Closing the Gap in Aboriginal women's reproductive health: some progress, but still a long way to go

Many Aboriginal and Torres Strait Islander women experience healthy pregnancies and have healthy babies.[1] Aboriginal* communities have provided leadership over decades in the development of primary health care services for Aboriginal women of all ages, during pregnancy and for their children. There have been additional improvements to tertiary level care for management of pregnant Aboriginal women and neonates. However inequalities persist and overall Aboriginal women experience increased perinatal and maternal morbidity and mortality compared with non-Aboriginal women.[1] The reasons for these persisting health inequalities are complex. Compared to other Australian women, Aboriginal women experience greater socio-economic disadvantage, racism, higher rates of incarceration, decreased English and health literacy, a lack of culturally appropriate and available services. Additionally, they have higher rates of early onset chronic disease, and detrimental health behaviours including use of tobacco, cannabis and alcohol, poor nutrition and lack of physical activity.[2,3] These influence women's health across the life-course in health promotion, preventive care and access to health care, and opportunities to access nutritious affordable food and exercise, affecting pre-conception health through pregnancy and post-partum.

In 2014, births where one of the parents identified as Aboriginal accounted for 5.9% of all Australian births.[1] Aboriginal mothers are younger with a mean age of 25.1 years compared with 30.9 years for all Australian mothers and are more likely to give birth as teenagers, particularly in remote areas.[1]Aboriginal women experience nearly double the rates of pre-term birth and low birth weight, 1.5 times the perinatal mortality rate and 5 times the maternal mortality rate of non-Aboriginal women.[4] Risks are higher in women from rural and remote areas perhaps reflecting increased socioeconomic disadvantage and access to health services.[4]

Aboriginal women are more likely to smoke in pregnancy, experience under- nutrition and increased BMI and despite birthing at a younger age are more likely to have chronic disease such as diabetes, chronic renal disease and rheumatic heart disease. [4-6]

Approaches required to improve the health outcomes for Aboriginal women and their babies in pregnancy include

i) Systems based approach: to address socioeconomic disadvantage, education and health literacy;
ii) Health services approach: to provide trusted, welcoming and culturally appropriate health services in both community-controlled and government sectors, facilitate better communication between primary and hospital based services, and utilise initiatives such as continuous quality improvement practices that lead to improved services, particularly where staff turnover is high;
iii) Families based approach eg. smoking prevention and quitting;
iv) Clinical guidelines: addressing specific needs of Aboriginal and Torres Strait Islander women in pregnancy eg. screening for infection in young women and those in areas where risk is high, screening for asymptomatic bacteriuria in first trimester;
v) Supporting the particular needs of rural and remote women in accessing care eg. ultrasound services

Whilst the majority of women live in urban areas, Aboriginal women are more likely to live in regional or remote areas than non-Indigenous women impacting their access to services.

This issue of *ANZJOG* presents papers on Aboriginal perinatal health across the spectrum of health research: from a population public health intervention to improve folate intake and decrease neural tube defects; to epidemiology, describing outcomes for mothers and babies in an urban setting in Melbourne, and another reporting trends over time in Western Australia (WA); and the final article examines the role of autopsy as a means to improve identification of causes of stillbirth in Aboriginal women.

The first paper assesses the impact of the introduction of mandatory fortification of folate and neural tube defects (NTDs).[7] These were first noted to be high in Aboriginal women in WA, possibly due to low folate in diet and low uptake of folate supplements pre-conception as well as additional increased risk due to high rates of diabetes. Encouragingly, the paper by Bower et al reports that the public health approach of fortification of flour has seen an increase in red cell folate in women and a decrease in NTDs.

There is a gap in knowledge around pregnancy health in urban Aboriginal and Torres Strait Islander women and the paper from Whish-Wilson et al discusses the outcomes for women

in Melbourne and, encouragingly, shows similar rates of pre-term birth and birth weight. Whilst smoking rates are lower than national figures for Aboriginal women they remain higher in this setting than for non-Aboriginal women.[8]

This contrasts with the paper from Diouf et al reporting on data in WA from 1986 to 2009 which reports some improvements in proportions of teenage births and pre-eclampsia, but increased diabetes and no change in pre-term birth, smoking, low birth weight and stillbirth rates.[9]

Determining the aetiology of stillbirth and neonatal death is important in addressing preventable factors that contribute to perinatal deaths. The final paper in this quartet from Kandasamy et al discusses the role of autopsy in determining the cause of perinatal deaths.[10] This currently has a low uptake in Aboriginal and Torres Strait Islander families and issues around supporting a culturally appropriate response to autopsy are discussed.

It is clear we need to have health system and non-health system approaches to reduce factors underpinning the health inequalities experienced by Aboriginal women and their children. Improved education of Aboriginal women is a key issue in the non-health system. In the health system integrated system-wide strategies as well as improved individual care are required to improve the health of Aboriginal and Torres Strait Islander mothers and babies and decrease the adverse outcomes currently experienced by many women and children. Further efforts are required to reduce the rate of smoking in pregnancy as this contributes significantly to the risk of fetal growth restriction, stillbirth and related health outcomes. There is a requirement for improved training of Aboriginal women to deliver health services in primary and tertiary care settings in partnership with other providers. Continued advocacy for funding and delivery of maternal and child health services providing culturally appropriate care as a part of the campaign to Close the Gap are required. A consistent, co-ordinated response over time is required of local communities, State and Territory governments, primary and tertiary health care providers committed to improving the health of Aboriginal mothers and babies.

Jacqueline Boyle

Monash Centre for Health Research and Implementation

School of Public Health and Preventive Medicine

Monash University, Melbourne, Victoria

Sandra Eades

Baker IDI Heart and Diabetes Institute

Melbourne, Victoria

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