

Inuit Health Frameworks and Maternal Care
Understanding the complexities of removing and returning birth to Inuit communities in
Northern Canada

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Key Terms:

Inuit: The Indigenous peoples of the Arctic. The word means the people in Inuktitut, the Inuit language. The singular of Inuit is Inuk (Indigenous and Northern Affairs, 2017)

Traditional Inuit territory: Three quarters of the Canadian Inuit population live in 53 communities in Northern Canada, called Inuit Nunangut which translates into “the place where the Inuit live”. This is split into four regions, Inuvialuit (NWT and Yukon), Nunavut, Nunavik (Northern Quebec) and Nunatsiavut (Labrador) (Indigenous and Northern Affairs, 2017).

Colonialism: Colonialism is defined as the control over another country. It is also the practice of domination, or the subjugation of one people by the dominant. (Kohn, 2014; Colonialism, (n.d.))

Biomedicine: This health model has been the dominant perspective in most western health care settings. In it, health is believed to be a negative state in that it is the absence of disease. There is an opposition between the body and the mind. Practically this health care model is practiced in a clinic or hospital, and the patient is little more than a passive follower of their doctors opinions of their health, a patient’s own opinions of their bodies are rarely taken into account. (Sabaté, 2003; Ivanitz, 2000)

Bio-medical model of childbirth: Within a biomedical model of health, childbirth has become medicalized. This model perceives women as abnormal, and defines pregnancy as pathological. A biomedical model of maternal care is one that redefines pregnancy as “hazardous”, and requiring “active intervention.” (Cahill, 2000)

Evacuation: The medical evacuation of pregnant women from Northern Communities to southern urban centres at 36 weeks gestation to deliver their children in hospital obstetrics wards (Douglas, 2010; Houd, Qinuajuak, & Epoo, 2003)

Community based health care: The provision of health care within the community of the patient. Used in this context as a method of returning birth to Northern Inuit communities (Tedford Gold, O’Neil, Van Wagner, 2007)

Culturally appropriate care: Health care that includes the cultural beliefs and practices of the patient. (Wilson, 2008). It is the “effective, sensitive, non-discriminatory communication, the positioning of the understanding of health from the patients’ experience, values or perspective, and a professional open to the creative application of services” (Nambiar-Greenwood, 2015).

Culturally competent: For most cultures pregnancy and birth are important social and cultural events, and is accompanied by norms and practices. As such a culturally competent model of maternal care attempts to incorporate and respect those norms and practices to providing a safer environment for the mother and child. (Coast, Jones, Portela, Lattof, 2014) “In the area of maternal-child nursing practice, possessing cultural competence means that the nurse is sensitive to the sociocultural context of women and children in the provision of holistic care.” (Callister, 2005)

Culturally safety: A concept developed in the late 1980’s by Maori nurse, Irihapiti Ramsden. It was developed as a framework for the provision of more appropriate health care for the Maori of New Zealand and emphasizes inward reflection by health care practitioners to encourage them to become open-minded and non-judgemental (Kruske, Kildea, & Barclay, 2006)

Introduction

The determinants of an individual's health are directly related to the social context in which they are situated. The concept of social determinants of health is defined by the World Health Organization as the “remarkable sensitivity of health to the social environment [...and that the] common causes of the ill health that affects populations are environmental” (World Health Organization [WHO] in Czyzewski, 2011, p.3). They are the social constructions that lead to higher rates of ill health in certain populations; an inequity produced by norms, policy or practices that results in an uneven distribution of power and uneven access to social resources (Commission on the Social Determinants of Health [SDOH] in Czyzewski, 2011; Czyzewski, 2011). More simply, they are the higher rates of ill health caused by discrimination, such as racism and sexism. One determinant almost unique to Indigenous peoples is the effects of colonialism, both the historical trauma and the continued legacies. Colonialism is and has been a prevalent force in Indigenous reality, so much so that it has “manipulated the historic, political, social and economic contexts shaping Indigenous/state/non-indigenous relations and account for ... the racism today. These combined components shape the health of Indigenous peoples” (Czyzewski, 2011).

The colonial impact on the health of Indigenous peoples in Canada is severe. The health indicators of the three indigenous groups in Canada, First Nation, Metis, and Inuit are significantly worse in comparison to non-Indigenous populations. The projected life expectancy for 2017 of the total Canadian population is 79 for men and 83 for women (Statistics Canada, 2015). Metis and First Nations life expectancies are similar, at 73-74 for men, and 78-80 for women (Statistics Canada, 2015). The Inuit have the lowest projected life expectancies of 64 for men and 73 for women (Statistics Canada, 2015). All health indicators for Indigenous and non-

Indigenous populations show similar discrepancies. Maternal and infant health statistics show a similar pattern.

As with life expectancy, the Inuit maternal and infant health statistics are the most dismal. The Inuit have higher rates of infant mortality at rates 2.66 times higher than the rest of the Canadian population, based on a 2010 study (Luo, Senécal, Simonet, Guimond, Penney & Wilkins, 2010). Inuit mothers are also more likely to be under 20 years of age, 20% compared to 6% of non-indigenous Canadians, and have higher rates of preterm birth. (Luo et al, 2010). Overall the situation is considered to be dire (Luo et al, 2010).

The Canadian government currently has a 'policy' of blanket evacuation for Inuit women to urban centres at 36 week's gestation to await the delivery of their baby in a hospital (Houd, Qinuajuak, & Epoo, 2003; James, O'Brien, Bourret, Kango, Gafevels, & Paradis-Pastori, 2010; Van Wagner, Epoo, Nastapoka, & Harney, 2007). Evacuation is damaging to the mother, community and culture and is a continuation of the trauma inflicted by colonisation (Douglas, 2011; Van Wagner, et al., 2007; Douglas, 2006). This paper will analyze this system of evacuation, and also the alternative Inuit community based health care service using an Inuit framework of health.

Purpose of study

The purpose of this study is twofold. The first is to establish exactly how evacuation is disruptive to Inuit understandings of health and consequently destructive to their communities and culture. The second is to study how culturally competent community based maternal health care fulfils Inuit health indicators and combats the destruction of evacuation.

Research Questions

The literature on culturally appropriate maternal health care in Inuit communities is not extensive. (Douglas, 2006; Douglas, 2010; Douglas, 2011; Van Wagner, Osepchok, Harney, Crosbie & Tulugak, 2012; Van Wagner, et al., 2007) Of that which exists, none apply Inuit health indicators onto evacuation and community based health centres (Couchie & Sanderson, 2007; Houd, et al., 2003; Douglas, 2010; Douglas, 2010) This paper will attempt to fill this gap, by answering two main research questions:

RQ1: There is an inherent assumption that the evacuation policy has had negative effects on Inuit communities. However, exactly how is still unclear. This research will explore how the practice of evacuation was destructive to Inuit understandings of health and well-being?

RQ2: The literature suggests that the Inuulitsivik Maternity is the most successful at returning culturally appropriate maternal care to Inuit communities, yet fails to provide a clear comparison between the Maternity and the Rankin Inlet Birthing Centre. This paper will attempt to understand why the Inuulitsivik Maternity is considered to be more successful than the Rankin Inlet Health Centre in returning birth to Inuit communities?

The history of maternal health care in Inuit communities is an important element to these issues and will first be outlined to provide context to the issue.

Background

Colonial incursion into the Arctic, the Inuit inhabited region of Canada, happened relatively late in comparison to other regions of Canada. Pre-contact Inuit society emphasized survival, a consequence of the harsh living environment of the north (Douglas, 2010). Large settlements were uncommon and their nomadic lifestyle revolved around the nuclear family; hunting, fishing, and gathering plants and herbs (Douglas, 2010). The belief structure was

animistic and blended the natural, supernatural and human world into one landscape, thus tying their identity and belief system heavily to the land (Douglas, 2010). Cooperation and avoidance of conflict were heavily stressed within Inuit society, another product of the difficult environment, and, while it was non-hierarchical, elders were respected for their wealth of knowledge, but were not granted overarching authority (Douglas, 2010). Important decisions within the community, “including those regarding childbirth, were made through consensus, not through either an authoritative body of knowledge, or a professional elite” (Douglas, 2010, p.113).

Traditionally childbirth occurred within the family groups, and familial camps were usually located close enough to for assistance to be close at hand (Douglas, 2006; Douglas 2010). Labour was commonly attended by a midwife, but if one was not available, the husband would provide assistance (Douglas, 2006; James, et al., 2010). Midwives were considered to be under the authority of the community elders and were trained through transmission of knowledge from one generation to the next. (Douglas, 2006; James et al, 2010). While they attended the birth, the mother retained control by choosing whichever position made them feel most comfortable (Douglas, 2006; Douglas 2010). Within the vast territory of the Arctic traditions and practices regarding childbirth frequently varied but also often had similarities. Many communities reported a specific birth attendant, whose only role was to cut the umbilical cord (Douglas, 2006) Their title varied between communities, and sometimes role was fulfilled by the midwives, in addition to their other responsibilities (Douglas, 2006). In all instances the person who occupied this role remained an important figure in the child’s life (Douglas, 2006). A Shaman was involved if spiritual interference was suspected during the birth, their role was to

“restore normal birthing conditions by removing interference from either a spirit or another, malicious shaman” (Douglas, 2006, p. 120).

While this short list of traditions can only provide a brief summary of a rich and varied culture and childbirth practices, it does highlight certain aspects. It demonstrates that Inuit belief systems and identities were irrevocably interwoven with the geography and environment. Childbirth was also very clearly a community event, with multiple members being intimately involved, while the mother retained the power to make decisions over her own labour.

Contact with European settlers began in the nineteenth century through explorers, fur traders and missionaries (Douglas, 2010). A breakdown of traditional Inuit health care began at this point, with missionaries discouraging Inuit spirituality and shamanism (Douglas, 2010). However, most Inuit still followed traditional medical practices, including those associated with childbirth (Douglas, 2006). It was not until after the Second World War that the Canadian government began to make a concerted incursion into the Arctic region. The goal was to extend Canadian political and administrative control into their Arctic territories (Douglas, 2006). Increased advances in medical knowledge and treatment among the Euro-Canadian populations created an excuse for this incursion, to allow for the collection of medical statistics (Douglas, 2006).

The first step that the Canadian government took was the creation of identity disks, which were used to collect medical statistics and control access to government services, such as healthcare and education (Douglas, 2006). The provision of these services was coupled with the enforcement of government policy driven towards permanent Inuit settlements (Douglas, 2010). All of this was spurred on by a national perception that Inuit health was in crisis, especially due to their high perinatal mortality statistics (Douglas, 2010). Perinatal mortality was used as a

symbol of the government's neo-colonial responsibility towards the Inuit population (Jasen, 1997). During the 1950's the government "insistently encouraged" the Inuit to move to the permanent settlements, each one set up with community health centres staffed by a nurse midwife (Douglas, 2006, p.122; Douglas, 2010).

The 1960's saw the movement of childbirth into these centres, however community involvement was still significant in both the pregnancy and the birth (Douglas, 2006). Midwives were brought over from Britain and New Zealand to staff the centres as there were no midwifery traditions in colonial Canadian society (Kaufert & O'Neil, 1997 in Douglas, 2006; Douglas, 2010). High risk pregnancies were evacuated to southern hospital, but the majority of births took place within Inuit communities. However, the practice of community birth rapidly changed due to a perceived superiority of southern hospitals, an improvement in air travel and a change in immigration policy. In the late 1970's immigration became restricted, reducing the number of midwives from Britain and New Zealand and replacing them with Canadian nurses, who were seldom experienced in midwifery (Douglas, 2006; Douglas, 2010). While the medical policy still officially advocated for community birthing medical staff reported increasing pressure to evacuate and by 1980 up to 98% of pregnant women were being evacuated to give birth leaving the health centres to deal with cases that were too late to evacuate (Kaufert & O'Neil, 1990; Douglas, 2006; Douglas 2009). In 1980 medical policy was changed to evacuate all women, regardless of individual situation, to hospitals to give birth (Kaufert & O'Neil, 1990). This was spurred by the belief that improvements to perinatal mortality and morbidity statistics was reliant on more sophisticated obstetric services (Douglas, 2006). This belief led to southern hospitals being the preferred sites for evacuation over regional hospitals (Douglas, 2006). In the span of only 20 years Inuit women went from experiencing traditional birth, in their own

home/community surrounded by their family and culture, to complete evacuation to the lonely and unfamiliar environment of hospitals in the south of Canada.

Ramifications of Evacuation

The adoption of medical evacuation has had many negative repercussions on Inuit mothers, families, communities and culture. Women are evacuated to urban centres at 36 weeks gestation to await the birth of their babies. Sometimes women are evacuated to northern cities, such as Iqaluit, but other times the cities are as far away as Winnipeg, Montreal, Ottawa or Yellowknife (James et al, 2010). As such mothers are often away from their home and families for weeks, which can extend to months, at a time (Van Wagner, Epoo, Nastapoka & Harney, 2007; Lalonde, Butt & Bucio, 2009). The pressures on Inuit mothers are complex. Nellie Tooliguk, a senior Inuit midwife, offers an enlightening analogy.

“Just imagine this: You are having a baby. A group of people with PhDs have decided that Denmark’s perinatal statistics are better than Canada’s. They decide it will improve the medical outcome for you and your baby if you are flown to Denmark three weeks before your expected delivery date. You will remain there, without your family, until your baby is born. You arrive alone in this place where you have never been. You can’t adjust to their strange food, so you eat very little for your last weeks of pregnancy. Everything is in a different language. Sometimes an interpreter is available. Your family calls after two weeks to say that your children have been taken to another relative’s. The house you know is already over crowded. The children cry on the phone to you, and you know you can’t pay for this phone bill when you return home. If you refuse this new plan, which has no evaluation of impact, you are considered selfish, undereducated and willing to put your family’s health at risk!” (Tooliguk, quoted in Couchie & Sanderson, 2007, p. 251)

As highlighted by Tooliguk, evacuation creates a stressful, confusing and isolated environment for Inuit mothers. The combination of stress and lack of traditional food often times results in pregnant women being unable to eat during a stage of pregnancy in which nutrition is extremely important and Inuit culture encourages pregnant women to consume mostly traditional foods. (Couchie & Sanderson, 2007) Not only are women deprived of their family and partners, but

they are disconnected from a supportive community; and often in hospitals when women “have lengthy labours, they may find themselves alone on occasion, which one Inuit midwife described as ‘incomprehensible in [Inuit] culture.’” (Couchie & Sanderson, 2007, p. 251; James et al, 2010) The trauma and stress have lasting effects on the mother and have been linked to postpartum depression and an increase in maternal and newborn complications. (Couchie & Sanderson, 2007) Such a negative experience in childbirth is different from the experience of non-Inuit mothers. Women living in Nunavut, of which the majority of the population are Inuit, report that they were “less satisfied with their maternity experience” and have “less information about pregnancy related topics” in comparison to mothers in other regions of Canada (James et al, 2010). In addition, Inuit mothers were more likely to smoke during pregnancy and experience both abuse and postnatal depression (James et al, 2010).

When mothers are removed from the family for extended periods of time the family and the community are put under significant stress (Van Wagner, Osepchook, Harney, Crosbie & Tulugak, 2012). Many husbands reported the worry associated with being away from their partner at such a crucial time, and having to wait for phone calls to know what was happening (Chamberlain & Barclay, 2000). Other problems are revealed once the mother returns home, some mothers reported that their younger children did not recognize them when they returned, while others stated that their older children resented the new addition, blaming the baby for the mother absence (Chamberlain & Barclay, 2000). The family is also put under economic stress; for example, there is the cost of the plane ticket if the father wishes to accompany the mother, the cost of days off if he remains to take care of the children, a cost of a child minder if no one else is available or, as mentioned above, the cost of telephone calls between the mother and her family and children who remained at home (Chamberlain & Barclay, 2000). The communities

have their own set of challenges created by the practice of evacuation. Lawford and Giles (2012) highlight some of these issues in their study of Canadian First Nation women in remote communities who are also subjected to medical evacuation. While First Nations and Inuit communities are culturally distinct, there are some parallels between their experience with evacuation. Lawford and Giles research indicates that community based birth created connections between family and community members, strengthening “social embeddedness¹” (Lawford & Giles, 2012; Richmond & Ross, 2008). However, when birth occurs thousands of miles away, these connections were not created. Indeed, Inuit mothers have reported that they feel that children born in the community have better relationships than those born away (Kornelsen, Kotaska, Waterfall, Willie & Wilson, 2011).

Inuit culture and identity are subjected to its own sufferings. As already stated Inuit culture and identity are intimately tied to the land. Being born on the land cements the Inuk identity, which is fragmented when birth happens hundreds or thousands of kilometers away from traditional territory (Douglas, 2006). Studies have shown that Inuit women in the Kivalliq region explicitly only identify their children who were born in the community to be real Inuit whereas children born in Churchill or Winnipeg are not (Douglas, 2006). One Inuit midwife described being born on the land as being “born an Inuit and ‘with a home’” (Houd, Qinuajuak, Epoo, 2003). The practice of evacuation caused a loss of traditional knowledge, as midwifery is traditionally a practice passed down through generations. Removing birth from the community has “interrupted traditional learning styles, including the generational transmission of birthing knowledge that since antiquity had served the Inuit population” (James et al, 2010, p. 2).

¹ “Social embeddedness refers to the connectedness of individuals to others in their social environments” (Barrera, 1986, quoted in Richmond & Ross, 2008)

While this short summary of the issue does not fully encompass the stress and trauma that evacuation puts on Inuit mothers, families, communities and culture, it does demonstrate that they are broad and far reaching. However, there are examples of retaliation and resistance. The most well known being the Inuulitsivik health center, which offers maternal care to Inuit communities around the Hudson's Bay coast (Van Wagner, Epoo et al. 2007; Houd et al, 2003; Lemchuck-Favel & Jock, 2004). Founded in 1986, this center offers culturally competent maternal care within a collaborative model that incorporates the knowledge and practice of the biomedical model. This center is identified as being "fundamental for community healing" and provides a solution to many of the above highlighted effects of the practice of evacuation (Van Wagner et al, 2007; Couchie & Sanderson, 2007). Another example of available Inuit maternal care is the Health Centre in Rankin Inlet, Nunavut. This center was founded in 1993 and offers community based, midwife assisted birthing (Douglas, 2011). This health centre is not considered to be as successful as the former, and there is much less of a focus on this centre within relevant scholarship. Despite one being more applauded, both are examples of retaliation in which birth is returned to Inuit communities. However, these two examples are of the few health centres that offer culturally appropriate² maternal care to Inuit communities, with the majority of other Inuit communities being forced to rely on evacuation to hospitals in large urban centres or in the south of Canada (off traditional lands) to give birth.

International Context

The information discussed above portrays a dismal situation faced by Inuit women, their families and communities. To further compound this issue Canada is a developed country with the funds and ability to not only provide adequate maternal care to its citizens, but commit to improving maternal care in developing countries as well. During the G8 summit, hosted by

Canada in 2010, Prime Minister Harper announced that Canada would “champion a “major initiative” (2010) to improve child and maternal health in developing countries” (Carrier & Tiessen, 2012, p.184). The Canadian government cites that “The Muskoka Initiative focuses on improving nutrition, reducing the burden of disease, and strengthening health systems to deliver integrated and comprehensive health services for mothers and children at the local level, where the need is greatest” (Government of Canada, 2016). This statement is applicable to the situation in Inuit communities in Canada’s Northern region. Their focus on ensuring “comprehensive health services” at “the local level” is a part of the overwhelming issue faced by Inuit mothers.

Carrier and Tiessen, in *Women and Children First: Maternal Health and the Silencing of Gender in Canadian Foreign Policy* (2012) state that “the hypocrisy of the Conservatives’ foreign policy is evident in that Harper preaches about the moral imperative of reducing maternal mortality even while not all Canadian women have access to quality health care” (2012, p.190). Their argument for this point centers on Inuit women, and highlights difficulties faced by Inuit mothers, families and communities in relation to evacuation. Carrier and Tiessen also point out that the lack of maternal care in the North is dangerous. The risk of a woman suffering complications, such as ectopic pregnancy, the leading cause of maternal death in Canada, prior to being evacuated to a hospital is high and there is little that could be done as their communities are not equipped with medical necessities (2012). They also touch on the cultural damage of evacuation, which was stated above, in that it breaks the connection to the land and creates a loss of Inuit identity should a child not be born on the land (Carrier & Tiessen, 2012).

The Muskoka Initiative had many problematic elements, with the most relevant for this study being that Canada has huge issues in maternal care faced in the Northern regions of Canada while championing a maternal and infant health initiative in developing countries.

Shirley Tagalik, who is a member of the health committee in Arviat Nunavut, in response to the announcement of the 2010 Maternal, Newborn and Child Health initiative stated “I don’t deny that other countries need help, but don’t they know what’s going on up here in their own backyard? We can’t take care of our mother and we need help” (White, 2010). Arviat is the third largest settlement in Nunavut and has Canada’s highest birth rate, yet has no doctor, hospital, midwife and no public nurse (White, 2010). They have seven “overworked” nurses to deal with the average of 70 women who are pregnant yearly, and so most women are evacuated to Winnipeg (White, 2010). Carrier and Tiessen summarise this problematic international hypocrisy by asking “if Harpers’ motives for championing maternal and newborn health at the G8 were truly motivated by a desire to “save lives” ... why has this desire for action not been translated in improved health services for Inuit women in Canada’s North?” (2012, p.191).

Literature Review

The literature that deals specifically with culturally appropriate maternal care in Inuit communities in Canada is not extensive. Therefore, the forthcoming literature review will situate this study within the broader context of global Indigenous maternal health care. That being said, while each of the sources studied specifically focused on maternal care, they tend to situate maternal care within the greater issues of Indigenous health care. As such many of the themes explored in this literature review may speak more generally to Indigenous health care as a whole, however each of the sources used were specifically focused on providing insights into Indigenous maternal health care.

Studies on Indigenous culturally appropriate maternal health care spans the variety of countries with Indigenous populations, concentrated mainly in the America’s and Oceania. A review of literature on the topic reveals seven major pervasive themes. These are: the existence

and recognition of political and socio-economic differences, the understandings of the broader historical context and trauma, the differences in understandings of health and society, the power dynamics of health care, the necessity of inwards reflection for health care providers, that culture is neither static nor homogenous, and the necessity of inclusion of Indigenous perspectives, opinions and control. Each of these themes will be presented and help to identify the successes and failures of Indigenous maternal health care worldwide.

Theme 1: Existence and recognition of political and socio-economic differences

The first theme, the existence and recognition of political and socio-economic difference, refers to the necessity for health care providers to understand that Indigenous patients inhabit a reality or social standing that is different from their own. Kruske, Kildea and Barclay (2006) focus on how health care and midwifery for Indigenous peoples would be more successful if these differences were recognized. They state that the development of a critical understanding of these differences is the first step to an effective health care system for Indigenous patients and identify that this is more effective at creating safety in health care settings rather than providing education on cultural taboos (Kruske, Kildea, and Barclay, 2006). Scholars identify that in order to accomplish cultural safety, a critical understanding of social, political and cultural structures is required (Ramsden in Williamson & Harrison, 2010). Such understanding leads to an identification of how these structures manifest themselves into an individual's health (Williamson & Harrison, 2010; Wilson, 2008). Wilson (2008) analyzes "socio-economic deprivation, ethnicity and race, colonization, and racism" as health determinants that go beyond the belief that genetics and disease are the only components of health status (p. 174). She furthers this analysis and identifies these socio-economic and political differences as causes for the "differential access and use of health services by Indigenous people" (Wilson, 2008, p. 174).

Recognition of such differences is essential for creating an environment of respect in health care settings (Birch, Ruttan, Muth, and Baydala, 2009). It may allow for Indigenous women to feel more comfortable and willing to use or seek out health services in all stages of pregnancy (Birch et al, 2009). The literature asserts that the reality of socio-economic and political differences between Indigenous and non-Indigenous women, and populations more generally, affects health and access to health services; something crucial to a successful pregnancy.

Theme 2: Understanding the broader historical context and trauma

The causes of the socio-economic and political realities are rooted in the subjugation and oppression Indigenous people have faced throughout history. Understanding and recognizing the impact of the historical trauma inflicted on Indigenous people and understanding the historical context in which they are situated is another crucial component of culturally appropriate health care. The literature asserts that historical traumas have a distinct effect on today's Indigenous populations (Kruske et al, 2006; Reibel & Walker, 2010; Wilson, 2008; Williamson & Harrison, 2010). Like socio-economic and political status, colonization is another social factor that determines the health of Indigenous populations and also determines Indigenous access to and use of health services (Wilson, 2008). In order to improve health service delivery to Indigenous communities, it is necessary for health practitioners to understand the relevance of history and its effect on the current situation rather than resorting to blaming Indigenous people (Kruske et al, 2006; Reibel & Walker; 2006). Creating a health environment where the impact of historical trauma is recognized may impact an Indigenous woman's decision to seek appropriate health care during and after pregnancy, whereas not recognizing this important component of Indigenous reality may lead to tension and conflict (Birch et al, 2009; Wilson, 2008). Indigenous communities have faced extreme trauma through assimilatory practices aimed at children,

including residential schools and the sixties scoop³, which should be recognized as affecting current childbirth experiences for Indigenous women birthing within a colonial/western biomedical system (Birch et al, 2009).

Theme 3: Differences in understandings of health and society

The realities inhabited by Indigenous people, both present and past, result in different understandings than those held by the dominant/colonial population. The literature reflects extensively on the differences between Indigenous and non-Indigenous understandings of both health and society and how this affects Indigenous maternal care. There exists a non-Indigenous belief in the superiority of a biomedical approach to healthcare in an institutionalized setting - (Watson, Hodson & Johnson, 2001). A biomedical approach greatly differs from the holistic understanding of health usually held by Indigenous peoples (Birch et al, 2009; Kruske et al, 2006; McLennan & Khavarpour, 2006; Watson, Hodson & Johnson, 2001) Such differences can lead to misunderstandings and an unsafe environment for Indigenous peoples. In Indigenous maternal care these differences manifest into specific problems. For example, Birch, Ruttan, Muth and Baydala (2009) highlight that within Indigenous understandings childbirth is a normal, but significant event. It is considered to be a component of wellness, and does not require undue interference (Birch, Ruttan, Muth & Baydala, 2009). This differs from a bio-medical understanding, where childbirth has become institutionalized and linked to the idea of illness. A different, indigenous perspective of childbirth feeds into different needs in risk scoring systems. Kildea, Kruske, Barclay and Tracy (2010) identify that western biomedical risk scoring suffers from a disconnect between the social, cultural and spiritual risk that Indigenous people associate with their health. For example, Australian Aboriginal and Torres Strait Islander leaders

³ The sixties scoop was a phenomenon where Indigenous children were taken out of their homes and away from their families to be adopted or placed in foster homes (Birch, Ruttan, Muth & Baydala, 2009)

emphasize the need to incorporate the cultural risk of removing birth from their traditional territory into the biomedical risk assessment processes. (Kildea, Kruske, Barclay & Tracy, 2010)

The literature further stresses that differences in understandings of health and society can manifest themselves in cultural misunderstandings that lead to an unsafe health environment. Kruske, Kildea and Barclay (2006) highlight the concept of shame within Australian Aboriginal and Torres Strait Islander peoples. They use the example of male doctors and nurses attending Australian Aboriginal and Torres Strait Islander women. While this would be considered routine for non-Indigenous women it breaches Australian Aboriginal and Torres Strait Islander culture and “can cause great shame and distress” (Kruske et al, 2006). Despite these very crucial differences in understandings of health and society, the literature asserts ways to overcome them and create a culturally safe environment. Wilson (2008) stresses the importance of the development of meaningful relationships with Maori women, the indigenous peoples of New Zealand. That their health needs will be met if their cultural beliefs and practices are valued and respected, such a practice would prevent Maori women from “being caught between health care providers delivering services informed by a biomedical worldview, and their own unique worldview and life circumstances” (Wilson, 2008). While Mobbs (1991, from Watson, Hodson & Johnson, 2001) cites differences in understandings of health and society as part of the underlying issues with communications between Indigenous and non-Indigenous peoples in health care settings, Coffin (2007) identifies brokerage as a mechanism to move towards a culturally safe practice, which “involves two-way communication where both parties are equally informed and equally important in the discussion. Communication and respect are of the utmost importance, values and ideas are not pushed but considerations from both sides are equally regarded” (Coffin, 2007, p. 23). Culturally competent, appropriate, and safe practice, therefore,

recognizes and works to overcome difference in Indigenous and non-Indigenous understanding with respect and communication.

Theme 4: Power dynamics of health care

In addition to having different understandings and social, political and historical realities, there exists a power dynamic between the health care provider and the patient. With Indigenous patients and western biomedical doctors this is compounded by the already analyzed differences in realities and understandings. The literature on the subject of culturally appropriate Indigenous maternal health care identifies the power dynamic. Western biomedical health care does not work in the holistic understanding of health care usually understood by Indigenous peoples. Western health care systems view the health care provider as “the expert and decision maker” a position of power that is not usually found in Indigenous cultures (Birch et al 2009). This power is further emphasized by the dominance of western culture over that of Indigenous populations. “Socio-political power relationships are epitomized and maintained through cultural dominance of Western medical practitioners” (Ellerby, 2001, quoted Birch et al, 2009). Such power imbalances exacerbate issues of marginalization of Indigenous voices over their own health care (Birch et al, 2009). In the context of Indigenous maternal care much of the literature highlights feelings of powerlessness and vulnerability in the face of this power imbalance and their lack of choice in regards to their pregnancy (Kornelsen, Kotaska, Waterfall, Willie & Wilson, 2011; Wilson, 2008). The literature surrounding maternal health care of the Maori people of New Zealand address the concept of biculturalism instead of the use of multiculturalism for discussions on cultural safety. Biculturalism addresses the power imbalance between the patient and health care provider, and identifies that all interactions between the two parties are bicultural due to “the culturally informed messages that are filtered between the giver of the message and

the receiver of that message” (Kruske et al, 2006). The literature, once again, stresses the importance of self-reflection by the health care provider on this power imbalance. Kruske, Kildea and Barclay (2006) state that it is necessary for midwives to be aware of their potentially intimidating status in their “powerful position as a health professional within the health system.” Recognition by health care professionals of the influence of the biomedical health care culture on providers and how it influences “beliefs and assumptions regarding appropriate health choices” is also cited as necessary for the creation of truly culturally appropriate health care (Birch et al, 2009).

Theme 5: Inwards reflection for health care providers

The previous themes outlined in this literature review focus on elements of Indigenous culture and understanding that the health care practitioner should recognize in order to create a culturally safe environment for Indigenous patients. However the literature stresses that in order to be cognizant of Indigenous culture, health care practitioners must look inwards, and assess their own culture, understandings and assumptions (Birch et al, 2009; Reibel & Walker, 2010; Williamson & Harrison, 2010; Wilson, 2008). Kruske, Kildea and Barclay (2006) identify that many health care providers have very minimal understanding of institutional racism faced by Indigenous people in health care and society, as they are constrained by their own cultural perspective. In order for health care providers to understand and accept difference, they must first be aware of the existence of their own culture, and what values and beliefs accompany it (Williamson & Harrison, 2010). This may come in the form of biases that could potentially impact their practice and relationship with Indigenous patients (Williamson & Harrison, 2010). Much of this theme relates to the presented previous themes, in that in order to be able to understand the differences in understanding of health and society, different political and social

realities, and different historical contexts, one must first be able to identify what their understandings and realities are. The contrast between western biomedical views and indigenous views necessitates the health care provider to assess their beliefs and assumptions on health, illness, and appropriate care and to address how they differ from those of their Indigenous patients (Birch et al, 2009).

Theme 6: Culture is neither static nor homogenous

Most of the above themes reference Indigenous and western culture, understandings or reality in a general way, however the literature also makes it clear that, while there may be some commonalities, culture is neither static, nor homogenous and it varies between groups, individuals and generations. Coffin (2007) identifies that a single Aboriginal liaison officer who is not from the area would not be able to fulfil their role as a point of contact, as they are unaware of the specific cultural nuances of the individual or group. There is a risk of stereotyping populations based on what is believed to be their cultural practices and beliefs, especially when health practitioners are provided with generic cultural information on ethnic groups (Williamson & Harrison, 2010). It is highlighted as an important component of culturally appropriate/safe that traditional cultural practices and beliefs are respected and accepted within health care environments (Birch et al, 2009). However, as Indigenous communities are in no way homogenous, stereotypes must be avoided by assessing the cultural needs of individual patients, rather than a group or community (Birch et al, 2009). Some Indigenous women may not choose to follow traditional childbirth customs, while others may, depending on the effect of their social condition (Williamson & Harrison, 2010). Wilson (2008), speaking about the Maori of New Zealand, identifies that nurses developing specific ways of practicing and thinking about certain cultures is problematic and that even the concept of “being knowledgeable about Maori culture is

fraught and not always possible [as] Maori were not a homogenous group pre-colonization, and great diversity in beliefs and practice is evident in contemporary Maori.” Culturally safe practice would therefore include open and meaningful conversations with each patient in order to assess which beliefs and practices need to be respected and incorporated in their health care practice (Birch et al, 2009; Wilson, 2008).

Theme 7: Inclusion of Indigenous perspectives, opinions and control

In order to create a fully culturally appropriate/safe/competent maternal health care system for Indigenous women the literature has established that Indigenous perspectives, opinions and control are required in health care implementation. While respect to indigenous women and their culture is necessary, in order to address “systemic inequities” in health care and society, marginalized Indigenous communities need to be actively involved in their health care system (Gabrysch, Lema, Bedrinana, Bautista, Malca, Campbell & Miranda, 2009). For example, in Australian Aboriginal and Torres Strait Islander communities the risk and safety assessment in birth are created from an Australian perspective, and do not address many of the social, emotional, and cultural risks that have been identified as important by the patient population (Kildea et al, 2010). This lack of control creates stress, social and psychological problems as the women’s and the Indigenous community’s needs and perspectives are not taken into account (Kildea, et al, 2010). A way to combat this is to provide birth services “on country,” and initiatives that should be led by the Indigenous community with an integrated support network and that includes training Indigenous women as midwives (Kildea et al, 2010). The literature further asserts that, along with community level initiatives, it is necessary for indigenous peoples to be more involved in policy design and implementation (Kruske et al, 2006). The approaches to including Indigenous perspectives and opinions into their own health

care, and specifically maternal care, ranges from listening and responding to the call for greater choice and control, to having Indigenous communities directly involved in the health care planning (Kruske et al, 2006; Kornelsen et al, 2010). However, while the strategies to accomplish this vary between sources, there is consensus on the necessity of Indigenous inclusion in health care provision in order to accomplish a more inclusive and culturally appropriate Indigenous health care.

The literature on Indigenous culturally-appropriate maternal health care centers around the above outlined themes which are: the existence and recognition of political and socio-economic differences, the differences in understandings of health and society, the power dynamics of health care, the understandings of the broader historical context and trauma, the necessity of inwards reflection for health care providers, that culture is neither static nor homogenous, and the necessity of inclusion of Indigenous perspectives, opinions and control. These themes or issues are directly translatable to the issue of culturally appropriate maternal care in Inuit communities. However, all of these themes work with the knowledge that western biomedicine is at odds with Indigenous world views. The understanding of exactly how these two systems conflict is glossed over more often than not. This research attempts to fill that gap for Inuit communities in northern Canada, specifically in relation to their maternal health care. Understanding the exact points of conflict will be beneficial in order to create systems or approaches that work to understand Inuit approaches to health, thus leading to more culturally appropriate maternal care.

Methodology

Research Design

This research employs an analysis of existing and relevant texts to explore the issues of evacuation and culturally appropriate maternal care in Inuit communities. In order to answer the research questions, thematic analysis was employed. The identification of themes in qualitative data is a widely used analytical tool, which allows scholars across disciplines to communicate ideas and similarly provides a bridge between quantitative and qualitative research methods, through the uses of codes (Boyatzis, 1998). Braun and Clarke (2006) identify that an analysis of pervasive themes “offers an accessible and theoretically flexible approach to analysing qualitative data” (p. 77). In this research, the identification of themes facilitated the analysis, as the corpus of data were sourced from a variety of academic disciplines. Thematic analysis provided a systematic way in which to create bridges between diverse studies and theoretical approaches, allowing for a clear and cohesive analysis, despite the variety of sources studied.

The methodology used for this research is content analysis. Hsiu-Fang and Shannon define content analysis as “the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes” (2005). They further split content analysis into three subcategories or approaches, conventional, directed, and summative. Each of these approaches follow the “seven classic steps” used in content analysis: formulating research questions, selecting samples, defining categories, outlining codes, implementing the coding process, determining trustworthiness, and analysis (Hsiu-Fang & Shannon, 2005). The goal of directed content analysis is to “extend conceptually a theoretical framework or theory” (Hsiu-Fang & Shannon, 2005). It uses existing research to identify key concepts to be used as the initial coding categories.

Directed content analysis is the most relevant qualitative research method to conduct this research. It allowed for the application of the Inuit specific framework for culturally relevant health indicators as an analytical framework, which is further explained and outlined below. The analytical framework predetermined the codes based on Inuit understandings of health. Hsiu-Fang and Shannon (2005) outline two approaches to directed content analysis. When the goal is to identify occurrences of phenomenon it is recommended to highlight any instances of the phenomenon and proceed with coding all highlighted paragraphs. The second is to start the coding process immediately, with codes that have been predetermined. The first approach reduces the risk of biases developing in the coding process, however “if the researcher feels confident that initial coding will not bias the identification of relevant text, then coding can begin immediately” (Hsiu-Fang & Shannon, 2005). This research employed the second approach and began coding immediately. While the risk of bias is higher, it allowed health indicators that were Inuit specific to guide the research. However, as the researcher is not a member of the studied community, using coding developed by Inuit community organizations allowed for the process to be guided by Inuit knowledge and understanding, rather than by the Euro-Canadian world view of the researcher.

Data Collection

The corpus of data used for this research was academic literature. Literature that focuses specifically on culturally appropriate maternal care in Inuit communities and maternal medical evacuation is not overly vast (Douglas, 2006; Douglas, 2010; Douglas, 2011, Van Wagner, et al., 2007; Van Wagner, et al., 2012). However, this allowed for a directed selection of existing research on the issue. The sources used come from a variety of disciplines however they were selected using the following criterion of selection:

- Published within the date range of 2000 – 2016, in order to provide a more current understanding of the issue.
- Scholarly journal articles retrieved from a database subscribed to by the University of Ottawa.
- The main focus of the article must be on Canadian Inuit maternal care, either in reference to evacuation or culturally appropriate community based maternal care options.

These criteria allowed for data sources from varied academic disciplines that give a more holistic view of the phenomenon, but ensure that the data is current and academic.

Data analysis procedure

Braun and Clarke’s “Using thematic analysis in psychology” (2006) and Attride-Stirling’s “Thematic networks: an analytic tool for qualitative research” (2001) were used as guides to the analysis process. Both works describe similar processes, with a total of six steps each. Both guides divide the process into slightly different steps. For this research Attride-Stirling’s (2001) process followed as her steps were broken down more thoroughly.

Attride-Stirling (2001) suggests the construction of thematic networks to conduct qualitative analysis; she stresses that the networks serve as a tool for analysis and interpretation, not as analysis themselves. Networks are made up of basic themes, organizing themes, and global themes with each theme building towards the next.

The following steps were used for analysis:

1. Code material – codes were pre-selected prior to analysis based off of the information presented in the Inuit-Specific framework for culturally relevant health indicators. These were then used to ‘dissect’ the text into passages or sentences. (Attride-Stirling, 2001)

2. Identifying themes – each coded passage/sentence was then analyzed to “extract the salient, common or significant themes.” (p.392) Passages were reread within the context of the code that they were associated with, in separation from the text as a whole to facilitate the identification of themes and patterns. After many themes were identified they were further refined to avoid repetition but broad enough to adequately cover a variety of ideas from different texts. (Attride-Stirling, 2001)
3. Construction of networks – the final themes identified in step 2 were then arranged into similar groupings. The groupings were made based on the research questions explored in this paper. This step was where thematic networks began to take shape. The themes taken directly from the text were used as basic themes. Their groupings were then analyzed to understand the underlying issue, which became the organizing theme. These were further analyzed to establish a global theme for each network. The networks were drawn out and physically represented in a non-hierarchical web around distinct global themes. Networks were then verified to ensure that the themes represent the data from the texts and vice versa. (Attride-Stirling, 2001)
4. Describe and explore the thematic networks – the process involved describing each network and understanding where patterns emerged. The preselected passages/sentences were then reanalyzed using the thematic networks as guides. (Attride-Stirling, 2001)
5. Summarize the thematic network – this process involved creating a summary of each network, identifying patterns that emerge throughout this summary and analysis. (Attride-Stirling, 2001)

- Interpret patterns – here the themes and patterns were analyzed in relation to the research questions. Each network and the patterns that emerges within them was used to answer elements of the research questions. (Attride-Stirling, 2001)

Analytical Framework

The analytical framework for this study is the Inuit-specific gender-based analysis health framework. This framework was developed by the Pauktuutit Inuit Women of Canada

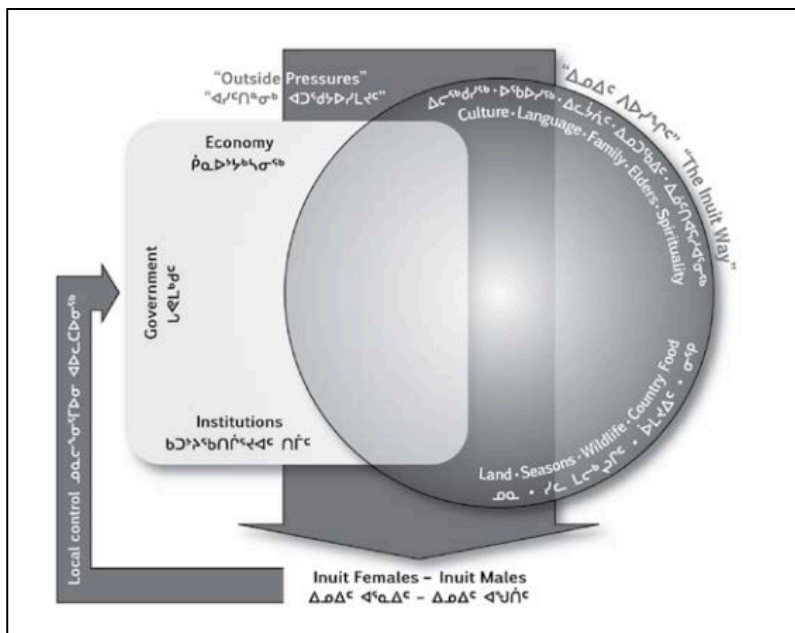


Figure 1
Pauktuutit Inuit Women of Canada, Rasmussen, D., & Guillou, J. (2012). Developing an Inuit-Specific framework for culturally relevant health indicators incorporating gender-based analysis. *Journal of Aboriginal Health*. 24-35.

(Pauktuutit) at the request of the Bureau of Women’s Health and Gender Analysis at Health Canada. It was born out of a need to create “culturally relevant indicators that reflect an Inuit view of health determinants, unlike current framework that assess the well-being of Indigenous groups using a non-Indigenous yardstick” (Pauktuutit, Rasmussen & Guillou, 2012, p. 24).

As well, it was born out of an understanding that Inuit health and well-being will not be improved until their unique perspectives are included in their health care (Pauktuutit et al, 2012).

The framework is a conceptual model to create a manner of looking at health and the factors that contribute to it (Pauktuutit et al, 2012). The Assembly of First Nations identifies that frameworks are not necessarily the truth, but are to be used as a tool to organize information. (From Pauktuutit et al, 2012) The factors that contribute to Inuit health and well being are

different from those that contribute to general Canadian well-being. Southern Canadian health indicators tend to include wage, employment, income, formal education attainment, mortality and disease (Pauktuutit et al, 2012). Inuit health indicators are more holistic, and focus on wellness rather than disease (Pauktuutit et al, 2012). These indicators are incorporated into the Inuit-specific gender-based analysis health framework.

The framework is devised out of key themes that contribute to Inuit health and wellbeing. These themes are categorized into three groups:

1. Elders, culture, language, family, community, and spirituality
2. Land, weather, animals, and country food
3. Euro-Canadian economy, institutions and government.

Each of these is incorporated into the diagram shown in Figure 1. The diagram shows “how Inuit life sometimes overlaps and incorporates the Euro-Canadian way of life, sometimes resists the Euro-Canadian way of life, and sometimes runs parallel to it” (Pauktuutit et al, 2012, p.29)

This framework was chosen as it will ensure that Inuit understandings of health are applied to the issue of evacuation and culturally competent health care, despite the researcher being of European descent.

The indicators outlined in the framework have been used as codes in order to conduct thematic analysis. Each of the thirteen indicators were applied to the literature as the first step in the above outlined methodology. Using pre-determined codes from the analytical framework ensured the research remained focused on answering the research questions.

Results

Application of the health indicators led to the creation of thematic networks. The following section will outline the networks that emerged through directed content analysis. Each

network is composed of three levels of themes, starting with the basic themes, progressing to the organizing themes and culminating in the global theme. Within the analysis of academic literature, three thematic networks were identified after an application of the codes derived from the analytical framework. These three networks were equally present in the analysis; their order of presentation does not represent a hierarchical structure. Each network will be outlined below.

Thematic network A:

The thematic network shown in Appendix A, Figure 1 has the following global theme – “*Collaboration and integration between knowledge’s and communities.*” It is comprised of three organizing themes and seven basic themes. This thematic network is centred around the idea of the divisive nature of Euro-Canadian biomedicine and traditional Inuit understandings of health and healing.

Organizing theme - Integrate Inuit culture and biomedicine to break down the divisive dichotomy. This organizing theme concerns the traditionally divisive and dichotomous relationship between Inuit understandings and desires in health care and the dominant Euro-Canadian biomedical model of health care. Much of the studied literature on the topic of maternal care in Inuit communities stresses the tension and perceived incompatible nature of Inuit health understandings and Euro-Canadian biomedicine (Douglas, 2006; James, et al., 2010; Van Wagner, et al., 2007). There are distinct differences between the two approaches to maternal care. Birth in Inuit communities has traditionally been more of a social event than in Euro-Canadian culture and there are specific approaches to a healthy pregnancy, such as a diet of country food, and Inuit approaches to labour (Douglas, 2006; Van Wagner, et al., 2007). Even in relation to outcomes, Inuit cultural norms treat perinatal mortality as an accepted part of the life cycle, whereas bio-medicine seeks perfect outcomes (Van Wagner, et al. 2007). However, Inuit

culture “is not a culture or society fossilized in amber, but one that is evolving” (Douglas, 2011, p.184). Inuit communities and health centres are working to become compatible with biomedicine. Douglas (2006) cited that the Inuulitsivik Maternity and the Rankin Inlet Health Centre are attempts to break down the dichotomy and create a hybrid form of health care, where the tools of biomedicine are combined within an Inuit framework. Inuit midwifery is the most cited way to accomplish this collaboration by providing maternal care that utilises the biomedical technology within an Inuit cultural paradigm (Douglas, 2006; James, et al., 2010; Van Wagner, et al., 2007; Douglas, 2011; Douglas; 2010).

Organizing theme – Government should collaborate not control. This organizing theme focuses on the role, both historic and current, of the Canadian government in Inuit maternal health care. Historically, the Canadian governments relationship to Indigenous peoples has been one of control. Douglas (2006) states that the government used perinatal mortality as the catalyst for a neo-colonial incursion into the Arctic. The process of colonisation discouraged traditional childbirth practices and subsequently resulted in blanket evacuation for all births (Douglas, 2006). Government control resulted in effectively removing childbirth from Inuit inhabited regions in Canada (Tedford Gold, et al, 2007). However, with the slow return of birth to the north the literature has begun to explore the role of the Canadian government. The consensus is that this role should be one of collaboration and facilitation, rather than of ordering and directing (Tedford Gold, et al, 2007; Couchie & Sanderson; 2007). Their role should be to adapt policies, legislation, infrastructure, and regulations to allow for the creation and success of community based and owned maternal health care programs (Tedford Gold, et al., 2007).

Organizing theme - Integration and legitimization of Indigenous sources of knowledge. This organizing theme centers around the importance of Elders in Inuit communities.

Traditionally midwives and birthing was under the authority of the Elders as they were considered to be the most experienced and respected in the community (Douglas, 2006). Their authority over childbirth was restricted when all women were evacuated to southern hospitals to give birth. However, recommendations on returning birth to the north and training Inuit midwives stress that Elder involvement is necessary (James, et al., 2010; Van Wagner, et al., 2012; Douglas, 2010; Couchie & Sanderson, 2007). Medical training is provided by southern midwives, while cultural maternity practices are taught by elders (James, et al. 2010; Van Wagner, et al., 2007; Douglas, 2010). Inuit communities require the incorporation of Elders to ensure that Inuit sources of knowledge are respected and integrated into a system supported by the facts of biomedicine (Douglas, 2010).

These organizing themes relate to the global theme “*Collaboration and integration between knowledge’s and communities.*” It is generally understood that Indigenous and Euro-Canadian communities are different and thus have different knowledges and understandings. This thematic network focuses on these differences, but through a lens of collaboration and integration. These themes become a pattern throughout this network. Collaboration between Inuit communities and the Canadian government that integrates Inuit culture and knowledge’s with those of biomedicine is highlighted as one way forward.

Thematic Network B:

The second thematic network, shown in Appendix A, Figure 2, is built around the following global theme – “*Community born, Inuit institutions lead to cultural revival and healing.*” It is comprised of three organizing themes and six basic themes.

Organizing theme – Necessity of community involvement. The literature asserts that traditionally childbirth was a communal event and responsibility (Douglas, 2006; Couchie & Sanderson, 2007; Douglas, 2011; Douglas, 2010). Its removal from the community had damaging effects, damaging the strength and spirit of the community (Van Wagner, et al., 2007). Furthermore, Inuit society connects an individuals' health to the communities' health and evacuation is described as disruptive and impacts the emotional and physical health of the individual and the community (James, et al., 2010; Douglas, 2006) Based on these understandings, it is clear that Inuit maternal health care requires involvement and ownership by the community. Van Wagner, Epoo, Nastapoka, and Harney (2007) state that involvement in birth “builds family and community relationships and intergenerational support and learning” (p. 231). Simonet, Wilkins, Labranche, Smylie, Heaman, Martens. Fraser, Minich, Wu, Carry and Luo (2009) indicate that a return of birth to Inuit communities could bring vitality back to communities along with other benefits. Overwhelmingly the literature recommends that Inuit communities be included as equal partners in the development of their maternal health care (Tedford Gold, et al., 2007, Douglas, 2006).

Organizing theme – Health institutions must be Inuit born, not southern. The Canadian incursion into the Arctic resulted in the encouraged settlement of Inuit communities into villages. These villages included “southern institutions such as trading centers, health centers, and schools” (James et al., 2010, p. 2). In order to counter the effects of a colonial interference in Inuit birth, the literature asserts that Inuit maternal health care must be born out of Inuit culture and community, while still incorporating the tools of biomedicine (Tedford Gold, et al., 2007; Douglas, 2011; Couchie & Sanderson, 2007; Douglas, 2010; Van Wagner, et al., 2012) The Inuulitsivik Maternity approach to maternal care is considered to have accomplished the creation

of an Inuit born health institutions (Van Wagner, et al., 2007; Tedford Gold, et al., 2007; Douglas, 2011). The risk scoring system of Inuulitsivik mimic's Inuit community structure, with each woman's individual case being reviewed by the Perinatal Committee, made up of midwives, medical professionals, and the community, and a care plan is produced (Douglas, 2010; Van Wagner, et al., 2007; Couchie & Sanderson, 2007). This structure and risk scoring ensures that the institution remains one that is in accord with Inuit epistemology of health (Douglas, 2010). On the other hand, the Rankin Inlet Birthing Centre is described as "a southern institute located in the Canadian Arctic" (Douglas, 2011, p. 183). It functions under a biomedical risk scoring system, rather than a communal one, and it cited as having difficulties finding community involvement (Douglas, 2011; Tedford Gold, et al., 2007).

Organizing theme – Community birth as cultural revival and healing. This theme focuses on the components of community birth, such as the presence of midwives and family. Evacuation is explored as being damaging and traumatizing to families, as isolating women from their partners and other children for extended periods of time results in lasting psychological impacts (James, et al., 2010; Douglas, 2011). Full evacuation is identified as being "culturally disruptive" and recreates "the trauma and social dislocation of the residential school experience" (Douglas, 2011; Douglas, 2006, p. 119; Van Wagner, et al., 2007, p. 370). The literature established that community birth would remedy these issues, healing and reviving both Inuit culture and families. Inuit midwifery can revive the culture by incorporating Inuit knowledge of promoting a healthy pregnancy, the benefits of a diet of traditional country foods, and Inuit specific approaches to labour into maternal care (Van Wagner, et al., 2007). It also allows for family members to be present through all stages of pregnancy, facilitating and constructing family relationships and intergenerational learning (Van Wagner, et al. 2007; Couchie & Sanderson, 2007).

These three organizing themes feed into the global theme – *Community born, Inuit institutions lead to cultural revival and healing*. Health institutions situated in northern Canada can be split into those that were built from grassroots Inuit movements and those implemented by the Canadian government. This network focuses on the maternal health institutions and themes of community roots and inclusion. Institutions having roots in the community, or at least community involvement, is necessary for a successful implementation, and the inclusion of cultural elements in these institutions such as midwifery and family allows for cultural revival.

Thematic Network C:

The third thematic network, shown in Appendix A, Figure 3, is built around the following global theme – “*Necessity of familiar customs and environment.*” This network is comprised of five basic themes and two organizing themes.

Organizing theme - Land and natural world are integral components of their identity and understanding. Traditionally Inuit identity and understanding was tied to their relationship to the natural world (Douglas, 2006; Douglas, 2010; Douglas, 2011). One study suggested that current conceptions of cultural identity do not necessarily place such an emphasis on place of birth as was done twenty years ago but that this change was brought about by the practice of evacuation (Douglas, 2011). Other studies suggest that bringing birth back to northern communities is important to be able to be “born Inuit” (Houd, et al., 2003). A disruption in cultural identity is identified as being the direct result of the practice of evacuation (Douglas, 2010; Couchie & Sanderson, 2007). Additionally, young Inuit midwifery students studying in southern Canada state that being away from the north for extended periods of time to be difficult, describing the process as studying abroad (James, et al., 2010). Douglas (2011) recognizes location of birth as

symbolic of Inuit authority over birthing. Furthermore, Inuit spirituality is intricately linked to the natural world. Understandings of natural life cycles results in a different approach to childbirth than those in southern Canadian communities (Douglas, 2011). As with many components of Inuit understanding spirituality is link with the land, and the natural, spiritual, and human worlds were conflated (Douglas, 2010). These understandings of the land and natural world have important elements of Inuit world view and understandings.

Organizing theme – Familiarity is a comfort and promotes well being. This theme centers around elements of the daily realities of Inuit communities, such as the speaking of Inuktitut, and the consumption of country foods. The literature highlighted that healthcare that facilitated an inclusion of these elements promoted a sense of well-being in pregnant women (Van Wagner, et al., 2007; Simonet, et al., 2009; Couchie & Sanderson, 2007; Douglas, 2006). Care offered in Inuktitut was shown to improve accessibility and communication, as health care providers are able to communicate and better understand the women's needs (Simonet, et al., 2009; Couchie & Sanderson, 2007). The consumption of country foods is another familiar element for pregnant women. Traditionally the Inuit diet consisted of mainly meat and fish, with the occasional Labrador tea and berries (Douglas, 2010). Modern Inuit rely on a similar diet of mainly seal and caribou, which is referred to as country food, the consumption of which contributes to their well-being, especially in pregnant women (Douglas, 2006). An Inuit approach to maternal care encourages the consumption of country food, to promote a healthy pregnancy (Couchie & Sanderson, 2007). Douglas (2006) suggests that any recommendations to alter this diet are the “anathema to Inuit culture” (p.128). Evacuation to southern hospitals does not allow for the consumption of country foods, as southern diets are made up of vastly different food groups. Thus evacuation is associated with a poor diet and women not getting the proper nutrition,

despite pregnancy being a time when nutrition is important (Van Wagner, et al., 2007; Couchie & Sanderson, 2007). Incorporating elements of Inuit culture, such as services offered in Inuktitut and availability of country foods, into a health care system would allow that system to promote well-being in Inuit communities.

These two organizing themes lead to the global theme – “*Necessity of familiar customs and environment.*” The daily lives of an individuals are made up of components that are frequently taken for granted, especially by the dominant population. These can be as simple as language, diet, and understanding that, when absent, can create unsafe environments. This network focuses on the themes of understanding and respect of difference and their inclusion.

Analysis

The thematic networks constructed for this analysis demonstrated the emergence of five themes. They are as follows – collaboration, integration/inclusion, community roots, and understanding and respect of difference. It should be noted that inclusion was identified as a prominent theme in two separate networks. Additionally, the themes of integration and inclusion are functionally similar and therefore will be studied together in this analysis.

This research relied on the Inuit-specific gender-based analysis health as its analytical framework, created by the Pauktuutit Inuit Women of Canada, in order to create a coding system. Use of the framework ensured that the research maintained an Inuit frame of reference. In it thirteen indicators are identified that are important to or can affect Inuit health. These indicators were applied to the literature in order to isolate relevant information and highlight themes that are important factors or elements in Inuit health care. These themes will be applied to evacuation, the Rankin Inlet Birthing Centre, and the Inuulitsivik Maternity to assess how each

satisfy the key elements of Inuit health. This analysis will be split into two sections, to answer the two research questions.

Research question 1: How was the practice of evacuation destructive to Inuit understandings of health and well-being?

The changes to Arctic health care that began around the 1950's resulted in the majority of Inuit mothers being evacuated to southern hospitals to give birth. This brought about extreme changes to Inuit approaches to childbirth and maternal care in a very short amount of time.

The negative effects of evacuation have been firmly established (Van Wagner, et al., 2007; James, et al., 2010; Douglas, 2011; Douglas, 2010). However, exactly how evacuation fulfills Inuit health requirements is more ambiguous. The themes identified in this research identified key features of Inuit health care. The following analysis will assess and explore medical evacuation for childbirth through these themes.

Collaboration

In the terms of Inuit maternal health care, the theme of collaboration refers to two distinct communities working together in order to create and establish a health care approach and system that is safe and beneficial for the target population. The evacuation of pregnant women to southern urban centres is the antithesis to this concept. The approach was born out of tactics of assimilation, introduced during the colonial incursion into the Arctic region. Interest in the Arctic peaked post World War II, and the Canadian government hoped to extend its political control over the Inuit by forcibly moving them to settlements with health care centres (Douglas, 2006). The approach of the Canadian government, as outlined above, resulted in “a de facto medical policy of uniform evacuation for childbirth throughout the Arctic” (Douglas, 2006, p.124). The

system that medical evacuation was developed from is one that functions on domination and oppression. Colonialism is inherently non-collaborative and any tool or approach used within such a system would share these features. Biomedicine and state-control are intertwined in Inuit history, with provision of healthcare being a tool to extend Canadian surveillance and control (Douglas, 2010). Health care professionals were expected to adapt to the Inuit population to southern norms, eventually ensuring that traditional approaches to childbirth were discouraged (Douglas, 2010). Communities and women would resist this control by concealing their pregnancies until they went into labour, at which point it was too late to evacuate and the birth had to happen in the community health centre (Douglas, 2010). Evacuation was imposed in the same manner, through pressure. Midwives describe the immense pressure placed on pregnant Inuit women to conform to the norm of evacuation, that they would be considered selfish, undereducated, and willing to put their child at risk if they refuse (Couchie & Sanderson, 2007). Inuit communities in Nunavik consider evacuation as a “colonialist approach to health care and to indigenous communities” (Van Wagner, et al., 2007, p.387). Evacuation is imposed through a system of domination and pressure, which is in contrast to the indicator of collaboration identified in this research.

Evacuation functions within the system of biomedicine, which is led by a hierarchical system that places the doctor as the expert and decision maker. Douglas (2010) describes that medical evacuation for childbirth operates within the “ridged universal nature of biomedicine” which gives “absolute control by professionals, who in scientific epistemology are assumed to have a special and exclusive understanding of natural knowledge...” (p. 116). The chapter on obstetrics within the First Nations and Inuit Health Branch (FNIHB) Clinical Practice Guidelines for Nurses in Primary Care (2011) demonstrates the procedure for implementing evacuation.

Within the section on pre-natal care, the subsection Monitoring and Follow-up outlines that the nurse should “Arrange for transfer to hospital for delivery at 36-38 weeks’ gestational age according to regional policy (sooner if high-risk pregnancy)” (FNIHB, 2011). Additionally, women should be “refer[ed] to a physician or obstetrician as soon as possible if high risk factors/markers are identified” (FNIHB, 2011). The language within these guidelines reinforces that these steps are assumed not to be recommended. There is no mention of discussion with a patient or the community, but rather that the guidelines are imposed. An attempt at collaboration between biomedicine and Inuit approaches to maternal health are not mentioned within the guidelines. The guidelines are one of the few government documents that act as a de facto policy for government offered maternal health care within Inuit communities. They establish that the process of evacuation does not encourage or offer any type of collaboration between the Inuit and biomedical communities.

Integration/inclusion

The indicator of integration/inclusion bears similarity to that of collaboration in that they both signify the coming together of two ideologies, understandings, knowledges, and communities. Integration/inclusion specifically highlights the different realities of the Inuit and the Canadian population, differences that lie in their language, understandings, knowledges, and diet. The study of the practice of evacuation through the lens of collaboration demonstrated that evacuation functions entirely within a biomedical model of health care. The contrast between Inuit culture and the culture of biomedicine is immense. There has been debate on whether Inuit culture can be integrated/included in biomedicine, or vice versa (Douglas, 2006). Their differences are considered so great that one scholar believed that there was a “fundamental conflict” between Inuit culture and biomedicine (Grondin, in Douglas, 2006, p. 126). While this

is the opinion of one scholar, and does not necessarily reflect reality, it does illustrate the distinct contrasts within the two ideologies. Evacuation operates within this contrast, and is the issue that sparked the debate (Douglas, 2006). This contrast highlights that there are minimal ways to incorporate Inuit understanding or health ideology into evacuation.

Even if one is to consider tangible elements of Inuit maternal health care, outside of the broader ideological differences, they are unable to be integrated or incorporated simply due to the nature of evacuation. Evacuation is unable to incorporate Inuit traditions, understanding, language and diet, as the pregnant woman is removed from familiar surroundings, and placed in a culturally difference location. Traditionally childbirth was a communal experience, mediated by the consensus, involvement and support of the community (Douglas, 2006). This tradition is unable to be upheld, when the woman is physically removed from the community. Furthermore, often childbirth in a biomedical model sees women left alone for periods of time, which is described as “incomprehensible in [Inuit] culture” (Couchie & Sanderson, 2007, p. 251). Additionally, the language spoken in southern hospitals is most often the two official languages of Canada, French and English. Inuit women often cite the difficulties and lack of understanding that comes from the language barrier (Couchie & Sanderson, 2007; Van Wagner, et al., 2007). Evacuation is unable to incorporate a traditional diet. Pregnant Inuit women are encouraged to eat traditional country foods, which are unavailable in southern urban centres, thus contributing to a poor diet (Couchie & Sanderson, 2007; Van Wagner, et al., 2007). These being incorporated or included in southern settings is unlikely, as both Inuktitut and country foods are not widely spoken or available outside of Northern Canada. Such distinct elements of Inuit childbirth are, in the majority, only available in Inuit inhabited locations. Thus, as evacuation removes the woman from these locations it is unable to fulfil the indicator of incorporation/inclusion.

Community roots

The next indicator is community roots, referencing the connection that maternal health care has with the community; how much is it a part of the community, and vice versa. Based on the two indicators explored above it is evident that evacuation has no community roots. It is a colonial tool imposed on Inuit communities (Douglas, 2010; Van Wagner, et al., 2007). Inuit communities describe the implementation of evacuation as having an “intimate, integral part of [their] life taken from [them] and replaced with a medical model that separated [Inuit] families, stole the power of the birthing experience from [Inuit] women, and weakened the health, strength, and spirit of [Inuit] communities” (Van Wagner, et al., 2007, p. 384). There are no community roots in the system of evacuation for childbirth. It was born out of a system that attempted to break down indigenous communities and force assimilation. As it was an imposed system, there was no community involvement or choice, it will be unable to establish community roots.

Additionally, many of the less physical aspects of community roots are broken with the implementation of evacuation. Removal of birth from Inuit communities has caused a breakdown of familial and community relationships (Van Wagner, et al. 2007). Lawford and Giles (2012) identify that participation in birth develops “interconnectedness” or “social embeddedness”, the strong connections created between the child, family, and community. Inuit women have also perceived that children born in the community have better relationships with community members than those born outside (Kornelsen, et al., 2011). Additionally, Inuit babies born off traditional land are not considered to be born an Inuit (Houd, et al. 2003). Traditional midwives identify that babies born in southern communities are born without a home (Houd, et al. 2003). This phenomenon goes as far as some women considering children that were born prior to

evacuation were real Inuit, whereas younger children, born in the system of evacuation were not (Couchie & Sanderson, 2007; Douglas, 2006). These connections are more abstract than a physical removal. However, as perceptions they do cause breaks in the community structure and the community roots. In essence evacuation prevents community relationships and community roots, and therefore does not fulfill this indicator.

Understanding and respect of difference

The final indicator identified in this study is understanding and respecting of difference, an indicator that is encompassed by much of the discussion above. The study of maternity care in Inuit communities is centred around different cultural views of health and health care. As already assessed, evacuation functions solely within a Euro-Canadian biomedical model of health care. Interviews of elders have cited some of the pressures and beliefs that surround evacuation. Jusapie Padlayt, a Salluit elder, stated “I can understand that some of you may think that birth in remote areas is dangerous... you must know that life without meaning is much more dangerous” (Van Wagner, et al., 2007, p. 386). This statement indicates that evacuation considers the biomedical safety of birth, however does not understand or respect the cultural difference of Inuit birth. Furthermore, Couchie and Sanderson highlight that medical professionals often have difficulty understanding why Inuit communities would prefer to return birth to communities that do not have “modern obstetric services” (2007, p.251). Such statements made about evacuation highlight that different conceptions of adequate health care are not understood or respected in the system of evacuation. Evacuation considers only the medical safety and not the broader, more holistic approach to health and healthcare of the Inuit.

Existing research has been completed that adequately shows the negative effects of medical evacuation for childbirth. This research has attempted to show exactly how evacuation is destructive from an Inuit understanding of health. The themes identified in this research were collaboration, integration/inclusion, community roots, and understanding and respect of difference, which were identified using the Inuit specific framework for culturally relevant health indicators. Evacuation was an approach to Inuit childbirth implemented in a colonial system by a colonial government. It relies on a Euro-Canadian biomedical approach to health care. It's ability to fulfill, or even to be able to adapt to, Inuit health indicators is slim to none. A system that relies on medical evacuation is damaging and destructive to Inuit understandings of health as it does not fulfill the indicators of collaboration, integration/inclusion, community roots, and understanding and respect of difference and exists within a system where Inuit indicators are unable to be included.

Research question 2: Why is the Inuulitsivik Maternity considered to be more successful than the Rankin Inlet Health Centre in returning birth to Inuit communities?

The alternative to evacuation to southern centres is community based birthing. The two most widely referenced examples are the Inuulitsivik Maternity and the Rankin Inlet Health Centre. The Inuulitsivik Maternity was opened in 1986 and the Rankin Inlet Health Centre was opened in 1993 (Van Wagner, et al. 2012; Douglas, 2011). The Inuulitsivik Maternity is considered the most prominent and successful at returning culturally appropriate birth to northern Inuit communities, a sentiment that is made clear by direct reference or comparison (Douglas, 2011; Tedford Gold, et al., 2007). Using the themes already identified, this study will analyse the Inuulitsivik Maternity and the Rankin Inlet Birthing Centre in order to establish why this opinion persists.

Collaboration

Once again in the context of Inuit health, collaboration refers to a cooperative relationship between communities in order to create culturally appropriate health care for the target population. The earlier analysis demonstrated that the practice of evacuation functions within a system of colonialism. The birthing centres were born out of attempts to find an alternative.

The Rankin Inlet Birthing Centre has a history that attempts to fulfill this indicator and create a collaborative institution. In the late 1980s an influential study concluded that evacuation caused cultural and social disruption, which lay at the root of many of social problems affecting Inuit communities (Douglas, 2011). In the early 1990's Inuit communities began lobbying for childbirth to be returned to their northern communities (Tedford Gold, et al., 2007). These factors pushed the Keewatin Regional Health Board and the Government of the Northwest Territories to fund a low risk birthing project in Rankin Inlet in 1992 (James, et al. 2010). The Birthing Centre has been supported by individuals and organizations such as the University of Manitoba, Pauktuutit, the Northern Medical Unit, and the Nunavut Department of Health and Social Services (Douglas, 2011). In 1995 the centre was reclassified from a pilot project to a full program, including a staff of three midwives, two Inuit maternity care workers, and a clerk interpreter (Tedford Gold et al., 2007). In 2002 Nunavut's Minister of Health and Social Services announced that expansion of the project to other northern communities was a priority for the government (Tedford Gold, et al. 2007). The history of the Centre is one of heavy government involvement and it has been identified as a "regional government initiative that has struggled for community input and involvement" (Tedford Gold, et al. 2007, p. 8). The midwives that staff the centre are all from southern Canada (Douglas, 2011) There is a midwifery training program

offered through the Nunavut Arctic College and the University College of the North, however Douglas (2011) identified that as of 2011 none of the graduates were Inuit. The Rankin Inlet Birthing Centre fulfils the indicator of collaboration insofar as it attempts to create a hybrid approach to Inuit childbirth, combining traditional Inuit midwifery with biomedicine. However, it was created within confines of the Euro-Canadian colonial state system and therefore contains many elements of the dominant culture, such as professional hierarchy and southern midwifery. Despite being the result of Inuit communities needs, the Rankin Inlet Birthing Centre only somewhat fulfills the indicator of collaboration.

The Inuulitsivik Maternity was founded as a midwifery led birth centre in 1986 in Puvurnituq, northern Quebec (Douglas, 2010; Van Wagner, et al., 2012). The Maternity was opened by the Inuulitsivik Health Centre, a 25 bed general hospital, with the goal of ending routine evacuation to southern hospitals (Van Wagner, et al. 2012). The Maternity was established “as a direct result of community activism by Inuit women and concerned health workers” (Van Wagner, et al. 2012, p.231). An investigation into evacuation, conducted by the Inuit board that governs the hospital, found that it caused a multitude of social ills within the Inuit community, which were similar to the results found in the research done for Rankin Inlet (Van Wagner, et al., 2012). Elders, childbearing women, and community leaders were all consulted in the creation of the Maternity (Van Wagner, et al. 2012). Douglas (2010) identifies that the Maternity was born out of a resistance to southern authority as the community of Puvurnituq was the only community to reject the James Bay and Northern Quebec Agreement and was chosen to be the site of the regional hospital. However, the incorporation of an obstetrics ward was met with resistance from Pauktuutit, the Inuit women’s society, who threatened to boycott the hospital unless a separate, traditional birthing suite, with Inuit midwives and

community involvement, was incorporated (Douglas, 2010). The “unusual level of assertiveness with respect to southern authority” resulted in the official creation of a community based, Inuit-midwife led birthing centre (Douglas, 2010, p. 115). Southern midwives were initially recruited to establish a midwifery training program for local Inuit women and now Inuit midwives are at the core of the midwifery service. (Douglas, 2010; Tedford Gold, et al., 2007). Additionally, the Inuulitsivik Maternity is the first formal Indigenous midwifery education program in Canada and graduates are eligible for registration with the Ordre des Sage-Femmes du Quebec, the provincial midwife regulatory body (Tedford Gold, et al., 2007; Van Wagner, et al., 2012).

While the Inuulitsivik Maternity was born out of a system of resistance it consisted of a collaboration of the western biomedical community and the Inuit community. The centre was established in collaboration with the regional hospital in Puvurnituq, and functions in place of an obstetrics ward. The initial centre created a collaborative structure with southern midwives, who taught the practical knowledge of midwifery (Douglas, 2010). Inuit midwifery students understood this system as collaborative, the theories, philosophy, or culture of the southern midwives were supplanted by Inuit sources, leaving the role of southern professionals to supplying the facts (Douglas, 2010). Furthermore, the dominant biomedical system in Canada is not rejected entirely. Women are still examined by the local hospital or clinics, and high risk pregnancies are still evacuated to southern centres (Douglas, 2010). Midwifery training emphasises Inuit ways of learning, such as observation, story telling, and case review, while evaluation is ongoing (Van Wagner, et al., 2012). Knowledge is passed from teacher to student using traditional methods, “while Inuit and non-Inuit midwifery knowledge and approaches blend” (Van Wagner, et al. 2012). The system and approach of the Inuulitsivik Maternity is one

of collaboration, more than that it is collaboration mediated from the Inuit community, rather than the dominant culture.

Integration/inclusion

The indicator of integration/inclusion refers to the knowledge and understandings of different communities, and its subsequent integration/inclusion. The difference between Inuit and Euro-Canadian knowledge and understanding in relation to health care have been established. Evacuation is unable to integrate or include Inuit traditions, understandings, language, or diet as it removes women from an environment where these are available. Both the Rankin Inlet and the Inuulitsivik Maternity operate in traditional Inuit territory and consequently each addresses the marker of integration/inclusion in a different manner to the system of evacuation. A study of the indicator of collaboration showed that the Rankin Inlet functioned within the Euro-Canadian biomedical system. One of the goals of the Birthing Centre was to return birth to northern Inuit communities, which it has accomplished to a limited degree. An audit conducted on the Rankin Inlet Birthing Centre from its inception in 1991 up to 2004 stated that of the 502 deliveries reviewed, 238 of them occurred in the Birthing Centre and the rest occurred in southern hospitals (Macaulay, Durcan, Gercai, Hatlevik & Williams, 2006). The audit established that the centre met acceptable Canadian standards of care and safety (Macaulay, et al., 2006). The numbers demonstrate that over half of the women were evacuated to southern centres and therefore for the women who are evacuated the fulfillment of the indicator integration/inclusion faces the same challenges as the system of evacuation.

Furthermore, the structure and approach of the Rankin Inlet Birthing Centre creates challenges for integrating/including Inuit knowledge and understanding. The risk-scoring method, which assesses which women are considered “low-risk” and are able to give birth at the centre, is based on one used in a biomedical system where decisions are made using a clinical

risk evaluation tool or through consultation with OB-GYN in Winnipeg (Douglas, 2011). Decision making remains in the hand of the professional biomedical elite, a system that is at odds with traditional Inuit community consensus. Additionally, integration of Inuit midwifery faces challenges in the Rankin Inlet Birthing Centre. While the Centre is midwife led, all are southern midwives who work on fixed contracts, and rotating through the north, affording the Centre no stability (Douglas, 2011). As of 2011, despite there being traditional Inuit midwives in Nunavut none worked at the centre, potentially due to the legal status of Inuit midwives being considered unclear although there were “ongoing attempts to incorporate their knowledge and traditions into the midwifery curriculum” (Douglas, 2011, p.182). A program established between the Nunavut Department of Health and Social Services and the Nunavut Arctic College is offered to educate midwives, and place them “within a regulatory framework [that] was seen as essential for safe and consistent practice” (James, et al., 2010, p.3). However, as of 2011 the program had not had any Inuit midwives graduate, but did have five students at various stages of the program (Douglas, 2011). The midwifery system at the Rankin Inlet Birthing Centre is based within the Euro-Canadian biomedical system with attempts to incorporate Inuit knowledge. Inuit who work at the centre usually do so as maternity care workers, where they offer counselling and translation (Douglas, 2011). The community in Rankin Inlet is provided health care that integrates Inuit language, and attempts to incorporate Inuit knowledge and understanding. However, the Rankin Inlet Birthing Centre does not completely fulfill the indicator of integration as it struggles to integrate Inuit midwifery as an important component of health care.

The Inuulitsivik Maternity was established as a resistance to southern authority over health care and is more successful in integrating Inuit knowledge and understanding. In contrast to evacuation and the Rankin Inlet Birthing Centre, where decision making is the responsibility

of health care professionals, the Maternity uses a traditional community consensus approach. Medical decisions, including where a woman should give birth, is decided by a perinatal committee (Douglas, 2010; Van Wagner, et al., 2012; Douglas, 2006). The perinatal committee is composed of midwives, the medical profession, and the community, with equal representation from all groups (Douglas, 2006; Douglas, 2010). The biomedical, professional decision maker system, used in evacuation and the Rankin Inlet Birthing Centre, has been replaced with a community consensus model that is in “accord with Inuit epistemology of health” (Douglas, 2010, p.115). Inuit midwifery is integrated directly into the “structured interprofessional health team” (Van Wagner, et al., 2012, p.231). Inuulitsivik midwives also provide services usually provided by public health professionals in Canada, including baby care, well-woman and sexual health care to non-pregnant women (Van Wagner, et al. 2012). Furthermore, presently the core service of midwives are local women trained in Maternity (Van Wagner, et al., 2012; Tedford Gold, et al., 2007). The training offered through the Inuulitsivik Maternity is the first formal Indigenous midwifery education program (Tedford Gold, et al., 2007). The Maternity allowed the community to reclaim Inuit midwifery knowledge and the midwives believe it is a “powerful tool to both preserve and regenerate Inuit birthing traditions and prove their compatibility with acceptable biomedical outcomes” (Douglas, 2006, p.127). The Inuulitsivik Maternity effectively integrates a community consensus model, compatible with Inuit health ideologies while giving Inuit midwives an environment to preserve and regenerate Inuit traditions. It therefore is successful at fulfilling the indicator of integration/inclusion.

Community roots

Evacuation for birth does not fulfill the indicator of community roots as it is a colonial practice that physically breaks the connection between Inuit women and their community. The

Rankin Inlet and Inuulitsivik Maternity fulfill this indicator but in varying levels. The Rankin Inlet Birthing Centre was initiated due to government and institutional support, as demonstrated in the analysis of the theme of collaboration. It was born out of community need and demand for local, community based birthing (Tedford Gold, et al., 2007). However, Douglas (2011) notes that while “the Centre has succeeded through unwavering support from the individuals and organizations that fostered its creation in the first place ...it has never become an Inuit institution, nor is it an integral part of the Inuit community” (Douglas, 2011, p.184). The support that fostered the initiation of the Centre was at the macro or organizational level. As with many northern communities, the need for local birthing was noted but that need did not translate into community involvement nor did it establish strong community roots. The Rankin Inlet Birthing Centre commenced its operations by advertising for a traditional Inuit midwife, however 25-30 years’ prevention and discouragement left Inuit midwives feeling unprepared to apply (James, et al., 2010). The centre has thus been left reliant on southern midwives which creates an environment where the midwives have very little connection to the location or population and, without any community ties, the southern midwives struggle to gain the trust of their patients (Tedford Gold, et al., 2007; Douglas, 2011) Midwives rotate through the centre on contracts, resulting in a high staff turn over and recruitment issues that have periodically prevented the centre from offering services (Tedford Gold, et al., 2007; Douglas, 2011; James, et al., 2010). Douglas (2011) identifies that, “while an important part of the health care system, the Centre remains limited in its relationship with the Inuit populations. Its limitations are those of a southern institution located in Nunavut. It has never become an Inuit institution, nor is it an integral part of the Inuit community” (p. 184). The Rankin Inlet Birthing Centre responded to the

need for community birthing in Canada's North. However, the support funneled from institutions was unable to help the Centre establish strong community roots.

The Inuulitsivik Maternity was similarly created to establish birthing options in the north. However, rather than being supported from the high level institutions and governments, the Maternity was built from resistance. The Puvurnituq community, being the only Inuit community to reject the James Bay agreement, has built on its initial resistance and established a level of assertiveness to southern authority (Douglas, 2010). Prior to any established birthing centre, traditional Inuit midwives were informally continuing to practice by assisting in births at the local hospital (Douglas, 2010). The original plan, to incorporate an obstetric ward in the hospital, was rejected by Pauktuutit, the Inuit women's society, who planned to boycott the ward unless it was established separately and incorporated training for Inuit midwives, community involvement and traditional Inuit birthing practices (Douglas, 2010). A perinatal committee was established to ensure that the community was involved in the birthing process and now "it is the community, in consultation with the mother, the midwife, and the doctor, which makes the decision to evacuate expectant mothers" (Douglas, 2010, p. 116). Inuit midwifery tradition had continued in this community but southern midwives were employed to help offer local Inuit midwifery training (Van Wagner, et al. 2012). The Maternity and its midwifery training was established in 1985, before official midwifery existed in the rest of Canada (Houd, et al. 2003). Now student midwives are chosen from the community, and most of the training is done by local Inuit midwives (Van Wagner, et al., 2007; Van Wagner, et al., 2012). The Inuulitsivik Maternity was built from a tradition of strong community assertiveness. It's community roots are what makes it successful at returning birth and makes it able to function without reliance on southern midwives

or southern institutions. The Maternity fulfills the indicator of community roots as without them the Inuulitsivik Maternity would not exist.

Understanding and respect of difference

Evacuation only considers and works within a biomedical approach to healthcare. The two northern maternal health care centers, Rankin Inlet and Inuulitsivik, provide understanding and respect to the differences between biomedicine and Inuit understanding of health. Each Birthing center, “to varying degrees, is one which the functional requirements of biomedicine (low perinatal risk) are mediated by the cultural and social benefits of local birthing; this produces a hybrid style of birthing that satisfies both Inuit culture and biomedical concerns with perinatal outcomes” (Douglas, 2011, p. 180). The indicator, understanding and respect of difference, refers to the differences in knowledges and understandings between the biomedical and Inuit communities.

The Rankin Inlet Birthing Centre was established to return birth to Northern communities and to provide an alternative to the cultural and social disruption of evacuation (Douglas, 2011). Its establishment shows recognition of the difference needs of Inuit communities and different health knowledges and understandings. The Centre originally advertised for a traditional Inuit midwife but was unsuccessful in finding one (James, et al., 2010). By attempting to create a space that recognizes different needs and attempting to hire a traditional midwife, the Centre made an effort to incorporate Inuit understandings and knowledges. However, despite these efforts the Rankin Inlet Birthing Centre remains a southern institution. As already mentioned, the Centre is reliant on southern midwives who rotate through on contracts. The Regional

Coordinator and the maternity care workers are Inuit, but their roles are restricted to counselling and language translation (Douglas, 2011). Decisions are made by a biomedical risk scoring system, and all but low risk births are evacuated to Winnipeg (Douglas, 2011). By offering a birthing facility in a northern community and offering services with an Inuit translator the Centre does incorporate elements of Inuit worldviews into its services. However, many women still face a reality of evacuation to southern urban centers and the general environment of the Centre is a biomedical one. Therefore, the Rankin Inlet Birthing Centre somewhat fulfils the understanding and respect of difference, in that it acknowledges differences between biomedical and Inuit approaches to health. However, it falls short of including these different approaches to health and health care in its health care delivery.

The Inuulitsivik Maternity has supplanted many biomedical traditions and replaced them with ones that fit with Inuit understandings and knowledges. As an Inuit institution the Maternity fulfils the indicator of understanding and respect of difference, and incorporates this into their health care provision. Douglas (2010) identifies that it could be argued that using southern midwives to train Inuit students would have simply imbued the Inuit midwives with a “modernist, biomedical paradigm” (p.115). However, the Inuit women who received such a training reject this argument, agreeing that they gained practical knowledge, but that they incorporated this knowledge into their cultural paradigm (Douglas, 2011). The Perinatal committee assesses women’s health by the traditional form of community consensus, a rejection of biomedical, professional decision making. Risk screening accounts for medical and social factors, and routine evacuation is considered a risky process (Van Wagner, 2007). Biomedicine is not rejected completely, relevant technologies are incorporated, and high risk births are still evacuated (Douglas, 2010). The Inuulitsivik Maternity shifts the dialogue, it was an Inuit

institution that incorporated elements of biomedicine, rather than the opposite. Understanding and respect of difference is the foundation on which the Maternity was built and it has created an environment where Inuit approach to health care, with its unique understanding and knowledge, is the basis to which elements of biomedicine are added.

Therefore, the Inuulitsivik Maternity is considered to be more successful at returning birth to northern Inuit communities because it is more successful at meeting the health needs of the target population. The elements or themes work as a grading system in this analysis and demonstrates that, while the Rankin Inlet does geographically return some births to the north, it does not provide a health service grounded in Inuit world view or health ideology. Each of the four themes presents situations where the Inuulitsivik Maternity builds their institution from an Inuit understanding while the Rankin Inlet Birthing Centre falls short of adequately incorporating the necessary elements.

Conclusion

This research was driven by an attempt to understand how three Inuit maternal care options satisfy Inuit understanding of health. Conducting content analysis on academic literature from a variety of backgrounds, this research identified themes that represent important components of Inuit health care. These themes were collaboration, integration/inclusion, community roots, and understanding and respect of difference. In applying these themes as important elements or indicators to medical evacuation for childbirth, the Rankin Inlet Birthing Centre, and the Inuulitsivik Maternity, this research was able to demonstrate how each option fulfills or does not fulfill Inuit health needs. Medical evacuation for childbirth was developed in a colonial system by the dominant power, fundamentally at odds with an indigenous health

ideology. Additionally, it removes women from the familiar environment of their community, and important elements of Inuit culture. The importance of returning birth, geographically, to Inuit communities is evident from the existence and support of the Rankin Inlet Birthing Centre and the Inuulitsivik Maternity. This research has asserted that the recognized success of the Inuulitsivik Maternity in comparison with the Rankin Inlet Birthing Centre is due to its ability to achieve almost complete fulfillment of Inuit health indicators and needs. Acknowledgement of the strengths and failings of different Inuit maternal care options allows for future Inuit maternal health care options to work with the successes and learn from the failures, in order to move towards a future with many culturally appropriate maternal health care options for Inuit communities. Further research will need to be conducted to explore best approaches to replicating the success of the Inuulitsivik Maternity in other Inuit regions in Canada.

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Appendix A

Thematic Network A:



Thematic Network B:

Thematic Network C:

