Improving outcomes for First Nations mothers and babies in Australia through culturally safe continuity of midwifery care: the time for scale-up is now!

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Australia is one of the safest places in the world to give birth. This is not the case for Aboriginal and Torres Strait Islander (hereafter called First Nations) peoples.[1] First Nations women are three times more likely to die in childbirth than non-First Nations women, and their babies are almost twice as likely to die in their first year of life. Preterm birth (birth before 37 completed gestational weeks) and being low birthweight (<2500 g) are also both substantially higher for First Nations babies, and are associated with significant morbidity and mortality.[1] Perinatal factors, such as preterm birth, are responsible for 85% of deaths occurring in the first 18 months of life.[2] Despite numerous government recommendations urgently calling for strategies to improve health outcomes for First Nations mothers and babies,[3] as well as a national 'Close the Gap' strategy aimed at reducing neonatal and child mortality,[2,4] to date there has been little improvement.

One strategy that *has* been effective, and that has demonstrated improvements in health outcomes for mothers and babies, is midwifery continuity of care. Numerous studies have found that midwifery-led continuity is associated with substantially better perinatal health outcomes,[5] and cost savings to the health system.[6] Despite these findings, and the substantially poorer health outcomes experienced by many First Nations women and babies, very few women having a First Nations baby have received continuity of midwifery care.

Our large research translation study (called Baggarrook Yurrongi, meaning 'woman's journey' in Woiwurrung language)[7] evaluated the capacity of four maternity services in Victoria, Australia, to implement, embed, and sustain a culturally specific caseload midwifery model of care. In the caseload model women have midwife-led continuity throughout pregnancy, labour, birth and the early postnatal period with a known midwife. In our study, new culturally specific and tailored caseload models for women having a First Nations baby were successfully implemented in three major metropolitan tertiary maternity services in Melbourne Australia, between 2017 and 2020. The models provided women with collaborative and coordinated care with a known midwife who had received appropriate cultural training and who helped women navigate their journey through the maternity care system. There was a 21-fold increase in access to the model (from 34 First Nations women ever receiving the model within the services to over 700 over a similar time period), and uptake of the model was high (90%).[7] Women were very satisfied with the care, and reported feeling emotionally, culturally and clinically safe and valuing the personalised care provided by a known midwife. This model differs from fragmented mainstream care where First Nations women usually receive care from a number of different and unfamiliar health care providers, and often experience racism.[8] In our study, we also found high rates of breastfeeding initiation and maintenance,[9] reduced smoking in pregnancy, and improved clinical outcomes. Midwives working in the model were also highly satisfied with the work, valuing building close relationships with women and providing continuity of care in a culturally sensitive way. Since completion of the Baggarrook Yurrongi study, the new models have been successfully embedded and sustained in the three hospitals, with the majority (over 400 women) per year having a First Nations baby receiving the culturally tailored continuity of care model.

Another recent study conducted in Brisbane, Australia, also evaluated a culturally specific midwifery continuity of care program like the Baggarrook Yurrongi caseload model for women having a First Nations baby. The program, based on 'Birthing on Country' principles (i.e. models that are co-designed with First Nations people, include a First Nations workforce, partnerships between primary and tertiary services, cultural strengthening programs, and wrap-around services to support pregnant women and their families) reported a 38% reduction in preterm birth and improved infant outcomes and reduced cost.[10]

Despite the strong evidence, government policies[3] *and* published frameworks to assist services in 'Birthing on Country' implementation,[10] the models are still only available to a small proportion of women having a First Nations baby in a small number of health services.

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Scale-up must be prioritised by Australian governments and by health services. Models should be developed in partnership with First Nations people and communities and enabled through utilisation of the RISE framework[10] that is designed to be used as a guide for local implementation. The framework allows for customisation of the model to the local community context through a participatory action process, enabled by strong partnerships and leadership from First Nations people and Aboriginal Community Controlled Health Organisations.[10]

There is little doubt that the urgency to improve health outcomes for First Nations peoples in Australia remains. There is also now clear evidence that culturally specific and tailored midwifery continuity models like Baggarrook Yurrongi and 'Birthing on Country' can help close the gap in the health outcomes between First Nations and non-First Nations peoples. Widespread scale-up must be prioritised to ensure all women having a First Nations baby receive this gold standard model of care. The time for scale-up is now.

Contributors

HMc wrote the first draft of the Commentary and all authors contributed to Commentary revisions. All accept responsibility to submit for publication.

Declaration of interests

The authors have nothing to disclose.

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