose the women in these communities to increased rates of anaemia, preeclampsia and premature birth; conditions that have the potential to complicate pregnancy or birth and necessitate tertiary level care. Given this, it is impressive to consider the finding that of all the babies born to mothers from Nunavik between 2000 and 2007, 86.3% of all births occurred in Nunavik. Equally impressive is the 2.1% caesarean rate (again, remembering that these statistics are for all pregnancies, all risk). While it may be tempting to then assume that this would entail higher rates of maternal or infant mortality, the statistics provided by this research show otherwise. For example, of the 1,372 women in the sample group, there was one maternal death in this period; sadly, a woman who passed away after a planned caesarean section in Montreal. These researchers concluded that their work 'supports previous findings that most women served by the Inuulitsivik [the local birthing service] midwives are able to birth safely in Nunavik'.

Based on this evidence, and the observations made of successful birthing services in rural and remote communities outside of Australia, the following recommendations are made:

- the continued development of midwifery/maternity carer management and clinical governance structures on both regional and national levels
- the provision of midwifery/maternity carer courses that enable students to remain in their communities for their training
- the establishment of structures/organisations dedicated to supporting, recruiting and retaining maternity carers working the rural and remote setting
- in the Northern Territory, the first step must be to strengthen and streamline the existing maternity services available to women living in remote communities. Women need access to skilled maternity carers to ensure safe, timely and appropriate maternity care.

References

1. Case A, Dempsey K, Zhang X. Northern Territory Midwives' Collection. Mothers and Babies 2012. Department of Health, Darwin, 2015.

2. Kildea S, Van Wagner, V. 'Birthing on Country', Maternity Service Delivery Models: A review of the literature. An Evidence Check rapid review brokered by the Sax Institute (http://www.saxinstitute.org.au) on behalf of the Maternity Services Inter-Jurisdictional Committee for the Australian Minister's Advisory Council, Sydney, 2012.

3. Stonnier J, Sakiagak L, Epoo B, Moorehouse K, Tayara M. To Bring Birth Back is to Bring Back Life: the Nunavik Story. In: Floyd RD, ed. Maternity Care Models on the Edge, in publication 2015.

4. Birth in Angus. Available from URL: http://birthinangus.org.uk/angus-midwifery-services/montrose/

5. Burnside M. NHS Highland Midwifery Guidelines: Planned Homebirth. Department of Nursing and Midwifery, 2014.

6. Stonnier J, Sakiagak L, Epoo B, Moorehouse K, Tayara M. To Bring Birth Back is to Bring Back Life: the Nunavik Story. In: Floyd RD, ed. Maternity Care Models on the Edge, in publication 2015.

7. Rural Midwifery Recruitment and Retention Service, accessed 5 November, 2014, http://www.midwiferyrecruitment.org.nz/.

8. Van Wagner V, Osepchook C, Harney E, Crosbie C, Tulugak M. Remote Midwifery in Nunavik, Quebec, Canada: Outcomes of Perinatal Care for the Inuulitisivik Health Centre, 2000 – 2007. Birth 2012, 39: 30

Presenter

Rosie Downing is passionate about and committed to the provision of accessible and appropriate maternity services for families living in rural and remote communities. Trained as a nurse and then a midwife, she has worked in public, private, community controlled, urban and remote health services around Australia, including as a Remote Area Midwife in two remote communities of Central Australia. Her interests in the social determinants of health in Australia lead her to complete a Masters of Social Health (Aboriginal Health), University of Melbourne. In 2014, with the assistance of a sponsored Churchill Fellowship (the Peter Mitchell award) she travelled through Scotland, Canada and Aotearoa/New Zealand to observe and learn from successful birthing services located in geographically remote communities. She currently works with the Alice Springs Midwifery Group Practice; a continuity of care service where 40% of clients come from rural or remote communities in Central Australia.