The increased incidence of preterm birth to Indigenous women is, as expected, associated with an increased likelihood of the birth of low birthweight babies (Figure 48, Tables 46 and 47). The likelihood of such low birthweight births of babies to Indigenous mothers was statistically significant in the low birthweight cohort (LBW, less than 2500g) (<2500g Indigenous vs <2500g non-Indigenous; odds ratio 1.95, 95% confidence limits 1.89, 2.00) and in the very low birthweight cohort (VLBW, less than 1500g) (<1500g Indigenous vs <1500g non-Indigenous; odds ratio 2.01, 95% confidence limits 4.48, 5.50).

Fig 48: Incidence of birth of babies with birthweights above and below 2500g in Queensland 1988-2007 by maternal Indigenous status (refer Tables 46 and 47)

Fig 49: Incidence of birth of low birthweight (LBW, <2500g) and very low birthweight (VLBW, <1500g) babies in Queensland 1988-2007 by maternal Indigenous status (refer Tables 46 and 47)
Indigenous women were significantly more likely to have an unassisted vaginal birth (Indigenous unassisted vaginal birth vs non-Indigenous unassisted vaginal birth; odds ratio 1.70, 95% confidence limits 1.67, 1.74) and less likely to have a caesarean section (Indigenous caesarean section vs non-Indigenous caesarean section; odds ratio 0.72, 95% confidence limits 0.70, 0.73) or an assisted vaginal birth (Indigenous assisted vaginal birth vs non-Indigenous assisted vaginal birth; odds ratio 0.43, 95% confidence limits 0.41, 0.45) than non-Indigenous women (Figure 50, Tables 48 and 49).

Fig 50: Mode of birth of women in Queensland 1988-2007 by maternal Indigenous status (refer Table 48 and 49)

However, when a selected cohort of women only cared for in public hospitals, with no previous pregnancies and between the maternal ages of 20 and 34, is examined (Figure 49, Tables 50 and 51) these differences largely disappear.

Fig 51: Mode of birth of women in public hospitals, aged 20-34, with no previous births in in Queensland 1988-2007 by maternal Indigenous status (refer Table 50 and 51)
2. MATERNAL AND PERINATAL MORTALITY

2.1 Definitions:

The previous reports by the Queensland Maternal and Perinatal Quality Council and Queensland Council on Obstetric and Paediatric Morbidity and Mortality (QCOPMM), which are the primary sources of data regarding maternal and perinatal deaths from 1988 to 2003, used the following definitions.

Fetal deaths = stillbirth:
Defined by the Registration of Births, Deaths and Marriages Act as a child whose heart has not beaten after it has been completely expelled or extracted from its mother and who is either of not less than 20 weeks gestation; or of not less than 400g by weight at birth.

Livebirths:
Defined by the Registration of Births, Deaths and Marriages Act as a child whose heart has beaten after it has been completely expelled or extracted from its mother.

Mothers:
Number of mothers is defined as the number of women having a pregnancy which resulted in a livebirth or fetal death.

Maternal death:
A maternal death is defined by the World Health Organisation (WHO) as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management. This definition excludes deaths from accidental or incidental causes.

The definition used in these report includes, in addition to the WHO definition, incidental deaths and deaths occurring more than 42 days after termination of the pregnancy, when their origin and illness related to the pregnancy3.

Maternal mortality ratio:
The maternal mortality ratio is defined as:

\[
\frac{\text{Number of maternal deaths}}{\text{Number of mothers}} \times 100,000
\]

Classification of maternal deaths:
Direct deaths are those which result from obstetric complications of the pregnant state (pregnancy, labour and puerperium) including deaths from interventions, omissions, inappropriate treatment, or from a chain of events resulting from any of the above. They are complications of the pregnancy itself.

Indirect deaths are those which result from pre-existing disease or disease that developed during pregnancy and was not due to direct obstetric causes, but which may have been aggravated by physiological effects of pregnancy.

Incidental deaths are those due to conditions occurring during pregnancy, where the pregnancy is unlikely to have contributed significantly to the death, although it is sometimes possible to postulate a distant association.

2.2 Maternal deaths:

Due to the cessation of QMPQC activity in 2005 the full reported maternal death data is only available in Queensland from 1988 to 2003 inclusive. Though the numbers of deaths are small, reducing the validity of any statements regarding statistical significance, there would appear to be an upward trend to the incidence of direct and indirect maternal deaths over this 20 year period (Figure 52, Table 52). This apparent trend may be related to more complete ascertainment of maternal deaths.

![Maternal mortality ratio in Queensland 1988-2003](image1)

In all but one of the triennia between 1988 and 2005 the maternal mortality ratio in Queensland was higher than the national Australian figure (Figure 53, Table 53).

![Maternal mortality ratio in Queensland and Australia 1988-2005](image2)
The majority of direct maternal deaths in Australia, in the four triennia from 1994 to 2005 were in the four categories of amniotic fluid and air embolism, hypertensive disorders of pregnancy, thrombosis and thromboembolism and obstetric haemorrhage. In the same period, the majority of indirect maternal deaths were found to be in the categories of cardiovascular disease, psychiatric disorders, non-obstetric haemorrhage and infection (Table 54).