

[Insert Table 1 Summary of relevance]

Introduction

This study was primarily based in Australia but aimed to draw on experiences from other English-speaking countries, specifically Canada, New Zealand (NZ) and the United States of America (USA). It is recognised that there are hundreds of Aboriginal and Torres Strait Islander nations across Australia with different languages, traditions and culture. When referring to Indigenous Australians, this is inclusive of all Aboriginal and Torres Strait Islander peoples. Similarly, Indigenous people in Canada are not a homogenous group. The studies incorporated in this meta-synthesis relate to both Inuit and First Nations peoples in Canada. The reason to analyse the experience of Indigenous women and babies across different countries is not to categorise them as a homogenous group; it is because they have a common experience of a history of disadvantage, exclusion and isolation from mainstream society. This has led to poorer health outcomes and is an international phenomenon ¹.

In Australia, the maternal mortality ratio (MMR) for Indigenous women from 2008-12 was more than double the non-Indigenous rate at 13.8 compared to 6.6 deaths per 100,000 women giving birth ². A higher proportion of Indigenous women smoke in their pregnancies, have smaller babies and preterm births ^{3,4}. Babies of Indigenous women have a neonatal mortality rate of 18 compared to 9 per 1000 live births of non-Indigenous women ⁴.

The main reasons for the poorer outcomes include the high rates of social, environmental and economic disadvantage amongst Indigenous women, potentially leading to lack of access to primary health care services such as antenatal care. The cultural responsiveness of antenatal clinics has also been a factor in Indigenous women not accessing care ⁵⁻⁸. Indigenous Australian women have lower attendance for antenatal care than non-Indigenous; 15 per cent of Indigenous women attended less than five antenatal consultations in comparison to 5 per cent of non-Indigenous women ⁴.

In addition, a higher proportion of Indigenous women live in remote areas contributing to challenges and complexities of maternity care ⁴. The health care policy in most Australian states and territories dictates that women living in remote communities need to be relocated to a regional centre at 36-38 weeks gestation to await labour and birth ⁹. The evacuation policy became routine in the 1990s across the Northern Territory. Women often travel alone to the regional centres – resulting in a lonely and isolated birth experience as they could not afford to have their families travel with them ¹⁰. Women's stress was often compounded by having to leave older children at home in the care of others ¹⁰. They were also unable to undertake any of the traditional birthing ceremonies being alone and away from their families and communities ⁹. The evacuation policy results in a significant lack of cultural safety for Indigenous women living in remote and rural areas.

Models of midwifery care

Midwifery-led continuity of care models are beneficial to all women ¹¹, but given the poorer outcomes for Indigenous women and babies in many countries, prioritising continuity of care services for Indigenous women could be beneficial. The systematic review of midwife-led continuity models of care, including 15 trials and 17,674 women, concluded that this model should be offered to all women with low risk pregnancies. Women receiving care in midwife-led models were more likely to know the midwife who cared for them in labour, have a spontaneous vaginal birth, were less likely to have an instrumental birth, use analgesia or anaesthesia, experience preterm birth or lose their baby before 24 weeks gestation ¹¹.

Due to the poorer outcomes for babies of Indigenous women and other risk factors, it has been recognised in Australia that the development of models of midwifery care for Indigenous women and babies was urgently needed ³. This was identified by the Australian National Maternity Services Plan that set out a five year vision from 2010-2015 to provide maternity care close to where people live in order to improve outcomes for Indigenous women and babies ¹². The models developed have been

based on midwifery-led care. Similar models have been established in other countries such as Canada, the world-renowned example being the Inuulitsivik Health Centre operating three birth centres in the remote region of Nunavik. It has been in existence for almost three decades, Inuit midwives have been trained to run the centres and it has provided safe and culturally competent care while returning birth to remote communities ^{13,14}.

A literature review was conducted by Kildea and Van Wagner, ¹⁵ primarily using the term 'birthing on country', to analyse the models that existed in Australia, Canada, NZ and the USA. Such models were defined as community-based and governed, developed by and/or with Indigenous people and incorporating traditional practice. These culturally competent models would have a connection with land and country, have a holistic approach to health care, would value Indigenous and non-Indigenous ways of knowing and learning and be able to assess risks and competently provide services. Despite some limitations of the studies, the conclusion was that 'birthing on country' models of care would most likely be of benefit to, and improve outcomes for, Indigenous mothers and babies. It was suggested that these models of care were appropriate for Indigenous communities living in remote, rural and urban areas ¹⁵. The literature review conducted by Kildea and Van Wagner was not a meta-synthesis, which is a rigorous search and synthesis of qualitative studies on a particular topic ¹⁶.

Quantitative research has also analysed models of midwifery care for Indigenous women and babies. The services analysed had reduced smoking rates ^{17,18}, reduced preterm birth rates and improved birth weights ¹⁹⁻²². Cost effectiveness was demonstrated in one service ²³ and another estimated a modest cost to the health care system ⁶.

While small studies have been conducted to analyse the experiences of women and midwives in the models of care, there has not yet been a synthesis. Therefore, it was considered important to

undertake a review of models of midwifery care for Indigenous women and babies to help guide practice development and innovations. The aim of this study was to examine qualitative research relating to the different types of midwifery models of care for Indigenous women that were available, and the experiences of women and midwives.

Methods

Design

A meta-synthesis of qualitative research was conducted using the approach outlined by Noblit and Hare ²⁴. A meta-synthesis is a rigorous search of qualitative studies on a particular topic. The purpose of a meta-synthesis is distinct from a quantitative systematic review in that it is searching for explanation of a particular phenomenon, rather than providing empirical evidence in relation to methods and procedure. A meta-synthesis has an interpretive intent with the purpose of obtaining a richer understanding of the topic under scrutiny to gain an insight that is greater than the sum of its parts ^{16,24}. Qualitative research aims to search for meaning of phenomena, therefore it is more concerned with idiomatic (meaningful) interpretations rather than semantic (literal) ^{24,25}. Idiomatic interpretation was applied rather than semantic, that is, the meaning was elucidated rather than literal interpretations.

This research did not require ethical approval as it used secondary data that is in the public domain. Despite not needing formal approval, ethical principles were adhered to in undertaking this study. Ethical considerations are important regarding Indigenous health research. It has been argued that a large number of research projects have only served the non-Indigenous researchers and done little to advance health services for Indigenous people ¹. There is good reason for mistrust on behalf of Indigenous people given errors of judgement due to cultural differences ²⁶. This research was conducted in the spirit of profound respect for Indigenous culture, autonomy and traditions. The

*Guidelines for ethical conduct in Aboriginal and Torres Strait Islander health research*²⁶ were followed, and consideration was made that the research was in the best interest of Indigenous people.

The search of the literature

A literature search was undertaken to identify the studies to be included. Walsh and Downe (2005) argue that the ideal goal is to investigate all literature on the chosen topic, not just a sample; therefore a robust, transparent search identifying all relevant literature is key to the quality of the study. Databases searched were CINAHL (EBSCO), the Cochrane Library, Interim, Medline (Ovid), Indigenous collection (Informit) and rural and remote health database (Informit). Search terms were 'Indigenous midwifery models of care', 'Indigenous midwifery', 'Indigenous', 'Indigenous peoples', 'Aborigine', 'Maori', 'Inuit', 'Eskimo', 'Indians, North American', 'midwifery', 'midwives' and 'maternal-child care'. Boolean operators, truncation and wild cards were used with the keywords to ensure integrity of the search.

The search was limited to qualitative articles in English between years 2000-2014. The initial search yielded 288 papers (see Figure 1). The titles were reviewed for relevance; and where it was not clear, abstracts were also reviewed. This led to 103 irrelevant articles being excluded. The studies were mainly from Australia, Canada, NZ and the USA. Mixed methods research that included a qualitative component was included. Titles that were related to midwifery or maternity care, but not related to Indigenous women and babies were excluded.

[Insert Figure 1 Literature search]

Careful consideration was given to the inclusion of two studies – one from Canada and one from the USA – that were not 'midwifery programs' and the care was provided by nurses^{18,27}. As it is quite

common for nurses to carry midwifery activities in Canada and the USA, to exclude these studies would mean not representing maternity care equivalent to midwifery care in the Australian context. This would have undermined the ability of this paper to examine services in those countries, which was one of the reasons for conducting the research. However, following the literature appraisal, the study from the USA was excluded due to its low methodological quality¹⁸.

In total, 18 papers were found that examined midwifery models of care for Indigenous women including six qualitative, five mixed methods, four retrospective, one descriptive and one prospective cohort study. A short news article and three unpublished reports were not included, as they were not peer-reviewed published research. The five mixed methods studies all had qualitative components, so in total 11 studies were included for quality appraisal. No studies were located from NZ. The literature review conducted by Kildea and Van Wagner (2012)¹⁵ also did not locate any research from NZ and commented that Maori women comprise a relatively large proportion of the total number of pregnant women and 'all programs aim to ensure they provide culturally responsive services'^{15, p. 17}.

Appraisal of the papers

A quality appraisal of the 11 studies was undertaken. A one-page checklist based on the summary framework by Walsh and Downe²⁸ was developed and used. This checklist includes elements such as whether the studies had a clear statement of aims, appropriate sampling strategy, ethical approach and evidence of relevance and transferability.

There were a number of aspects of the literature appraisal that were difficult to determine. For example, it was unclear whether literature reviews were performed in two studies. These may not have been absent within the studies themselves, but omitted due to restrictive journal word counts. Similarly, appraising 'full reflexive accounting' was difficult, as these were often absent in journal

articles for the same reason. It was important to appraise the design and methodology of the papers, and these were included in the appraisal framework by Walsh and Downe²⁸.

Participants

After the quality appraisal, and exclusion of two of the eleven studies, nine studies were included in the meta-synthesis – six from Australia and three from Canada (see Table 2)^{6,8,17,27,29-33}. Of the six Australian studies, two did not publish the number of participants. Of the four that did, there were 320 participants in total, 83 women who used the services, 18 midwives, two Aboriginal Health Workers, five Aboriginal Maternal Infant Care workers, one community member, 194 health staff and 17 external stakeholders. Of the three Canadian studies, one did not publish the number of participants. One published the total number, but not the breakdown of service providers, recipients and other participants. There were 96 participants in two services.

[Insert Table 2 List of services included in meta-synthesis]

Of the six papers that published the number of participants in Australia and Canada, there were a total number of 416 participants. It was not possible to determine how many of these were women who used the services, as the data presentation was not uniform; some studies did not distinguish between pregnant women and other community members, and some studies did not distinguish between midwives and other health care professionals.

Coding and theme development

The full papers of all nine studies were uploaded onto NVivo, version 10.2.0³⁴ and there was an initial search for key phrases, metaphors, ideas and concepts conducted by the first author. When the coding was complete, there was an assessment of the 'hierarchy' of codes. Some codes were a

lot more dominant throughout the studies, the main example being 'continuity of care' and related themes. Some codes were not as dominant, but were considered significant and were mentioned in a number of studies, for example, 'negative experiences' and related themes. Some codes were only mentioned once or twice in one or two studies and could not be grouped with other codes so were excluded. All themes were entered onto an excel spreadsheet and concepts were grouped, moved and merged, until the four main themes were developed. The first draft of themes was taken to a meeting of all three authors where the themes were further developed.

Findings

From the nine studies analysed in the meta-synthesis, four main themes emerged: valuing of continuity of care, managing structural issues, having negative experiences with mainstream services and recognising success. There were a number of sub-themes, illustrated in Figure 2.

[Insert Figure 2 Themes resulting from the meta-synthesis of nine qualitative analyses]

Valuing continuity of care

Continuity of care enabled relationships between pregnant Indigenous women, midwives and other people involved in their care (in some cases, Aboriginal Health Workers (AHWs); in South Australia, known as Aboriginal Maternal Infant Care (AMIC) workers). A fundamental element of building relationships was effective communication. Through the support provided to pregnant women, trust was built that enabled feelings of empowerment to women, which led to midwives becoming their advocates. The elements of support, trust, advocacy and empowerment comprise some of the benefits of continuity of midwifery care. Within continuity of care were a number of sub-themes – building relationships, supporting women, communicating effectively, developing trust and facilitating an environment conducive to empowerment.

Continuity of care enabled relationships to be established between midwives, AHWs and women.

One woman said '*I look forward to my visits because I was coming to visit friends*' and women found that they could '*have a laugh with them* [the midwives]' ^{17, p. e512}. The relationships helped establish trust and empowerment; women felt as though they had an active say in making decisions ²⁹. The relationships enabled midwives to become strong advocates for women ³¹. For example, in the Darwin Midwifery Group Practice (MGP), Australia, staff observed that women had a '*far more balanced and maybe equal relationship*' with midwives ^{31, p. 5}, which indicated that they felt their relationship was not based on power differences, but more on a partnership model. When midwives worked in partnership with women, they recognised that women brought their own knowledge, skills and needs. Midwives seemed to bring their skills regarding pregnancy and birth but aimed to work with women in a manner that empowered them to bring about the best possible birth outcomes.

Knowing the story of the woman was identified as an important aspect of relationship-based continuity of care ^{8,17}. This facilitated the building of relationships; a woman described the benefits:

It's good coming here too because you know you're going to see the same people all the time. It's not a different doctor or a different midwife every time who's going to ask you the same questions over and over again ... she [midwife] knows your full-on history from the first visit to, you know, your last visit. She knows everything about you, which is good. ^{8, p. 6}

Many studies found that communication with women was better within the Indigenous midwifery services than with mainstream health services and this was facilitated through the continuity ^{6,8,29}.

For example: '*E [the midwife] uses a certain language the women understand – they can relate to it – they seem to understand and accept things a lot better if it's in their terminology*' ^{6, p. 18}. The ability of

care-givers to listen effectively was identified as making a positive difference to the quality of care and this again was bound together with the continuity of care^{29,33}.

Over the time that women were provided with continuity and got to know their service providers, trusting relationships developed, for example: *'Daruk [the name of the service] knows your background – they know your needs. You feel at home at Daruk – you can talk about any problems that you have'*^{6, p. 18}. It was appreciated that the care providers already knew the stories of the women and they didn't have to repeat information; this led to increasing trust⁸. MGP midwives in Darwin, Australia, were described as *'a face they have learned to trust'*^{31, p. 5}.

Women who had continuity of care throughout the intrapartum period had an active say in the decisions regarding their care throughout their labour. This resulted in increased feelings of empowerment:

The Women's Business Service empowers women to be able to say what they want. To give the women a choice. They didn't listen to me when I had my children, but they listened to my daughter and let her do what she wanted to do. She had support in labour. It makes a big difference.^{29, p. 380}

The theme valuing continuity of care and related sub-themes were dominant within the data and reflected the importance of this aspect of the services. Continuity of care enabled a positive experience for Indigenous women.

Managing structural issues

The second theme was about the way care and the service was organised or structured. Different services had a range of experiences with practical or structural issues such as appointment times and

locations, staffing issues and other administrative problems. The data provided a rich tapestry of lessons for the future establishment of new services. The sub-themes were access, addressing staffing issues, Indigenous heritage of staff, and institutional obstacles.

Accessibility of services covered a range of dimensions relating to antenatal care – broadly classified as anything that impacted on the ease for women to attend antenatal consultations and access antenatal care. It included transport, availability of parking, clinic opening hours, waiting time, child-friendly services, physical structure and location of the consultation space, and the availability and flexibility of midwives. There were no data that explained accessibility of intrapartum or postnatal services.

Some services offered consultations in women's homes or at other locations that suited them for antenatal care. Midwives working with some services had a more flexible approach, for example a woman explained that *'I rang one time to say I couldn't come to antenatal check-up because I didn't get off work till 5 p.m. – so they waited till I could get there'* ^{6, p. 18}. One woman explained how the structural issues of access were managed, saying *'If you couldn't get there they would come and pick you up'* ^{17, p. e512}.

Some of the structural issues were workforce-related. For example, in Rankin Inlet, Canada, it was sometimes difficult to find enough staff to keep the service running at capacity as midwives were rotated through from southern areas. It was also difficult to retain staff due to the remote location of the service ³⁰.

Related to the structural challenge of staffing was achieving an appropriate cultural mix of staff. Discussion of the Indigenous heritage of staff was evident in the data. There was a mixed response regarding this issue. Some data reflected that it was important for caregivers to be Indigenous in

order to provide culturally appropriate care; other studies reflected that Indigenous women were most concerned that midwives were competent, and that the cultural background was not crucial to the quality of and satisfaction with their care. For example, in Australia in the Murri Clinic, women valued other aspects of maternity care:

I'm more concerned about their qualifications and how much experience they've had I'm not really worried about whether they're Indigenous or not. ^{8, p. 7}

In South Australia, however, having AMIC workers helped Indigenous women engage with mainstream health services:

I think it's important to know how to deal with mainstream services. They don't know our way and sometimes they push things the other way – that they want them. But I think it's important to have strong Aboriginal women working in the program so that we can stop and say: 'No, hang on a minute, that's not the way to do it, that's not the way we do it, when it comes to our women, this is how it should be done'. ^{33, p. 5}

In the analysis of the service in Rankin Inlet (Canada), it was concluded that as the midwives were not of Inuit heritage, they were not able to establish a social or cultural connection with women. This was in contrast to the successful Inuulitsivik Maternities in Nunavik where Inuit midwives now run the birth centres, and therefore have a stronger connection with women ³⁰.

In the establishment of the Kinisopi Midwifery Clinic on a First Nation reserve in Manitoba, Canada, there were numerous and profound institutional obstacles as explained by a midwife:

We were given a room in the hospital to establish a clinic, but because they were a federal hospital and we were provincial employees we were not allowed to access patient records. So we couldn't access the records. We also couldn't order lab work. There was a pharmacy and we could prescribe, but that was because the pharmacy was privately owned but within the building. So there we were. We had an education program, we had a room, we were equipping the room, but we cannot actually practice. ^{32, p. 985}

The problems in Manitoba were described as a 'jurisdictional abyss' whereby the provincial level of government was responsible for the provision of safe birthing facilities but the funding of health care on First Nation reserves was a federal responsibility. The federal government funded the transportation of women for birth services, but this was where the responsibility ended, therefore creating a policy barrier for midwives to practice in First Nation communities ³².

Having negative experiences with mainstream services

The third main theme was having negative experiences with mainstream services. The negative experiences were generally not associated with care provided by the Indigenous-specific services. The context within which there were negative experiences fell into two main categories: firstly, experiences with mainstream health services prior to the establishment of the service and secondly, experiences with mainstream health services when the service did not provide continuity of care, in particular when going to hospital for intrapartum care. Prior to the establishment of the remote birthing service in Rankin Inlet, Canada, women had to travel long distances from their communities. One woman said:

I went from having a huge support in my home to going far away to Winnipeg, and just for the shock of it ... not knowing the medical staff, and ... meeting them for the first time and immediately having to trust them was really hard for me. ^{30, p. 182}

Women travelling to regional centres in Central Australia were described as 'lost' in the system. This was demonstrated by this midwife's quote:

They wouldn't turn up for their appointments. They didn't know what was going on or where they should be. There was this huge gap for remote women...where there was just no support. ^{31, p. 4}

Information sharing and communication between regional centres and remote communities was at times poor, making it difficult for health care providers in remote communities to provide quality care. For example, a midwife explained:

Women would have caesareans and wouldn't know why. Or have a big bleed. Or the baby is in the Special Care Nursery and they have no idea [why]. And they have come back to the community and there has been no documentation that has followed. ^{31, p. 4}

Women described feeling isolated as they did not have any family or friends visiting them, for example: *'lonely ... I would see other ladies ... partners and family. I would be by myself with my baby'* ^{31, p. 3-4}. Indigenous women found the experience in hospital alienating, reporting rarely seeing other Indigenous people: *'I felt isolated from support – in hospital they wouldn't let any of my people in'* ^{6, p. 18}. Another example demonstrated the decreased worth that Indigenous people can feel: *'They'd talk down to you – they don't make you feel comfortable. I always thought of myself as dumb [in hospital]'* ^{6, p. 18}. Hospital staff also recognised these issues. One staff member explained:

Indigenous women felt discriminated against a bit – they would come into a crowd of people at antenatal clinics and just were not good at coming back. ^{6, p. 18}

Women who attended the Murri Clinic expressed disappointment and feelings of abandonment when they did not have continuity of carer through the intrapartum period. They reported feeling ‘scared’ and/or ‘shamed’ when people they did not know entered their room unannounced, particularly at times when they were being examined. One woman said *‘I was kind of like covering myself. [I felt] shame. ... was like, embarrassed’* ^{8, p. 8}. Another comment was *‘I think it’s a very private time labour, and I think you should have a choice as to who is to be there’* ^{8, p. 8}. These negative experiences with mainstream services happened when continuity of care was not available.

Recognising success

The fourth main theme is recognising success with sub-themes of: a ‘special’ service – signs of success; importance of community links and community control; and benefits for mothers and babies. Most of the services examined by the studies had some degree of success, that is, there was an improvement in maternity care provided to Indigenous women. However, some were more successful than others. The greatest success was among the services that provided continuity of care and those with strong community links and participation.

Being ‘special’ was an important aspect of the services. Women attending the service in Malabar, Sydney, Australia, described their care as ‘special’ and more than just a midwifery service: *‘it’s more than just having a baby – it’s about establishing networks, play groups, all sorts of sessions for mums to get together and talk and learn’* ^{17, p. e513}. One woman said *‘I want others to know that the level of service here is really unusual – compared with any other service [in health or otherwise] – it’s really rare’* ^{17, p. e513}. Similarly, a service in Western Sydney, Australia, was valued in particular for the non-judgemental and sympathetic nature of the care provided ⁶.

Continuity of care assisted efficiency and enabled thorough antenatal care in the Murri Clinic, Australia. One midwife said: *'if they don't turn up to an appointment we know about it and we follow it up'* ^{31, p. 5}. There was also increased efficiency, for example *'we don't get those early labourers sitting, waiting like we would have done'* ^{31, p. 5}. The MGP in Darwin, Australia, also made a significant difference to maternity care. A service provider explained:

I think it's made us think differently, as service providers ... it's just lifted the game ... we all waited so long for a service like this for remote women, and we've got it and we all value it ... in valuing that service I think it's changed the way we think about how we provide the care for [all] women. ^{31, p. 321}

The success of bringing birth back to the community by a service in remote Canada was described:

When the Birthing Centre here first opened, people were very hesitant to deliver here. But, once there were a few births here, and hearing people going on the radio saying, "My daughter just delivered a baby girl this morning!" When they started hearing people doing that, then they start thinking, "Oh, she didn't even have to leave home! ... Her husband was right there! The kids are there, they see their sister right away!" ^{30, p. 182}.

A participant described the importance of another service in regional Victoria, Australia:

It's an important service for the women. Girls are having their first baby, they're reassuring them, and telling them everything. It's good, especially as some girls don't have their mother around. ^{29, p. 380}

Clients at this service had a high level of confidence in caring for their baby when they went home²⁹.

Other signs of success were found in South Australia, where midwives and AMIC workers developed a constructive working partnership in providing quality care to Indigenous women, as described by an AMIC worker here:

... I think non-Aboriginal people and Aboriginal people working together is a good way. Non-Aboriginal people can't offer the service without us, but we can't do it without them either ... the clinical knowledge that we learned from the midwives, you know, without that, we couldn't do our work properly. But the same thing, they couldn't do it without us because they need our cultural knowledge. They need to know the way we deal with people. And I think the good thing is this; they teach us the clinical way and we teach them the cultural way

...³³, p. 5-6

Community input and control of the services were also integral to their degree of success. Smith et al.²⁷ discussed the importance of Indigenous voices being heard in the process of research design and implementation. This required adequate time and resources. Douglas³⁰ argued that the limited success of the service in Rankin Inlet, Canada, was due to the lack of community participation and control. This was described by an interviewee:

*If we're going to be setting up a Birthing Centre in any community it has to be supported by the community first. And it has to be supported by the front-line workers, I mean the nurses. And, we can only talk about what we have here and how we run it.*³⁰, p. 182

There were cultural benefits to families being able to attend births, as described by two midwives from the South Australian service:

I have been to beautiful births with the mothers, the grandmothers, the aunties and the kids - beautiful. Not all the time; but we have had some; and the girls that have got it are the births that do go right. ^{33, p. 8}

It's wonderful when the grandmothers are there and it's done traditional way, those ones do really well. It's so rich and fulfilling. ^{33, p. 9}

These experiences demonstrate wonderful benefits for mothers and babies and success of the services.

Discussion

There were four main themes resulting from the meta-synthesis: valuing of continuity of care, managing structural issues, having negative experiences with mainstream services and recognising success. The findings suggest that the most successful models of midwifery care for Indigenous women were those that provided continuity of care. The success was judged by the number of positive comments from services recipients about relationships developed with their caregivers. It was also judged by the comments expressing disappointment when continuity of care was not available. This is consistent with evidence from a systematic review recommending midwife-led continuity of care for all women ¹¹. Given the poorer outcomes for Indigenous women and babies in many countries, prioritising continuity of care services for Indigenous women could be beneficial.

In the example of the Darwin MGP, Australia, the benefits of continuity of care flowed onto the broader health system. The connection established between Darwin MGP midwives and Indigenous women led to greater insight into the women's lives and circumstances. This insight was passed

through the MGP midwives to all maternity services and staff and had a positive impact on cultural responsiveness, awareness and safety throughout maternity services. Indigenous women articulated a difference in treatment, not just from the MGP midwives, but from all staff ³¹. Other benefits of continuity of care was the increased efficiency with missed antenatal appointments being followed up and women less likely to come into the hospital in early labour ³¹. Similar benefits for Indigenous women have been found in the Women's Business Service (WBS) in regional Victoria, Australia, where clients were more confident in caring for their baby when they went home, possibly due to the greater level of support received in the postnatal period after hospital discharge ²⁹.

Establishing community links and control

The findings suggest that the services that were community controlled were highly valued and better able to effectively provide midwifery services to Indigenous women and babies. Community control facilitated an environment whereby communities could be empowered to build themselves a better future. This has been seen elsewhere, for example, Indigenous people have been more likely to accept decisions that are made via a model of community control rather than a biomedical risk approach ³⁰. Similarly, Eckerman et al. ³⁵ argue that Indigenous communities had a more holistic approach to health, as opposed to a biomedical approach.

The experience at Rankin Inlet in Canada was a valuable lesson for modeling or structuring Indigenous midwifery models of care ³⁰. Here, a biomedical risk scoring method was introduced to determine whether women needed to evacuate the local community for higher-level care. What constituted low and high risk was not detailed; it was determined through a clinical risk evaluation tool and advice from an obstetric consultant. Douglas ³⁰ reported that historically more than half of the births were determined to be high risk and evacuated, although this was also influenced by staff shortages. This decision-making process was criticised, and the study concluded that if there were greater community control over this process, the service would be more successful ³⁰. In using a

biomedical system and not giving control to the local Inuit authority, the service was disconnected from the local community. Even difficult decisions, like the need for evacuation or for caesarean section, would have been more acceptable if decided upon by the community's delegated representatives. Community control over these decisions enables Inuit authority over birthing practices, rituals and place of birth³⁰. In addition, the midwives were not from the local community and rotated through the area from the south, which made it more difficult to gain the trust of Indigenous women. While the service was valued for returning some births back to the local community, its success was limited and was described as a 'southern institution located in the Arctic'³⁰. Of all the studies in this meta-synthesis, this was the only one analysing returning births to a remote community, so it was not possible to compare or contrast this with experiences from other studies.

Mitigating negative experiences

Findings suggest that negative experiences of Indigenous women in mainstream care due to hostility and racist comments received from staff may result in them not accessing health care. While women described experiences of racism, midwives in the Indigenous services also recognised the issue and had observed that Indigenous women sometimes did not access antenatal care due to their negative experiences^{6,31}. This demonstrated a lack of cultural safety. This phenomena reported in qualitative research give some indication of the reasons why Indigenous people do not access health care and why the standard of health of Indigenous people is lower than the rest of the population. Experiences of racism are widespread and well documented^{10,36-38}. This needs to be addressed to fundamentally improve access to health care.

Indigenous women have had negative experiences in mainstream maternity services. This meta-synthesis has found that women have had positive experiences in Indigenous models of midwifery care that provide continuity of care. This suggests that expansion of these services would be of

benefit to the health outcomes for Indigenous women and babies. The study of the Murri Clinic, Australia, a service that provided continuity of care, found that ongoing cultural education of staff helped provide optimum cultural safety for Indigenous women ⁸.

Cultural background of staff

The cultural background of staff has been recognised as a factor influencing cultural safety. In Australia in 2012, Aboriginal and Torres Strait Islander midwives made up 0.7% of the total number of those employed, or around only 200 in total ³⁹. In contrast, of all the women who gave birth in the same year, 4% identified as Aboriginal or Torres Strait Islander ⁴⁰.

The data from this meta-synthesis suggests that some Indigenous women were not concerned about the Indigenous heritage of staff; they were more concerned with competency and compassionate, non-judgmental care ⁸. However, in services where it was possible, the ability to access an Indigenous midwife was valued. This occurred in Malabar, Sydney, Australia, ¹⁷ and in Rankin Inlet, Canada, where it was felt that there was a stronger connection with Indigenous midwives ³⁰. Similarly staff at the Murri Clinic, Australia, found that the input of the Indigenous Liaison Officers (ILOs) and Indigenous midwives helped the provision of culturally appropriate care ⁸ and AMIC workers helped Indigenous women engage with services ³³.

Accessibility

Issues with antenatal clinics and antenatal appointments dominated the data relating to accessibility and the structural challenges. Matters of relevance were transportation, the physical location and structure of the clinics, the child-friendliness of the clinics, waiting time, opening hours, availability and flexibility of midwives. This study suggests that a flexible approach is important in creating an accessible environment for Indigenous services. This means being flexible with appointment time

and location. Transport may not be easy for women who do not have a car, so transport services can assist women's ability to access antenatal appointments^{5,6,17}. The potential cost of car-parking services can make it prohibitive for women living in poverty. Having child-friendly services and ensuring the space is welcoming for women, partners and children promotes access. In addition, the space needs to be somewhere that women feel safe to disclose personal information, contrary to the fishbowl-like antenatal clinic described by a midwife from the Murri Clinic³¹. With all these considerations, where appropriate it may be worth considering the option of home visits, or other locations convenient to women.

Returning birth services to remote communities

One of the key issues identified in the literature for Indigenous women is that remote-dwelling women have to relocate to regional centres to give birth. They have to leave their families and communities, resulting in loneliness and isolation at a significant time of their lives^{9,10}. Whilst services analysed in this meta-synthesis had varying degrees of success, only one of them reported on returning births to a remote community in Rankin Inlet in Canada³⁰. This study reported that the success of the service was limited due to the lack of community control and was contrasted to the successful community controlled Inuulitsivik Health Centre. Unfortunately there was no qualitative data found analysing the Inuulitsivik Health Centre. Instead, quantitative studies and other literature have reported on the success of the service^{14,15,41}.

In Australia, remote-dwelling women who had to re-locate to give birth and were part of the Darwin MGP service reported a more positive experience with their maternity care³¹. But this model did not return birth to the communities. In Australia, administrative and legal barriers exist that prevent the ability of midwives to provide birth services in remote communities. Issues such as midwives not having prescribing rights, the necessity of supportive medical officers⁴² and Medicare eligibility^{43,44} have made it difficult to establish midwifery services in remote areas. However, the National

Maternity Services Plan states that providing birthing services in remote areas should be trialed,¹² but this policy has not been enacted. Other reports have also recognised the need for and benefit of midwifery services in remote areas^{15,44,45}. Pressure needs to be applied to government to enact the policies to enable full scope of midwifery practice, including intrapartum care, in remote communities.

Limitations of this study

The findings of this meta-synthesis are limited in that the only study that returned births to a remote community was in Rankin Inlet, Canada, but as reported earlier, it had limited success due to the lack of community control³⁰. This is an indication of how much progress has been made to date on the provision of midwifery services to Indigenous women and babies living in remote areas, and how much more progress should be made in coming years.

Other limitations include that there are only nine studies included, and six of those are from Australia. No studies were found from NZ and no quality data from the USA. Also, none of the authors are Indigenous peoples. The participants in the primary data were midwives employed by the services, and women who used the services, so there is potential bias for positive reporting.

Conclusion and implications for practice

The findings of this meta-synthesis reinforce the evidence that midwifery-led continuity of care models are beneficial to all pregnant women. The services for Indigenous women that provided continuity of care had the greatest success and should be seen as the way forward for the development of future services. It is optimum for services to be developed from the ground up, or by the community and from the community. Where this does not happen, it is crucial that services are formed with Indigenous community input and control and that efforts to improve cultural safety are

undertaken in mainstream health services. Current initiatives to bolster the proportion of Indigenous midwives should continue and be enhanced where possible. Along with this, targeting the increase of Indigenous midwifery staff in Indigenous services could make a difference to the accessibility of Indigenous midwives to Indigenous women.

Lessons can be drawn from this meta-synthesis regarding accessibility of antenatal consultations and negotiating administrative hurdles. It is important that antenatal consultation times and locations are convenient and in a comfortable environment for the woman and her family – home visits could be an option; if not, care should be taken to make the consultation space accessible. Midwives and women need to lobby government to widen midwifery practice, including intrapartum care, in remote communities. An analysis of outcomes comparing Indigenous women who use mainstream health services with those who use midwifery models of care for Indigenous women and babies would be beneficial.

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