Timing of transfer for pregnant women from Queensland Cape York communities to Cairns for birthing

John W Cox

To the Editor: More than 30 years ago, I was employed by the Commonwealth Government's Maternal Mortality Committee to identify and evaluate factors contributing to maternal and infant mortality among Aboriginal Queenslanders. At that time, government policy was to transfer all pregnant Aboriginal women from their rural communities or missions to Cairns Base Hospital at 32 weeks' gestation until 7–10 days after birth.

Findings I presented in a report to Queensland Health in 1977[1] and at the Australian College of Paediatrics Annual Meeting in 1979[2] included:

- Babies of women who were compulsorily transferred at 32 weeks' gestation to Cairns Hospital had lower neonatal death rates. It was assumed that — as Aboriginal women had unreliable gestational age assessments, antenatal care was irregular, and birthweights were lower than for other races[3] — the risk of premature deliveries could be avoided by early transfer.
- There was a lower rate of breastfeeding among mothers transferred to Cairns, largely because if they opted to bottle-feed they could return home after 3–4 days (rather than waiting 7–10 days in Cairns to ensure breastfeeding was established).[1]
- Growth failure was common in the month after weaning.[4]
- Bottle-fed babies experienced slower weight gain and higher rates of illness.[5]
- Suboptimal growth in bottle-fed babies during the early postnatal months predisposed babies to poor growth patterns during infancy[6] and increased death rates.[7]
- Women returning to their communities took with them infections acquired during the hospital stay in Cairns.
- Separation anxiety or maternal deprivation was common among children left in their communities.
- There was decreased family bonding (eg, between the father and the new child) and sibling resentment at maternal separation.
- There was unquantifiable resentment at having babies born away from the ancestral lands.
- Women delayed admitting their pregnancies in an attempt to remain in their communities, resulting in fewer antenatal visits.

The antenatal transfer policy has been in effect for 30 years, despite conflict between those who were predominantly concerned with maternal and perinatal mortality (who favoured compulsory delivery in Cairns Base Hospital), and those (myself included) who were concerned about the effects on children's growth and development.

During this time, I have observed weakening family and community bonds, increasing alcohol and substance misuse and sexual abuse, low school attendance, poor employment records and domestic violence. My studies of Aboriginal and non-Aboriginal children born in Cunnamulla in western Queensland followed the same cohort of children from birth[8] for 20 years.[9] The presence of a father who was employed at the time of the child's birth acted as a role model for the future and was more effective than all other social interventions with respect to the child's successful education or employment 20 years later, irrespective of race or subsequent social support or interventions offered to the child during school years.[9,10]

Arnold and colleagues' recent article in the Journal records a situation almost unchanged from 30 years ago, with the exception that antenatal ultrasounds have allowed transfer to occur at 36 weeks' instead of 32 weeks' gestation.[11] Enormous resources of goodwill, effort and money have been spent in these communities over 30 years, yet the family disruption, unemployment and abuse statistics remain at variance with the Queensland norm.

Perhaps the time has come to allow low-risk births to occur in selected towns, where the mother can be surrounded by her friends and relations, and be in closer contact with her ancestral land. I endorse the article by Arnold et al and hope they are more successful in implementing change than I have been.

John W Cox, Paediatrician
Toowoomba, QLD.
drjohncoxchildhealth@bigpond.com

1 Aboriginal, maternal and infant deaths as a component of Queensland deaths: an investigation into the problem in selected regions and recommendations for the future planning of health services. Brisbane: Queensland Health Department, 1977. (Report No. D7706.)
2 Cox JW. Aboriginal births — at missions or in major hospitals. Presented at the Australian College of Paediatrics 24th Annual Meeting; 1979 May 3; Canberra.
3 Cox JW. The effect of racial origin, geographical location and antenatal care on an infant's birth weight. *Aust Paediatr J* 1978; 14: 165-168.

4 Cox JW. Effect of supplementary feeding on infant growth in an Aboriginal family. *J Biosoc Sci* 1978; 10: 429-436.
5 Cox JW. A longitudinal study of the changing pattern in Aboriginal infants' growth 1966–76. *J Biosoc Sci* 1979; 11: 269-279.
6 Cox JW. Growth characteristics of preschool Aboriginal children. *Aust Paediatr J* 1979; 15: 10-15.
7 Cox JW. Infant mortality in 12 Aboriginal settlements: Queensland 1972–1976. *Med J Aust* 1979 Spec Suppl; 1: 8-9.
8 Cox JW. The antenatal and perinatal characteristics of socio-economically depressed Caucasians. *Aust N Z J Obstet Gynaecol* 1981; 21: 20-23.
9 Cox JW. The social and educational outcome of a cohort of rural children in relation to the racial and socio-economic groupings of their parents. *J Paediatr Child Health* 1996; 32: 99-102.
10 Ferrari J. Black or white: poverty's not working. *The Weekend Australian* 1996; 18-19 May: 1.
11 Arnold JL, de Costa CM, Howat PW. Timing of transfer for pregnant women from Queensland Cape York communities to Cairns for birthing. *Med J Aust* 2009; 190: 594-596. ❑