Migrant women less likely to have unassisted birth, study finds

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Indian women who had migrated to Australia were more likely than Australian-born women to have caesarean sections or instrumental births, the study found. Credit: http://www.flickr.com/photos/34547181@N00

Some groups of migrant women in Australia are at a higher risk of medical interventions in childbirth that may lead to health problems for the mother or child, a new study has found.

Medical interventions include caesarean sections, use of epidural painkillers, episiotomies and use of instruments such as forceps or vacuum caps to assist with vaginal birth.

The study, conducted by researchers at the University of Western Sydney and published in the journal *BMC Pregnancy and Childbirth*, looked at all women giving birth in NSW between 2000 and 2008 and compared outcomes for women from the top seven migrant countries to women born in Australia.

The researchers excluded from the study women with high risk pregnancies, such women carrying twins or were under 20 years of age or over 34 years of age.

The study found that some groups of migrant women with low-risk pregnancies were less likely than Australian-born women to have a normal, unassisted vaginal birth.

"The highest caesarean section (31%), instrumental birth rates (16%) and episiotomy rates (32%) were seen in Indian women, along with the highest rates of babies [with low birth weights]," the researchers wrote in their paper.

Overall, Lebanese women had the highest rates of stillbirth, with 7.2 out of every 1000 babies in this group being still born.

"The finding that Indian women (the leading migrant group to Australia) have the lowest normal birth rate and high rates of low birth weight babies is concerning, and attention needs to be focused on why there are disparities in outcomes and on effective models of care that might improve outcomes for this population," the researchers wrote.

Health problems

Professor Hannah Dahlen, lead author of the study and Professor of Midwifery at the University of Western Sydney, said interventions such as caesarean sections could save lives when needed.

However, the health risks associated with such interventions meant they should only been done when medically necessary.

"We know that women who have c-sections are more likely to have a c-section next time they give birth, their babies are more likely to be admitted to special nursery care, there are often feeding and breathing problems and in subsequent pregnancies there is a higher likelihood of problems with the placenta," she said.

Forceps and vacuum deliveries were also linked to higher risk of health problems for the mother and baby, said Professor Dahlen.

"We know the babies are much more likely to have injuries and the mother's perineum and pelvic floor suffers more when you have the baby pulled out rather than if you push it out," she said, adding that episiotomies can also extend and are more painful than a tear.

"Having an epidural has a big impact on whether you have a normal birth. You are more likely to have a forceps birth or have your labour slow down with an epidural and need to have synthetic hormones to speed labour up."

Professor Dahlen said the study did not examine why women in some migrant groups were having more assistance during birth than the rest of the population.

"That's what we will look into now. My colleague Professor Virginia Schmied and I are starting to interview Indian women about their ideas around birth, some of their traditions and cultural practices around it, so

we can get a better understanding of the reasons behind these trends," she said.

"I don't think there is anything less capable about these women but I think perhaps our system is perhaps less capable of supporting them than it could be. We need to look at new models of care that provide support that is acceptable and effective."

Professor Dahlen said the low birth weight rates among Indian women may reflect birth weight expectations based on Caucasian babies.

"Many Indian women are petite and small featured so perhaps nature has just been kind enough to give them smaller babies and this is not necessarily a medical problem but may unwittingly be turned into one."

Caution required

Dr Meredith McIntyre, Senior Lecturer in Midwifery at Monash University, said the new study was important and extensive.

"Antenatal services need to better meet the needs of this group of women. Closer monitoring is required in an antenatal service that caters to the special needs of a group of predominantly non-English speaking women. Interpreter services are expensive with a reliance on telephone services," said Dr McIntyre, who was not involved in the study.

Dr McIntyre said that Indian women who entered Australia on their husband's student visa would not have access to publicly funded health maternity care.

"Private maternity care is known for its high intervention rates in childbirth. The findings related to Lebanese-born women and increased rates of stillbirth requires much more information to form an opinion. It

is a very concerning finding that suggests current models of maternity service provision is not meeting the health needs of this group of women."

Professor Caroline Homer, director of the University of Technology Sydney's Centre for Midwifery, Child and Family Health, said the new study was interesting but urged caution in applying the findings.

"It is an interesting population-based study that can shed light on some possible associations between country of birth and interventions but it cannot prove cause and effect," said Professor Homer, who was not involved in the research.

"Country of birth is a very blunt measure and cannot provide information about when women migrated or about their primary language or their ability to speak English. We know that language contributes to women's ability to easily access the health system and seek care so there may be other things going on to contribute to these findings that this study was unable to measure."

Professor Homer said that special care must be taken not to make assumptions about possible outcomes for women purely based on country of birth.

"In terms of the reasons for outcomes like stillbirth, I suspect there are many other factors that are contributing to these issues and being born in one specific country is probably only one of them."

Professor Homer said more research was needed into why women from some countries have different expectations around birth and may seek different types of care.

"The findings from women born in India is important to study further.

What are the childbearing expectations of this group of women? What sort of care options would they access that could alter their outcomes?" she said.

More information:
www.biomedcentral.com/1471-2393/13/100/abstract

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