Reflections

Antenatal care for asylum seeker women: is "good enough" good enough?

A high standard of pregnancy care should be provided for all women

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According to the contract signed in 2012 between the Department of Immigration and Citizenship (now the Department of Immigration and Border Protection [DIBP]) and International Health and Medical Services (IHMS), health care provided to asylum seekers detained by the DIBP should be "open, accountable and transparent" and "broadly comparable with health services available within the Australian community".[1] How does the care of pregnant asylum seeker women measure up to these criteria?

It is known that there have been and continue to be significant numbers of pregnant women detained on Christmas Island and Nauru, as well as in mainland Australian detention centres. In December 2013 and April this year, I visited the three Darwin facilities where pregnant women were detained, having been transferred from Christmas Island in the latter weeks of pregnancy. From these visits, from personal discussion with medical staff in Australian hospitals who have cared for pregnant asylum seeker women, and from the report of the Physical and Mental Health Subcommittee of the Joint Advisory Committee for Nauru Regional Processing Arrangements (JAC),[2] leaked to the *Guardian* in May this year, I have gleaned the following information.

There are currently 304 women in detention on Nauru, 208 children aged under 17 years and 10 unaccompanied minors. There are 128 women and 196 children in detention on Christmas Island, including 70 babies (who are stateless, as Australia does not issue birth certificates to babies born to asylum seeker women).[3]

At the time of writing, there is no obstetrician on either Christmas Island or Nauru, no paediatrician on Christmas Island, and no paediatrician attached to the IHMS on Nauru. The Christmas Island clinic is not equipped to deal with obstetric emergencies such as preterm labour. The Republic of Nauru Hospital has limited obstetric facilities; this year at least one woman in preterm labour was transferred, at 31 weeks, to Brisbane, a process taking more than 30 hours and costing $85 000. The JAC report in February noted there is no blood bank on Nauru (Nauruans themselves rely on extended families to donate blood in an emergency; this is not an option for asylum seekers).[2] Globally, haemorrhage is the most common cause of pregnancy-related death.

Some antenatal care is provided on Christmas Island and Nauru, but the obstetric qualifications and experience of the doctors appear limited. In 2013, women were being sent from Christmas Island to Darwin or Perth for standard ultrasound screening, returned to Christmas Island, and then brought to Darwin some time after 34 weeks' gestation to await birth. Partners and other children were also brought to Darwin but sometimes separately and several weeks after the woman, causing severe stress within families. In the latter part of 2013 and the early months of this year, around 50 such women are believed to have given birth in Royal Darwin Hospital (RDH). No plans were put in place by the DIBP to assist RDH in dealing with this increased workload.

There were frequent delays within the detention system in arranging antenatal care at RDH, and many women arrived in the hospital already in labour but without any details of their previous history or of any antenatal care. They were, however, accompanied by an impressive number of security officers — several independent observers have reported a guard for the woman, a guard for her partner and a guard for the baby, once born. While there is some suggestion that arrangements may now have improved in Darwin, it is noted that the number of pregnant women detained has dropped there and risen in Adelaide and Melbourne, where similar problems in communication continue and lead to difficulties in the provision of high-quality care.

Women were returned from Darwin to Christmas Island when the baby was 4 weeks old, and this practice is continuing at other hospitals. Mothers in Darwin had little help with lactation, and breastfeeding was not encouraged. In the "welcome" pack provided to new mothers by IHMS are feeding bottles and formula, although the facilities for adequate preparation and sterilisation of bottles were limited in the Darwin centres. These practices contravene World Health Organization and UNICEF recommendations, including the early initiation of breastfeeding within 1 hour of birth and exclusive breastfeeding for the first 6 months of life.[4]

Nauru is hot, humid and crowded. Asylum seekers live in tents that leak and preclude privacy. The island is very small and much of it is uninhabitable following phosphate mining. There are problems with disposal of rubbish and sewage, and limited facilities for the collection of groundwater. Accommodation on Christmas Island is also crowded and hot. The potential for the spread of communicable diseases

is high in both places. These physical problems are enormously compounded by the isolation of a closed detention environment, with overwhelming anxiety about the uncertain future asylum seekers face.

The result for most asylum seekers is depression. Much has already been published about the mental health of male asylum seekers and the manifestations of depression, including self-harm.[2] In the case of pregnant women, depression can have a direct and deleterious effect on the wellbeing of the fetus, through alterations in the production of the hormones needed for healthy pregnancy. There is a recognised association of antenatal depression with miscarriage, preterm labour and small-for-gestational-age babies.[5] Antenatal depression is likely to merge into postnatal depression (PND). PND is also likely after the return of women to offshore detention. I personally saw women suffering PND in Darwin, and it has been reported on both Nauru and Christmas Island.[2] Untreated PND can result in failure of the bonding and attachment between mother and child that is essential for healthy mental and physical development. The JAC reported that the Edinburgh Postnatal Depression Scale, which is validated for use in different cultural groups, is in use on Nauru and that most women are reaching scores of 24, when the cut-off score for significant depression is 10. However, no information can be obtained as to what treatment, if any, is being offered to these women.[2]

Members of the Australian Government and others have described health care facilities in detention centres, including Nauru, as being as good as those in mining camps or in regional Australia.[6] This is a double whammy. Apparently, regional Australia must accept services that are just "good enough" and asylum seekers should do the same.

I have practised obstetrics for 20 years in regional Queensland; our aim is always to provide services equal in quality to those provided in urban areas. In regard to maternity care, this has involved setting up outreach specialist services, employing general practitioner obstetricians and midwives in remote areas, providing ongoing inservice training for staff working in rural areas, implementing protocols across the region for managing complications, and liaising closely with the Royal Flying Doctor Service for both routine and emergency care. True, it is not always possible to provide exactly the same care in the same time frame in remote areas of Australia, but aiming to do so is essential.

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For residents of Australia, maternity care, both obstetrician- and midwife-led, is offered from the first trimester up to the 6-week postnatal check in both public and private systems. This includes decisions as to whether the woman is at low or high risk and where, therefore, she should be advised to book for the birth. Specific screening and diagnostic tests are available at various gestational ages for all women, as is the provision of specialist care if needed. Emphasis is also placed on the social and mental health aspects of pregnancy care, the aim being to send mother and baby home to the best possible environment. These principles are in the interests of all Australians. Very little of this, however, is currently being provided to asylum seeker women in detention.

Women on Nauru and Christmas Island, and indeed in detention on mainland Australia, are the responsibility of Australia. They and their babies should receive exactly the same standard of care as women resident in Australia. This may well mean that women detained offshore must be transferred back to the mainland as soon as pregnancy is diagnosed. "Good enough" is not good enough, in regional Australia, on Nauru and Christmas Island, or anywhere else where Australia is responsible for the care of pregnant women.

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2 Physical and Mental Health Subcommittee of the Joint Advisory Committee for Nauru Regional Processing Arrangements. Nauru site visit report 16–19 February 2014. http://s3.documentcloud.org/documents/1175048/hmhsc-jac-site-visit-report-final-1.txt (accessed Jun 2014).

3 ChilOut (Children out of immigration detention). Stats + reports. http://www.chilout.org/statsreports (accessed Jul 2014).

4 World Health Organization. Infant and young child feeding. Fact sheet no. 342. Geneva: WHO, Feb 2014. http://www.who.int/mediacentre/factsheets/fs342/en (accessed Jun 2014).

5 Bernard-Bonnin AC; Canadian Paediatric Society. Maternal depression and child development. Paediatr Child Health 2004; 9: 575-583.

6 Conditions on Nauru better than in Australian mining camps – Julie Bishop. *Guardian Australia* 2013; 20 Dec. http://www.theguardian.com/world/2013/dec/20/conditions-on-nauru-better-than-in-australian-mining-camps-julie-bishop (accessed Jul 2014). ❑