BIRTHING: ABORIGINAL WOMEN

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Introduction

In this presentation I want to give the historical and social aspects of Aboriginal birthing in our country from pre-contact to medical intervention.

I begin by quoting my mother's words when I met her again in 1977:

> You been born here in this country and this land owns you and you come back any time.

In my mother's time birthing was carried out in one's own country with all the rituals and traditions such as squatting over a prepare hole in the ground covered with soft grass and leaves as well as soft red sand. The female midwives such as my grandmothers and other designated women attended to give physical and emotional support such as holding and massage; this relieved the discomfort of labour. More particularly it removed fear, and fear is responsible for so many prolonged and complicated labours. Birth in our traditional society was always 'Women Business'.

Being born on our land allowed us to be regarded as traditional owners of that land so although I was removed at the age of 5 years, my people recognized me as a traditional owner as I was born on my country. Remember how Benelong and Barangaroo wanted their baby to be born in Government House Sydney a few years after the invasion! This would establish the baby's credentials as a traditional owner of the heart of the European settlement.

Men as male relatives were important in the postnatal period, since they were involved in ceremonies directed to establish the baby as a 'being'. It is worth reflecting that if a baby was still born or died in the early neonatal period, it would never exist as a being.

There is anecdotal evidence that before the European invasion and particularly before the dispersal that preceded the incarceration of the first people in missions and Government settlements, pregnant Aboriginal women suffered few medical complaints during pregnancy.

Of course the diet was strict during pregnancy; no red meat only fish and non-meat food. As well as breast feeding, the umbilical cord was cut by a sharp stone and the placenta was buried. Bush birthing was the norm. Aboriginal

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women were not accepted to give birth in the hospitals in our part of the country; therefore I don't have a birth certificate. In some parts of Australia during the 19th century Aboriginal midwives were the only people with expertise to act as midwife for black and white women. Dame Mary Gilmore in her memoir describes her early years in rural New South Wales. She acknowledged that the only women with any expertise in managing child-birth in the white frontier communities of those times were Aboriginal women. She goes so far as to say that Aboriginal women had far more experience than the white doctors, when they were available. Mary Gilmore recollected that:

> …Two well-respected nurses of the colonial period days in Wagga gained their midwifery knowledge from Aboriginal women and subsequently taught a local doctor whose obstetrical skills were insufficient for isolated rural practice.[1]

My husband's grandmother had in attendance a traditional Aboriginal midwife when she gave birth in the Murchison goldfields of Western Australia in the 1890s.

After World War II, Aboriginal women in the South were forced to live on fringes of the town while their sisters in the North and Centre of the Continent were still living in remote communities, although every aspect of their lives was controlled by the State. The former might be delivered in the local hospital, but may have been segregated to an iron shed at the back, which could be hot or cold. Those in remote communities and on cattle stations might choose to be delivered in the bush which was an attempt to keep away from the authorities, so that the baby would not be seized and removed to a mission settlement. Such a strategy destroyed the traditional rituals that surrounded childbirth.

However, in Australia the advent of increased medical intervention saw the bar raised in how labour was managed. It was done with the best of intention, although had a background of the power struggle between doctors and midwives that began in the 18th century in Britain.

Ultimately this struggle included a struggle within the medical profession as to who should conduct the confinement of women. The obstetrician won the struggle, so fewer and fewer medical graduates and midwives were given the training to feel competent to help confine women in rural and remote Australia. This translated into political action where withdrawal of resources means there are few if no birth services in remote parts of Australia.

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[1] Mary Gilmore, *Old Days, Old Ways: a Book of Recollections* (Angus & Robertson, 2nd ed, 1934) 152; cited in Judith Ann Barber, 'Concerning Our National Honour: Florence Nightingale and the Welfare of Aboriginal Australians' (1999) 6 *Collegian: Journal of the Royal College of Nursing Australia* 1, 36-39.

O'Neill has described how:

> The closure of maternity wards in regional public hospitals by state governments has meant that women living out of the cities now have longer distances to travel to deliver their babies. It's a trend that flies in the face of the Federal Government's funding initiatives to improve the choice of expectant mothers, particularly in regional areas.[2]

On the one hand, evacuation of my people to tertiary health centers ensured that complications of labour were competently managed. But on the other hand, the community from which they were sent was unable to compensate for the disruption of those ceremonies that could not be carried out in the absence of the pregnant women. We see this as an important factor in the breakdown of the traditional values in many Aboriginal communities, which leads to an increase in risk factors for girls and women during pregnancy and labour. For example, a woman with child might return from her confinement in a city hospital to find her other children neglected and her husband moved in with another woman.

After graduating in general nursing in 1966, I travelled to New Guinea for a holiday and I happened to meet a nursing sister from one of the Pacific Islands. We did a medical village visit and she went to see a patient in another part of the village. While she was away a near-term mother's waters broke so I panicked and ran to inform her. She laughed and said 'my dear girl these women have been having babies this way for centuries'. It was then I realised I had to do my midwifery if I was going to be working among women. So I enrolled in midwifery, but soon learnt that city birthing was different to my traditional birthing.

Intervention in this country

Some 30-40 years ago it was decided that maternal and neonatal mortality could be reduced by compulsory evacuation of Aboriginal women in late pregnancy to regional hospitals for delivery. This occurred all across the North from the Kimberley's, Arnhem Land, Cape York and the Centre of Australia, and recently I heard white and black women from Tennant Creek have to go to Alice Springs to have their babies. A report from the top end points out:

> Cultural safety can only occur, when difference in culture are recognized and respected and these differences are incorporated into health services delivery. Australia has not progressed very far towards providing cultural safety for the Aboriginal population.[3]

I believe this represents two sides of the coin. On the one hand, life-saving

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[2] Australian Broadcasting Corporation, 'Rural Babies at Risk: the Human Face of Health-care Cuts', *The 7.30 Report*, 21 September 2009 (S. O'Neill).

[3] Bawinanga Women's Centre, *Health and Birthing in the Bush* (Bawinanga Women's Centre, Maningrida, NT).

medical interventions are put within reach On the other hand, women not only had more delayed labour, but required greater intervention. We have known for some time that extreme anxiety felt by women in labour or even before confinement can lead to the production of hormones like adrenaline and cortisone which will slow down uterine contractions and prolong labour.

This strategy caused greater conflict, as Aboriginal babies were no longer being born on their land. Did this well-intentioned strategy lead to generations of children and young adults who had lost their identity, and whose behaviour reflected this loss? There is evidence that some Inuit's not born on their land are not seen as belonging, just as in Australia one's birth place can establish (or not establish) connection with one's land. For the establishment of Native Title through the current legal system whereby babies born after their mothers were evacuated should have the address of their country entered on their birth certificate rather than that of the hospital where they were delivered.

According to a Canadian paper about best practices for returning birth to rural and remote Aboriginal communities:

> Women, who are flown from their communities to give birth, also if they have lengthy labours, face language barriers and cultural norms and expectations that may be different. … Comments from Inuit women who had given birth to their first children in their communities but later ones away in urban centre, that "only their first children were real Inuit, not the later ones".[4]

This comment would create untold concerns in the Australian context.

Here are some recommendations put forth by Couchie and Sanderson:[5]

- Physicians, nurses, hospital administration, and funding agency (both government and non-government) should ensure that they are well informed about the health needs of First Nation, Inuit, and Métis people and the broader determinants of health.
- Midwifery care and midwifery training should be an integral part of changes in maternity care for rural and remote Aboriginal communities.
- Midwives working in rural and remote communities should be seen as primary caregivers for all pregnant women in the communities.
- Protocols for emergency and non-emergency clinical care in Aboriginal communities should be developed in conjunction with midwifery programs in those communities.

I understand that lower risk births are now emerging in the Canadian communities, but that birth with a high risk of complication is still being

[4] Douglas Vasiliki Kravariotis, 'Childbirth among the Canadian Inuit: a review of the clinical and cultural literature' (2006) 65(2) *International Journal of Circumpolar Health* 125.
[5] C Couchie & S Sanderson, 'A report on best practices for returning birth to rural and remote aboriginal communities' (2007) 29(3) *Journal of Obstetrics and Gynaecology Canada*, 250-254.

evacuated.[6]

Larocque[7] presented a paper to the Invitational Gathering on Indigenous Birthing and Midwifery in Washington DC on May 7th 2008 and based the approach of her paper on the following assumptions:

- Labour support is a right that all women have access to if they choose, regardless of where they come from or who they are; and
- Pregnancy is a complex interaction of biophysical, psychological, social/cultural and spiritual factors.

I am suggesting that dislocation of identity is one of the reasons why young Aboriginals began to drink alcohol excessively, leading to a breakdown of taboos and early pregnancy. Among my Walmadjari people these sexual liaisons may be 'wrong – side' and this can create further social disruption. Add to this an increasing prevalence of smoking which will further the risk of foetal asphyxia. These effects may lead to premature labour, low birth weight and increased prenatal mortality (including still births), as well as foetal alcohol syndrome leading to brain damage and poor intellectual development. This may in turn lead to further inability to become Aboriginal leaders in the future.

Sweet[8] has pointed out that:

> Child birth is essentially Women's Business, a natural female act being performed since the beginning of time; however it is the medical profession that has gained control of providing care for childbearing women to the detriment of many women's experience.

I argue that evacuation of an Aboriginal to a city hospital for delivery has produced not only social disruption in her family and community, but also has had the effect of prolonging her labour because of the fear engendered through removal to a foreign environment. What could be a normal delivery at home is turned into an abnormal one with an increasing risk of medical intervention (e.g. forceps, caesarean section, tears and post-partum bleeding etc). It is recognised that good antenatal care will usually find out who is at high risk of developing complications of labour, but it is useless if women are so fearful of being evacuated that they won't attend for such care. Pregnant women have a right to good obstetric care, although it can be difficult to arrange in remote areas.

First Nations in Canada believes that women should not only have close midwife support, but also continuous support from which they term *a doula*,

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[6] Douglas Vasiliki Kravariotis, above n 4, 117-132.

[7] Marlene Larocque, 'Doula Care and Practice for First Nations Women and Families'(Paper presented at the Invitational Gathering on Indigenous Birthing and Midwifery, Washington DC, 7 May 2008).

[8] Linda Sweet, 'Childbirth and the illness focus' (1997) 10 *Australian College of Midwives Incorporated Journal* 4, 21-25.

(this refers to a specially trained birth companion who provides labour support). Earlier in the paper, I mentioned that this also occurred in traditional Aboriginal birthing. The Cochrane review found that 'continuous support during labour improves birth outcomes and has no known risk'.[9] In 12 studies such a system was found associated with the following:

- 51% reduction in caesarean births;
- 25% reduction in labour length;
- 71% reduction in oxytocin augmentation; and
- 57% reduction in the use of forceps or vacuum.[10]

We in Australia are well behind. Official data about Aboriginal maternal deaths was very poor before the 1990s.[11]

A paper from Professor De Costa's group in Cairns noted the social disruption caused by evacuating women from Cape York to that city for confinement.[12] I quote from the findings of this paper the following about babies born to evacuated mothers:

1) Such babies had lower neonatal birth rates;
2) Lower rate of breast feeding in the transferred mothers;
3) Growth common in the month after weaning;
4) Bottle-fed babies had slower weight gain and more illness;
5) Such slow weight gain predisposed to increased infant mortality;
6) Separation anxiety or maternal deprivation was common among children left;
7) Decreased family bonding;
8) Resentment at having babies born away from their country; and
9) Women delayed presenting for antenatal care.

Studies have shown that stress during labour and delivery is associated with delayed lactation. Thus the babies of Aboriginal women will be disadvantaged in having to be bottle-fed as Cox's letter indicates.[13] Apart from changing time of evacuation from 32 to 36 weeks nothing has changed since. In other words the gains made by evacuation have been offset by the losses. There is little point in delivering a live baby if that baby fails to thrive and has a decreased

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[9] Ellen D Hodnett, Simon Gates, Justus Hofmeyr, Carol Sakala, Julie Weston, 'Continuous support for women during childbirth' (2007) Cochrane Database of Systematic Reviews 3, Art. No.: CD003766. DOI: 10.1002/14651858.CD003766.pub2.

[10] KD Scott, PH Klaus, and MH Klaus, 'The obstetrical and postpartum benefits of continuous support during childbirth' (1999) 8 *Journal of Women's Health & Gender-Based Medicine*, 1257-1264.

[11] National Health and Medical Research Council, *Report on maternal Deaths in Australia 1985 -87* (Canberra, 1991).

[12] JL Arnold, CM de Costa & PW Howat, 'Timing of transfer for pregnant women from Queensland Cape York communities to Cairns for birthing' (2009) 190 *Medical Journal of Australia* 10, 594-596.

[13] Julie Wolfram Cox (2009) Letter 'Timing of transfer for pregnant women from Queensland Cape York communities to Cairns for birthing' (2009) 191 *Medical Journal of Australia* 10, 580-581.

life expectancy.

I acknowledge that our geography and population density make it very difficult, but not impossible, to organise midwives backed up by obstetric teams so women can be confined on their country. But modern technology should be able to determine who represents a low risk for complications during labour and who will not with greater accuracy than in the past. Those at low risk should at least be given the choice of midwife attendance; in other words, not penalised if they don't want to be evacuated. This strategy is being practiced successfully in Nunavit. If evacuation is carried out the child born outside its country should not, I repeat not, be penalised by having only the actual birth inscribed on its birth certificate, but also include its country of origin. In other words evacuation should not deprive these children of their identity. Finally the rigid bond between general nurse and midwife, put in place by the medical profession should be loosened so that more midwives can be trained and be available in remote and rural Australia.

Conclusion

I recommend the following:

- Those Aboriginal women at low risk of complications of labour are confined in or near their own country and those facilities such as provision of midwives are made available for this to happen; and

- That Aboriginal babies born to mothers evacuated from their country for delivery should have the name of that country entered on their birth certificates.