No. 251, December 2010

Returning Birth to Aboriginal, Rural, and Remote Communities

This policy statement has been reviewed by the Aboriginal Health Initiatives Committee and approved by the Executive and Council of the Society of Obstetricians and Gynaecologists of Canada.This policy statement has been endorsed by the Indigenous Physicians Association of Canada, the Canadian Association of Midwives, and the Aboriginal Council of Midwives.

J Obstet Gynaecol Can 2010;32(12):1186–1188

INTRODUCTION

Giving birth close to home has been a significant maternity care issue for many years in rural and remote communities in Canada. Twenty-one percent of the Canadian population live in rural communities, and a significant number of this group are Aboriginal. Rurality is a powerful determinant of women's health, as a geographic and a sociocultural influence[1]; therefore, considerations of rural maternity care services and health care must take both place and culture into account.

In recent years, Canada's maternity care has been in crisis. The shortage of maternity care providers (family physicians, obstetricians, nurses, and midwives) is well-documented.[2] In rural and remote regions of the country, maternity care services are in decline [3] because regionalization and system restructuring have led to centralization of services.[4] Klein et al.[5] suggested that these changes will lead to serious health and social costs for women giving birth and for their families.

EFFECT ON WOMEN IN REMOTE COMMUNITIES

Women in rural and remote communities in Canada are less likely than their urban counterparts to have access to satisfactory care. They must usually leave their communities to give birth,[3] and they often experience labour and delivery without the presence and support of family and community members. Childbirth has therefore become a stressful event that disrupts rather than strengthens families and communities. Transfer out of the community for birth is costly for the family and the community, as well as for the federal health care budget. The large economic and social costs to families include support for women living away from the community and childcare for the children left behind. Teenage girls may be in particularly vulnerable situations when left without their mothers for weeks at a critical time in their development.

Traditionally, Aboriginal women gave birth in their communities. Cultural practices established strong community roots for the mother, her infant, and the family, and the children born in the community developed a clear sense of identity that helped them to become resilient and responsible members of that community.

By the 1970s, the efforts to decrease maternal mortality and morbidity in the general population led to the move towards hospital deliveries for all women. This in turn led to the transfer of pregnant women out of Aboriginal, rural, and remote communities, sometimes several weeks before they were due to give birth.

Countries, including Canada, that have indigenous populations are now questioning this practice and the cost to women and their families and communities.

BRINGING BIRTH CLOSER TO HOME THROUGH MIDWIFERY AND COLLABORATIVE COMMUNITY CARE

Birth programs have been established in some communities in direct response to lobbying from women, their families, and their communities, who were unwilling to accept the removal or absence of support for women who want to give birth in their own communities. In remote communities, women usually give birth in small centres without immediate

Key Words: Birth, delivery, community, Aboriginal, rural, remote, pregnancy, obstetrical care

surgical back-up available, and emergency air-evacuation to a centre with surgical facilities may take several hours. Because residents of remote communities are exposed to risks those in urban centres would find unusual or unacceptable, they often view risk from a different perspective. Aboriginal women know there are risks attached to giving birth in the community, but for many, these risks are outweighed by the benefit of having the support of family and community members before and during the birth.[6]

In addition, programs in Canada and Australia have shown that women with low-risk pregnancies can safely give birth in remote communities without immediate surgical back-up.[4]

More needs to be done if women in rural communities are once again to feel confident that giving birth outside a hospital can be safe. The SOGC believes that women with low-risk pregnancies should have the option of giving birth in their own communities but emphasizes the need to be vigilant and to encourage continuous monitoring and evaluation of outcome and safety. This will help women to feel confident in choosing to give birth in their communities. The SOGC Joint Policy Statement on Normal Birth asserts that "risk assessment is not a once only measure but a process continuing throughout pregnancy and birth. Referral of the woman to a higher level of care may be required when signs of complications become apparent."[7]

The support of the community is important, and women, community leaders, and elders all need to be involved in promoting the return of birth to their communities. Their advocacy and the promotion of holistic care and spiritual, mental, emotional, and physical health will help to bring about normalization of giving birth in the community. Common factors in successful services are effective collaborative relationships and excellent communication among all caregivers: midwives, nurses, doulas, family physicians, and obstetricians. Rigorous training and protocols need to be established in each community. Ultimately each woman should decide where she wants to give birth once she is informed about the advantages and risks of giving birth in a community centre or unit that cannot provide emergency Caesarean section.

The SOGC has led the way in promoting returning birth to the community for women at low risk of complications by developing multidisciplinary collaborative care models.

In 2006, the SOGC published Guideline and Implementation Tools for Multidisciplinary Collaborative Primary Maternity Care Models. "The model is based around a core team of health professionals that are the direct and continuous contact point for women."[2] The team members, who may come from various health professions, provide woman-centred care. Birth services in remote or rural communities should adopt a collaborative care model, which is flexible and can increase the quality and availability of maternity services for all women. Integral to effective collaborative care is a birth plan, which should include preparing the referral hospital to provide culturally competent care so that if a woman must be transferred or elects to deliver outside the community, her cultural practices and traditions will be understood and respected. Strong support from and links to referral hospitals also help to make birth in rural and remote communities as safe as possible, and midwives and community health care providers need to work with the referral hospital to ensure that each woman is monitored throughout pregnancy and that women at high risk of complications are directed to specialized centres. Women must be fully informed of the risks and benefits so they can make an informed choice about where to give birth. A woman's right to choose should be respected.

SUMMARY

The SOGC strongly supports and promotes the return of birth to rural and remote communities for women at low risk of complications. Training and protocols need to be established to ensure proper identification of women with low-risk pregnancies.

The SOGC encourages the establishment and facilitation of programs that will return birth to rural and remote communities. The following are essential to the success of these initiatives.

- Providing women with the knowledge they need to understand the risks and benefits of giving birth in the community so they can make an informed choice.
- Respecting women's right to choose where they give birth.
- Ensuring the support of community leaders and elders and ensuring that women are part of the planning and implementation of birth plans.
- Creating policies and procedures to facilitate optimal communication, planning, trust-building, and overall collaboration between caregivers within the community and in the supporting referral centres.
- Developing protocols for clinical care for the community birth initiative and the referral centre and in collaboration with all health care providers.
- Ensuring that continuous monitoring and evaluation of risk during pregnancy and labour are understood to be critical and are in place at all times.
- Ongoing documentation and annual review of experience.
- Reporting back to the community on the successes and challenges.
- Developing a campaign to inform SOGC members, governments, communities, and the population at large about the benefits of birth in the community.

REFERENCES

1. Sutherns R, McPhedran M, Haworth-Brockman M. Summary report: rural, remote and northern women's health: policy and research directions. Centres of Excellence for Women's Health; 2004. Available at: http://www.pwhce.ca/pdf/ rr/RRN_Summary_CompleteE.pdf. Accessed July 14, 2010.
2. Multidisciplinary Collaborative Primary Maternity Care Project (MCP2): guidelines and implementation tools for multidisciplinary collaborative primary maternity care models. Ottawa: MCP2; 2006. Available at: http://www.mcp2.ca/english/studies_reports.asp. Accessed October 6, 2010.
3. Kornelsen J, Grzybowski S. Rural women's experiences of maternity care: implications for policy and practice [monograph online]. Ottawa: Status of Women Canada; 2005. Available at: http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.123.2946&rep=rep1&type=pdf. Accessed July 14, 2010.
4. Summary of the state of rural maternity care in B.C. Vancouver: Rural Maternity Care Research; 2005. Available at: http://www.ruralmatresearch.net/downloads/Summary_state_rural%20maternity_BC.pdf. Accessed July 14, 2010.
5. Klein M, Johnston S, Christilaw J, Carty E. Mothers, babies, and communities. Centralizing maternity care exposes mothers and babies to complications and endangers community sustainability. Can Fam Physician 2002;48:1177–5. Available at: http://www.cfp.ca/cgi/reprint/48/7/1177. Accessed July 14, 2010.
6. Kornelsen J, Kotaska A, Waterfall P, Willie L, Wilson D. The geography of belonging: the experience of birthing at home for First Nations women. Health Place 2010;16:638–45.
7. Halpern S. Joint Policy Statement on Normal Childbirth. J Obstet Gynaecol Can 2008;30:1163–5. Available at: http://www.sogc.org/guidelines/documents/gui221PS0812.pdf.. Accessed July 14, 2010.