



*Exploring Models for Quality Maternity Care  
in First Nations and Inuit Communities:  
A Preliminary Needs Assessment*



**Final Report on Findings**



National Aboriginal Health Organization (NAHO)  
Organisation nationale de la santé autochtone (ONSA)  
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We are grateful to the members of the Peer/Community Review Team for volunteering their time and contributing their expertise, guidance and advice to assist the Centres in carrying-out the project and in developing culturally appropriate and responsive methodologies, structures and processes to undertake this needs assessment.

Most important, we wish to extend our gratitude and appreciation to the First Nations and Inuit women for their participation in the focus groups and their invaluable contribution to this needs assessment by sharing their maternity experiences and providing their thoughts and recommendations for the improvement of maternity care in First Nations and Inuit communities. We also recognize and appreciate the contributions of the maternity care practitioners who also shared their experiences as maternity care providers in First Nations and Inuit communities and for equally providing their suggestions and recommendations to improve First Nations and Inuit maternity care.

We greatly value your contributions and sincerely hope that the information collected as part of this needs assessment and as outlined in this report will assist First Nations and Inuit communities, Aboriginal and non-Aboriginal health and maternity care providers and all levels of government in improving the quality of maternity care for First Nations and Inuit women.

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## Introduction

In November 2003 the First Nations and Ajunnginiq (Inuit) Centres at the National Aboriginal Health Organization (NAHO) jointly submitted a proposal for funding to the First Nations and Inuit Health Branch (FNIHB) of Health Canada to conduct a preliminary assessment of maternity care needs in First Nations (reserve-based) and Inuit communities. The proposal was developed in consultation with the Health Secretariat of the Assembly of First Nations and the Health Committee of the Inuit Tapiriit Kanatami. In December 2003, FNIHB agreed to provide approximately \$140,000 to the Centres at NAHO to conduct the needs assessment.

*Exploring Models for Quality Maternity Care in First Nations and Inuit Communities: A Preliminary Needs Assessment* (hereafter referred to as The First Nations and Inuit Maternity Care Needs Assessment Project) constitutes participatory action research, and as such, utilized qualitative methods selected and developed with the assistance of a Peer/Community Review Team of First Nations and Inuit volunteers with experience in First Nations and Inuit health and maternity care. The methods selected and developed gathered information on the experiences and needs of First Nations and Inuit women in respect of their maternity care, as well as the experiences and perspectives of health care professionals working in the area of First Nations and Inuit maternity care. The qualitative needs assessment focused on understanding the experiences and perspectives of First Nations and Inuit women, as well as that of maternity care professionals, as a means of identifying issues, priorities, best practices and suggestions for improving maternity care in First Nations (reserve-based) and Inuit communities.

The needs assessment study consisted of a series of focus groups with First Nations and Inuit women, focus group participant questionnaires and professional informant interviews.

The primary research technique for the needs assessment was through facilitated focus groups with First Nations and Inuit women aimed at gathering experiential information. Separate focus groups were held with First Nations and Inuit women in respect and response to the distinct and diverse needs of each. Accordingly, separate First Nations and Inuit –specific Facilitator’s Guides were developed to outline the approach, objectives, goals, questions and the proposed agenda for the focus groups. Focus group participants were asked to share their knowledge of current maternity programs and services offered or available in their communities. Focus group questions and discussions were directed at identifying programs and services, as well as gaps in relation to prenatal, birthing and post-natal care. While the primary focus was in respect of First Nations (on-reserve) and Inuit community services, participants also described services offered and available outside of their community. The focus group approach supported and encouraged oral story-telling, best practices and solutions.

To complement the information gathered during the focus groups and as a means of collecting some baseline information and data, First Nations and Inuit –specific focus group participant questionnaires were developed and completed by focus group participants. The purpose for the questionnaires was to assist in defining and profiling the experiences of the First Nations and Inuit women in terms of their access and use of maternity care services and programs, and in collecting some tombstone data.

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The second element of this needs assessment involved the administration of a telephone questionnaire to health care professionals practicing in the field of First Nations and Inuit maternity care. The purpose of the questionnaire was to gather some base line information with a focus on obtaining professional perspectives on the needs, best practices, challenges, and potential solutions on maternity care for First Nations and Inuit women in Canada.

The First Nations and Inuit Maternity Care Needs Assessment Project was carried out between December 2003 and March 2005 and was divided in three phases:

- Phase I: Preliminary planning and the development of a work plan, methodology and measurement instruments (December 2003 – May 2004).
- Phase II: Initiation and completion of needs assessment activities through focus groups, focus group questionnaires and informant interviews (May – August 2004).
- Phase III: Literature review and report, analysis and consolidation of findings, preparation and dissemination of final report on findings (August 2004 – March 2005).

This report details the findings of the First Nations and Inuit Maternity Care Needs Assessment Project. The report identifies the issues, priorities, best practices, and suggestions for improving maternity care in First Nations and Inuit communities that were provided by the First Nations and Inuit focus group participants and professional informants working in the area of Aboriginal maternity care. The analysis provides preliminary information on the experiences and needs of First Nations and Inuit participants in respect of their perinatal care. The experiences, perspectives and challenges of the professional informants in the provision of maternity care to First Nations and Inuit women are also detailed.

The report identifies the gaps in current First Nations and Inuit maternity care and outlines solutions to addressing these gaps, as offered and articulated by the First Nations and Inuit women that participated in the needs assessment as well as the professional informants.

It is recognized that this preliminary needs assessment study was not sufficiently wide-spread to make conclusive findings, nor was the sampling large enough to firmly identify the influencing factors that could contribute to an improvement in the availability, accessibility and quality of maternity care for First Nations and Inuit women. However, the findings are consistent with other research and literature on the subject-matter and the experiential information that was provided, as well as the issues and gaps that were identified by the focus group participants and the professional informants confirm and substantiate the existing research and knowledge-base on First Nations and Inuit maternity care.

In this context, the information gathered and reported in this preliminary needs assessment study can contribute to, and assist in, further informing the development and implementation of new models for quality maternity care programs, services, and strategies for First Nations and Inuit women and in their communities.

This final report of findings is presented in two separate parts consisting of the First Nations (Part I) and Inuit (Part II) findings. Each part consolidates the results and findings of the focus groups, the



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focus group questionnaires and in the informant interviews. The introductory sections of the report include the objectives and anticipated outcomes of the project; provide highlights from the literature review to contextualize the findings; provide background information on the First Nations and Ajunnginiq Centres and the needs assessment team; and outline the methods used, and activities undertaken, to develop and implement the maternity care needs assessment.

## **Objectives and Anticipated Outcomes**

The overarching objective of the First Nations and Inuit Maternity Care Needs Assessment Project was to identify issues, priorities, best practices and suggestions for improving maternity care in First Nations (reserve-based) and Inuit communities with the intent of building on the research that has already been completed, and with a view to assisting First Nations and Inuit leadership in obtaining preliminary information on the experiences and needs of First Nations and Inuit women, as well as health care professionals, in the area of maternity care.

In this context, through focus groups, First Nations and Inuit women had the opportunity to share and discuss their experiences and needs in respect of their maternity care. Through the informant telephone interviews with health professionals, the First Nations and Ajunnginiq Centres gathered information on the experiences, views and perspectives of maternity care providers (medical doctors, nurses, midwives and other community-based maternity health care workers) in respect of First Nations and Inuit maternity care needs and issues.

The First Nations and Inuit Maternity Care Needs Assessment Project responds to the importance of issues surrounding the provision of maternity care services in First Nations and Inuit communities, by contributing to the knowledge base regarding First Nations and Inuit maternity care. Some of the key anticipated outcomes are as follows:

- Raising awareness among First Nations and Inuit of the key issues relating to maternity care in their communities.
- Assisting First Nations and Inuit leadership, health and other governmental authorities and health/maternity care professionals and researchers in gaining a better understanding of the experiences, perspectives and needs of First Nations and Inuit women in respect of their maternity care, as well as the experiences and perspectives of maternity care providers working in, and/or with, First Nations and Inuit communities.
- Facilitating and supporting capacity-building among First Nations in developing and implementing community-based strategies in respect of maternity care.
- Informing and influencing federal, provincial and territorial legislative and policy frameworks and programs and services in respect of the provision of maternity care to First Nations and Inuit women and their communities.

Recognizing the critical importance of maternal and child health in First Nations and Inuit communities, it is hoped that this project will inform the elaboration of models for quality maternity care in First Nations and Inuit communities that will require additional necessary and sustainable

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resources for implementation. Therefore, it should be anticipated that this needs assessment will raise the expectations of First Nations and Inuit communities, and therefore, appropriate response and commitments to these communities will require the active engagement of First Nations and Inuit leadership and of the First Nations and Inuit Health Branch of Health Canada.

## The Context

A literature review of relevant research and information relating to First Nations and Inuit maternity care, conducted as part of this needs assessment, identified that the cornerstone of maternal child health care for First Nations (on-reserve) and Inuit communities remains the medical evacuation of women from remote, isolated, and semi-isolated communities to tertiary care centers at 36 weeks of pregnancy. The women give birth in major urban areas, separated from their families and communities.

Even in communities where women are not evacuated long distances to give birth, frequent barriers persist in respect of First Nations and Inuit maternal and child health, including, but not limited to: the lack of access to health care and transportation; compromised continuity of care as a result of staff shortages and turnovers; shortages of food; the lack of appropriate and affordable housing; and the absence of culture-based perinatal outreach and support programs for Aboriginal women.<sup>1</sup>

The need for comprehensive maternity care services was well established in the 1996 Report of the *Royal Commission on Aboriginal Peoples*.

In 1996, RCAP reported that stillbirth and perinatal death rates among Indians were about twice the Canadian average; and among Inuit living in the Northwest Territories (NWT), the rate was about 2.5 times the Canadian average.<sup>2</sup> RCAP cited that neonatal and infant deaths were largely the result of Aboriginal living conditions and the lack of health care choices of Aboriginal pregnant women and new mothers.<sup>3</sup> It is critical to note that First Nations and Inuit women are at greater risk for a variety of conditions and complications arising during pregnancy, childbirth and postpartum.

According to Health Canada's *Statistical Profile of the Health of First Nations in Canada*, 2003, the First Nations infant mortality rate remained 1.5 times higher than in the Canadian population in 1999 with 8.0 deaths per 1,000 live births (based on 65 deaths) among First Nations (0 to 1 year), compared with 5.5 for Canada as a whole. The *Statistical Profile* also reaffirmed that the First Nations birth rate remains higher than that of the Canadian population, with a much higher proportion of First Nations women giving birth under 25 years of age (in 1999, this proportion was 58 per cent).<sup>4</sup>

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<sup>1</sup> Linda Cree, *Exploring Models for Quality Maternity Care in First Nations and Inuit Communities: A Preliminary Needs Assessment – Literature Review* (Ottawa: National Aboriginal Health Organization, March 2005) p. 4.

<sup>2</sup> Royal Commission on Aboriginal Peoples, *Report of the Royal Commission on Aboriginal Peoples*, Volume 3, "Gathering Strength," Chapter 3, "Health and Healing" (Ottawa: Government of Canada, 1996). Available online at: [http://www.inac.gc.ca/ch/rcap/index\\_e.html](http://www.inac.gc.ca/ch/rcap/index_e.html).

<sup>3</sup> Linda Cree, *Exploring Models for Quality Maternity Care in First Nations and Inuit Communities: A Preliminary Needs Assessment – Literature Review* (Ottawa: National Aboriginal Health Organization, March 2005) p. 4.

<sup>4</sup> Health Canada, *A Statistical Profile of the Health of First Nations in Canada* (Ottawa: First Nations and Inuit Health Branch, Health Canada, 2003). Available online at: [http://www.hc-sc.gc.ca/fnihb-dgspni/fnihb/sppa/hia/publications/statistical\\_profile.htm](http://www.hc-sc.gc.ca/fnihb-dgspni/fnihb/sppa/hia/publications/statistical_profile.htm). Almost one-quarter (23.7 per cent) of all First Nations births involved teenaged mothers (ages 15 to 19 years), as compared with around five percent (5.6 per cent) of Canadian teens of the same age

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Issues relating to midwifery and maternity care have been a priority of Inuit women for many years. Inuit live in 53 communities spread across two provinces and two territories. The majority of these communities are served by nursing stations only. There are no specialists located in these communities, and Inuit women requiring maternity care in a hospital setting are relocated thousands of miles from their homes and families to locations in the south.

In a discussion paper on *Maternal Health Care in First Nations and Inuit Communities*, prepared by Dawn Smith for the Office of Nursing, FNIHB, Health Canada, Smith found that maternal child health care in First Nations (on-reserve) and Inuit communities falls short of national and international standards, relies heavily on the evacuation of women in late pregnancy for medically safe births and minimizes attention to key factors influencing perinatal health and development.<sup>5</sup> Smith's study determined that maternal child health care can be improved when program design was community driven, culturally safe, and delivered by a multidisciplinary team; and focused on early recruitment, the development of trusting relationships, adequate resources, ongoing training and support, effective information management, and well-developed protocols for transfer between health care organizations and community involvement.<sup>6</sup>

Smith further emphasized that effective maternal child health care programs for First Nations and Inuit should consist of the following key factors:

- community control or involvement;
- cultural safety or appropriateness;
- the development of a trusting relationship with a primary care giver; and
- home visiting/a multiple intervention approach.<sup>7</sup>

In its 2002 public opinion poll on First Nations health and health care in Canada entitled *What First Nations Think about Their Health and Health Care*, First Nations respondents were asked how easy it was for people in their community to get appointments with health care providers. Over one-half (52 per cent) of First Nations respondents reported that it was “somewhat” or “very” difficult to access appointments with obstetricians/gynecologists and 59 per cent reported the same in respect of access to midwives.<sup>8</sup>

In its discussion paper on *Midwifery and Aboriginal Midwifery in Canada*, NAHO synthesized the main gaps in current policy and practice relating to maternity care services and summarized that services are inconsistent with the growing body of evidence on positive health outcomes and with

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group in 1997. First Nations females aged 10 to 14 years had an age-specific birth rate 9 times that of the average Canadian rate for the same age group.

<sup>5</sup> Linda Cree, *Exploring Models for Quality Maternity Care in First Nations and Inuit Communities: A Preliminary Needs Assessment – Literature Review* (Ottawa: National Aboriginal Health Organization, March 2005). Also see, Dawn Smith, *Comprehensive Maternal Child Health Care in First Nations and Inuit Communities: A Discussion Paper* (Ottawa: Office of Nursing Services, First Nations and Inuit Health Branch, Health Canada, August 8, 2002).

<sup>6</sup> Ibid.

<sup>7</sup> Ibid.

<sup>8</sup> National Aboriginal Health Organization, *What First Nations Think about Their Health and Health Care* (Ottawa: First Nations Centre, National Aboriginal Health Organization, 2005).

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international best practices and further suggested that new models were required for community-based maternity care in Aboriginal communities.<sup>9</sup>

In September 2004, the First Ministers from the federal, provincial and territorial jurisdictions held a meeting in Ottawa to discuss health care in Canada. Following this meeting a number of commitments were made by the federal government on Aboriginal health, including a \$400 million commitment for health promotion and disease prevention programs focusing on, among others, enhancements to child and maternal health programs.<sup>10</sup>

Despite all the research evidence and information relating to the current state of First Nations and Inuit maternity care and the impacts on First Nations and Inuit women, their families and communities, the lack of comprehensive, accessible and quality maternity care for First Nations and Inuit women remains a persistent health issue for First Nations and Inuit communities.

## **Background on the Organization**

NAHO was established in 2000 with five national Aboriginal representative organizations as its founding members.<sup>11</sup> It is a non-governmental and non-political Aboriginal organization committed to advancing the health and well-being of Aboriginal peoples through knowledge-based strategies and activities, and is reflective of Aboriginal peoples' understanding and endorsement of the critical role of information and knowledge in the collective empowerment of Aboriginal individuals and communities in matters of health.

Since its establishment, NAHO has aspired to becoming a leading edge organization with the key objectives of raising awareness of Aboriginal health issues, promoting Aboriginal community-based research, improving the recruitment, retention and support to Aboriginal health workers/professionals, and protecting Aboriginal traditional knowledge and healing practices.

As a distinct part of NAHO's design three centres of excellence were established in 2001 each specializing in the health of the three Aboriginal populations: First Nations, Inuit and Métis. A Governing Committee governs each Centre, enabling it to identify, communicate and address the health priorities of each population. Hence, in order to fulfill these objectives, the Centres must design and maintain a continuum of research via ongoing stakeholder relations and adherence to an impeccable ethics process.

### ***The First Nations Centre***

The First Nations Centre (FNC) at NAHO fosters a community-based approach to health research. That is, it adopts a collaborative approach, working with First Nations regional organizations and

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<sup>9</sup> National Aboriginal Health Organization, *Midwifery and Aboriginal Midwifery in Canada* (Ottawa: National Aboriginal Health Organization, February 28, 2004). Available online at: [http://www.naho.ca/english/pdf/aboriginal\\_midwifery.pdf](http://www.naho.ca/english/pdf/aboriginal_midwifery.pdf).

<sup>10</sup> Health Canada, "Commitments to Aboriginal Health," *Health Care Renewal* (Ottawa: Health Canada, September 2004). Available online at: <http://www.hc-sc.gc.ca/english/hca2003/fmm/index.html>.

<sup>11</sup> The five Aboriginal representative organizations are: the Assembly of First Nations, the Métis National Council, the Inuit Tapiriit Kanatami, the Congress of Aboriginal Peoples and the Native Women's Association of Canada.

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other community-based groups. In so doing, it aspires to build the capacity of First Nations to collect and analyze information on health status, issues and risk factors with the intent of assisting First Nations to better plan health programs and services by having evidence on their needs and the impacts of various programs, services, policies and investments. Its main objectives are to:

- Conduct, facilitate and promote research on First Nations health to assist First Nations and their communities.
- Disseminate results of health research and information to First Nations communities.
- Build First Nations capacity in respect of research and research analysis, health career development and health governance.
- Advocate, advance and support First Nations traditional knowledge, values and practices in First Nations health.
- Develop and enhance partnerships and relationships relating to First Nations health research, policies/strategies, capacity-building and promotion.

The FNC's core activities in the area of research are to:

- Conduct ongoing research and analysis on various issues relating to First Nations health to First Nations communities and leadership to support their planning, priority-setting and decision-making on matters pertaining to First Nations Health.
- Facilitate and support the development and sustainability of First Nations culturally relevant and responsive health research and information systems, structures and institutions as key elements of First Nations self-determination and self-governance.
- Influence and support the improvement of First Nations health outcomes through knowledge generation and translation.

### ***The Ajunnginiq (Inuit) Centre***

The Ajunnginiq Centre's mandate is to promote practices to restore a healthy lifestyle and improve the health status of Inuit. Its overarching objectives are to:

- Improve and promote the health of Inuit through knowledge-based activities.
- Promote understanding of health issues affecting Inuit.
- Facilitate and promote research and develop research partnerships that respond to the research priorities of Inuit, and increase the number and capacity of Inuit researchers.
- Foster capacity building and participation of Inuit in health care professions.
- Affirm, promote and protect Inuit traditional cultural, environmental and health-related knowledge and associated intellectual property rights.

The Centre works closely with the Inuit Tapiriit Kanatami on health priorities as identified by Inuit through the National Inuit Health Forum in 2000 and through ongoing discussions and working relationships with regional partners through the National Inuit Committee on Health.

During 2001/2002, the Ajunnginiq Centre conducted five regional workshops to confirm its priorities and activities. Discussions with community members confirmed the urgency and importance of improving maternal health care in Inuit communities, and recommendations included conducting further, more detailed discussions on the issue.

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Priorities for the Ajunnginiq Centre include Inuit health human resource capacity building, and assisting with efforts to expand the services available in the communities. Knowledge translation and knowledge transfer are key elements of the Centre's work. The Ajunnginiq Centre will play a key role in facilitating the participation of Inuit women in the proposed focus groups, and will link this activity to those of its member organizations regionally and nationally.

## **The First Nations and Inuit Needs Assessment Team**

The First Nations and Ajunnginiq Centres at NAHO jointly led and coordinated the First Nations and Inuit Maternity Care Needs Assessment Project. To assist them in the development and implementation of the project the Centres contracted the facilitation services of Carolann Brewer and Pat Baxter, First Nations women who individually and collectively have substantive experience in working with First Nations and Inuit women. Each brought various skills and expertise of asset to the project.

Initial planning for the First Nations and Inuit Maternity Care Needs Assessment Project took place between December 2003 and May 2004, during which time the First Nations and Ajunnginiq Centres worked with the Aboriginal consultants to develop and finalize a work plan and a draft methodology and measurement instrument design for the needs assessment.

Working with the Centres, Ms. Brewer and Ms. Baxter assisted in the development of the methodology for the needs assessment, and on behalf of the Centres were responsible for the development of the questionnaires and facilitators guides for the focus groups with First Nations and Inuit women; conducted the focus groups in Vancouver, Saskatoon, Winnipeg, Ottawa and Iqaluit; and prepared preliminary reports on the outcomes of each focus group. In addition, they developed the questionnaires for the informant interviews, conducted the interviews; and prepared a report of the findings of the informant interviews. Mr. Germain Paul, Service de consultant autochtone (a francophone Native consulting firm operating in Quebec) was contracted by the FNC to organize and conduct two focus groups in Quebec (Wendake and Mashteuiatsh), as well as to prepare the preliminary reports on findings.

The First Nations and Ajunnginiq Centres were responsible for sample identification and recruitment for the focus groups, as well as sample identification for the health professional informant telephone interviews. The Centres were also responsible for the coordination of focus group preparatory activities, including the organization of travel and logistics for all sessions.

In July 2004 a methodology report on the project was developed and submitted by the First Nations and Ajunnginiq Centres to Health Canada. The purpose of this report was to provide an overview of work and activities under Phases I and II of the needs assessment project, including the rationale for the project and its scope of work and methodology, and to report on the implementation of the needs assessment activities (i.e. focus groups with First Nations and Inuit women and informant telephone interviews with health care professionals), as well as planning for subsequent phases of the project.

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Ms. Linda Cree, Researcher/Writer with the Policy Research Unit of NAHO assisted the needs assessment team by researching and preparing a comprehensive literature review on First Nations and Inuit maternity care.

Four data bases were developed by the First Nations Centre based on the data collected as part of the First Nations and Inuit focus group questionnaires and the First Nations and Inuit –specific data that was collected through the professional informant interview questionnaires. Using the databases, aggregate data tables were developed by the Centres to conduct the analysis and report on baseline findings of the questionnaires.

Ms. Brewer and Mr. Phillip Bird were engaged by the Centres to conduct the analysis of the data collected on the First Nations and Inuit focus group questionnaires and the First Nations and Inuit -specific informant interview questionnaire, synthesize the findings of the First Nations and Inuit focus groups and prepare final reports of findings in respect of the First Nations and Inuit maternity care needs assessment. Ms. Brewer conducted the analysis and developed the final report of First Nations findings and Mr. Bird conducted the analysis and prepared the final report of Inuit findings.

A volunteer Peer/Community Review Team composed of First Nations and Inuit individuals with knowledge and expertise in matters pertaining to Aboriginal women’s health and perinatal care assisted the Centres in the development and implementation of culturally relevant methodologies, structures and processes to undertake the needs assessment. In particular, the Peer Review provided input and commentary on the methodology and survey instruments for the focus group and informant interview questionnaires; the methodology report; and the final report on findings.

## **Methods and Activities**

This needs assessment study consisted of focus groups, participant questionnaires and professional informant interviews.

Facilitated focus groups with a total of 43 First Nations and Inuit women were conducted in seven different locations across Canada over the period of May and June 2004. Four different facilitators followed a standardized guide, asking predetermined questions that had been designed to investigate specific areas of their maternity experiences from diagnosis to post-partum experience. Findings were reported in facilitator reports which summarized the input of the focus group participants. Information gleaned by the focus groups was supplemented by a tombstone questionnaire that was provided to focus group participants for their completion. The tombstone questionnaire garnered baseline demographic information on the focus group participants.

In addition, a questionnaire was administered by telephone to 23 health and maternity care professional informants to gather experiential information on the perspectives and experiences of maternity providers practicing in First Nations and Inuit communities, and/or providing maternity care services to First Nations and Inuit women.

A Peer/Community Review Team composed of First Nations and Inuit volunteers with experience and expertise in Aboriginal health and maternity care assisted the Centres by providing guidance and advice to the Centres in carrying-out the project and in developing culturally appropriate and

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responsive methodologies, structures and processes to undertake the needs assessment. Specifically, the Peer Review team reviewed and provided comments on the survey instruments, the Facilitator's Guides, the methodology report and the final report on the findings of the needs assessment.

## **Focus Groups with First Nations and Inuit Women**

The primary research technique for the First Nations and Inuit Maternity Care Project was through facilitated focus groups with First Nations and Inuit women aimed at gathering experiential information. The First Nations and Ajunnginiq Centres, with the facilitation services of Aboriginal consultants, conducted a series of focus groups with First Nations and Inuit women in key locations across Canada between May and June 2004.

First Nations and Inuit women participated in the focus groups on a voluntary basis in response to a call for expression of interest which was disseminated by the First Nations and Ajunnginiq Centres to First Nations and Inuit communities across Canada in May 2004.

It was determined early within the project development and planning process that separate focus groups with First Nations and Inuit women would be most appropriate in order to respect and respond to the distinct and diverse cultural, linguistic and other needs of First Nations and Inuit women.

Accordingly, a total of eight focus groups<sup>12</sup> were held over the period of May and June 2004, with six focus groups with First Nations women and one focus group with Inuit women. The focus groups took place as follows:

- Winnipeg (May 18-19, 2004);
- Saskatoon (May 20-21, 2004);
- Vancouver (May 20-21, 2004, two concurrent focus groups);
- Ottawa (May 26-27, 2004);
- Iqaluit (June 8-9, 2004, Inuit-specific)
- Wendake (June 17, 2004); and
- Mashteuiatsh (June 18, 2004).

Participants in the focus groups held in Vancouver, Saskatoon, Ottawa, Wendake and Mashteuiatsh included First Nations women who:

- were 18 years of age and over;
- had given birth within the last three years;<sup>13</sup>
- are First Nation (reserve-based) in decent; and
- were selected from each of the four directions (north, south, east and west locations) within a particular region.

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<sup>12</sup> Initial planning for the focus groups foresaw a total of five focus groups with First Nations and Inuit women in Vancouver, Saskatoon, Winnipeg, Ottawa and Iqaluit. However, due to the overwhelming response received by the First Nations Centre from First Nations women across the country who wished to volunteer as participants in the focus groups, an additional focus group was held in Vancouver and two francophone focus groups were held in Quebec to accommodate French-speaking First Nations women.

<sup>13</sup> Children aged three to five are often considered pre-school and are eligible for services such as Head Start. It was thus considered appropriate that this study target mothers of children below that age since their experiences with maternity (prenatal, birthing and postnatal) and maternal care would be more recent.



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The focus group in Winnipeg included the participation of First Nations women (18 years of age and over) who had lost children at birth, or shortly thereafter, within the last three years. It was felt that First Nations women who have experienced this trauma deserved their own session to accommodate their experiences in a sensitive and appropriate manner.

The focus group in Iqaluit included Inuit women from across the North who:

- were 18 years of age and over;
- had given birth within the last three years;
- are Inuit in decent; and
- were selected from each of the four directions (north, south, east and west locations) within a particular region.

A total of 43 women participated in the focus groups, ranging in ages from 16 to 38 years of age, of which, 33 First Nations women participated in the focus groups held in Vancouver, Saskatoon, Winnipeg, Ottawa, Wendake and Mashteuiatsh and 10 Inuit women participated in the focus group held in Iqaluit.

The largest focus group was held in Iqaluit with 10 Inuit participants. The focus groups with First Nations participants were slightly smaller. In Vancouver (2 focus groups) there were 6 participants per focus group; in Saskatoon there were 7 participants; the focus groups in Ottawa and Wendake had 4 participants each; and the focus groups in Winnipeg and Mashteuiatsh included 3 participants each. With the exception of the focus groups in Wendake and Mashteuiatsh which took place in one day due to logistical considerations, all focus groups were scheduled for 1.5 days in length.

The focus group in Iqaluit included women from Nunavut, Labrador, the Inuvialuit and Nunavik regions. First Nations women from almost every region of the country volunteered to participate in the focus group sessions. Accordingly, First Nations women from British Columbia and the Yukon participated in the Vancouver focus groups; First Nations women from Alberta, Saskatchewan and Manitoba participated in the focus group in Saskatoon; the focus group in Winnipeg included women from Manitoba; the focus group in Ottawa included First Nations women from Ontario and the Maritimes; and the focus groups in Wendake and Mashteuiatsh included First Nations women from Quebec.

The focus groups in Vancouver, Saskatoon, Winnipeg and Ottawa were conducted in English and the focus groups in Wendake and Mashteuiatsh in French. The focus group in Iqaluit was conducted in Inuktitut, with simultaneous translation and recording capacity into English for reporting purposes and hosting the session. With the exception of the focus groups held in Quebec,<sup>14</sup> the proceedings of the focus group sessions were recorded and transcribed to assist in the qualitative analysis around themes and sub-themes and report writing.

Focus group participants were provided with a small stipend to encourage their participation. All travel arrangements and related costs, including air/ground transportation, accommodations, meals and incidentals for First Nations and Inuit women participating in the focus groups were covered

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<sup>14</sup> Participants in the focus groups in Wendake and Mashteuiatsh requested that no audio recording take place during the sessions.

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respectively by the First Nations and Ajunnginiq Centres. Day care services were available on-site in the Iqaluit focus group and the Centres covered the travel costs, including, transportation, accommodations and meals, for one family member to accompany women participating in the focus groups to assist with child care for those mothers bringing their children to the focus group locations.

A series of Facilitator's Guides were developed to outline the approach, objectives, goals and questions, and the proposed agenda for each focus group sessions. The questions supported and encouraged oral story-telling, best practices and solutions. Given the need for consistency in core data, the Facilitator's Guides provided a basis for comparable input. In recognition and respect of the distinctiveness and diversity among Aboriginal groups, one Facilitator's Guide was developed for the focus group sessions that were held with First Nations women in Vancouver, Saskatoon, Ottawa, Wendake and Mashteuiatsh and one was developed for the focus group with Inuit women to be held in Iqaluit. In light of the sensitive nature of the Winnipeg focus group a separate Facilitator's Guide was also developed for this session.

Focus group participants were asked to share their knowledge of current maternity programs and services offered or available in their communities. The questions were directed at identifying programs and services, as well as gaps in relation to prenatal, birthing and post-natal care. While the primary focus was in respect of First Nations (on-reserve) and Inuit community services, participants also described services offered and available outside of their community.

Despite a variety of circumstances and backgrounds, the facilitators reported that participants were uniformly eager to share their maternity experiences and liked the focus group approach. They responded positively to the study and were enthusiastic about their ability to provide input into the report. Although there were some expressions of scepticism in relation to the outcomes, most felt that this was an exercise that held promise for the future of First Nations and Inuit women's maternity care.

## **Focus Group Questionnaires**

As a means of gathering some baseline information and data, each participant in the focus groups was asked to complete a questionnaire. The purpose for the information gathered was to assist in defining and profiling the experiences of the First Nations and Inuit women in terms of their access and use of maternity care services and programs. Questions included, but were not limited to: the type of prenatal care and programs available in their communities; access to maternity care providers; satisfaction in respect of the services that were accessed; medical or other interventions; and issues relating to traditional Aboriginal practices within the context of maternity care. Tombstone data was also collected as part of the questionnaire, such as date of birth, income, education, number of children, etc.

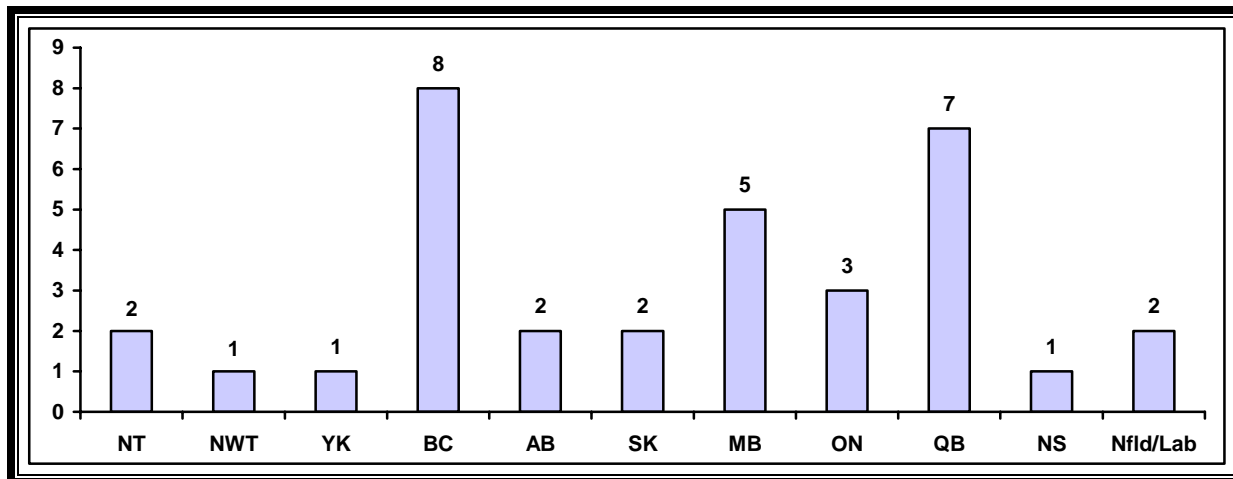
Two questionnaires were developed respectively for the First Nations and Inuit focus group participants in consideration and respect of the distinct and diverse cultural, linguistic, geographic and other needs of First Nations and Inuit women.

Of the 43 First Nations and Inuit women that participated in the focus groups, 34 were eligible to complete the focus group questionnaire.<sup>15</sup> Accordingly, 29 out of the 33 First Nations focus group participants completed the questionnaire and 5 of the 10 Inuit focus group participants did the same. Focus group participants that completed the questionnaire were from a number of regions across Canada, including: Nunavut (NT); the Northwest Territories (NWT); the Yukon (YK); British Columbia (BC); Alberta (AB); Saskatchewan (SK); Manitoba (MB); Ontario (ON); Quebec (QB) Nova Scotia (NS) and Newfoundland/Labrador (Nfld./Lab). (See Chart 1)

## Professional Informant Telephone Interviews

The second element of this preliminary needs assessment involved administering a telephone questionnaire to health care professionals practicing in the field of First Nations and Inuit maternity care. The purpose of the questionnaire was to gather some base line information with a focus on obtaining professional perspectives on the needs, best practices, challenges, and potential solutions on maternity care for First Nations and Inuit women in Canada.

A call for expression of interest was disseminated by the First Nations and Ajunnginiq Centres to First Nations and Inuit communities across Canada, in May 2004, requesting volunteers to participate in the professional informant telephone interviews. In response to this call, 23 health service providers were selected to be interviewed, of which 19 qualified to be included in the analysis and report on First Nations maternity care needs assessment and 4 qualified for the Inuit maternity care needs assessment study.<sup>16</sup> Informant interviews with health/maternity care professionals began in late May 2004 and were completed in August 2004.



**Chart 1:** First Nations and Inuit focus group questionnaire respondents by region

<sup>15</sup> A total of nine focus group participants (four First Nations and five Inuit focus group participants) were not eligible to complete the focus group questionnaire because they had not been pregnant or birthed within the last 3 year period. However, their input and comments as part of the general focus group discussions have been incorporated in the overall findings and results in this report.

<sup>16</sup> The 19 maternity care professionals that were included in the First Nations needs assessment analysis and report (Part I of this report) had worked with First Nations women and/or in First Nations communities; likewise the 4 professional informants that were included in the Inuit needs assessment analysis and report (Part II of this report) had worked predominately or exclusively with Inuit women and/or in Inuit communities and settlements.

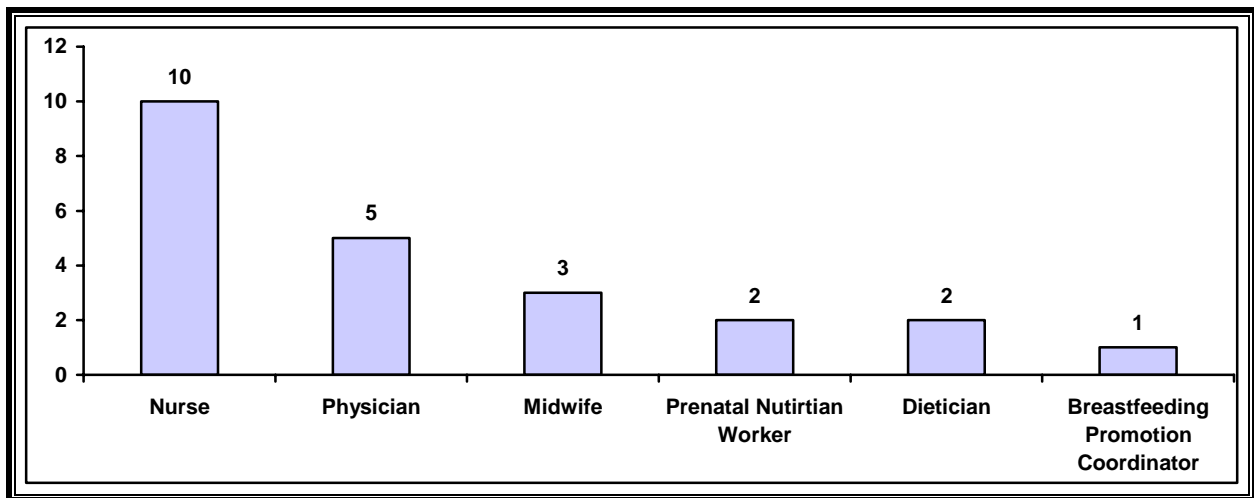
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Health professionals were selected for interviews based on the following criteria:

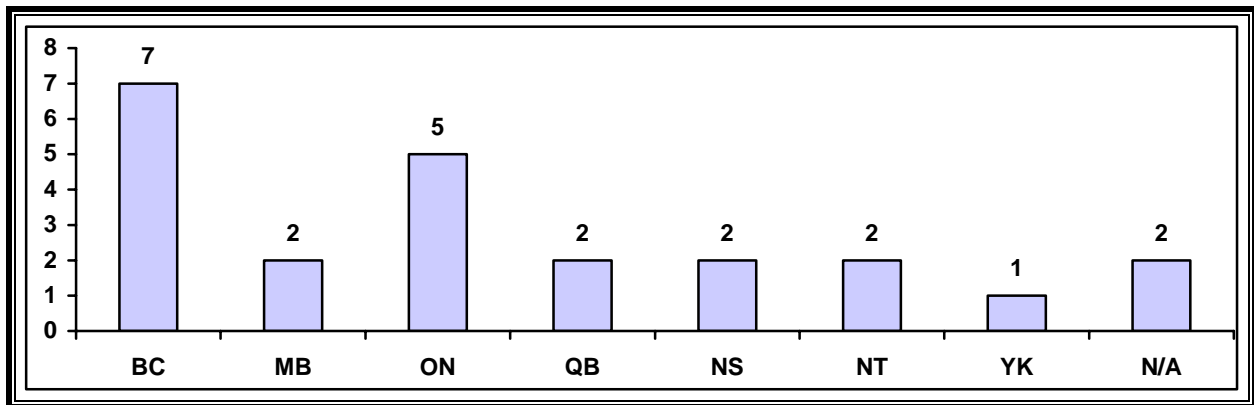
- individuals that work directly with First Nations (reserve-based) and/or Inuit communities;
- individuals that are of First Nation and Inuit decent; and
- individuals that have worked directly in the maternity care area within the last 3 years.

Of the professional informants selected for interviews, 19 were female and 4 were male. All provided some sort of maternity service to First Nations (reserve-based) or Inuit women. Ten were nurses and five were physicians. Two were prenatal nutrition workers, and two were dieticians. In addition, 3 midwives and a breastfeeding promotion coordinator were interviewed. (See Chart 2)

The last region of practice for the majority of professional informants was British Columbia (7 out of 23) followed by Ontario (5 out of 23), the rest were from three other provinces, including, Manitoba, Quebec and Nova Scotia, and two territories, including Nunavut and the Yukon. Two professional informants did not indicate their last region of practice. (See Chart 3)



**Chart 2:** Number of professional informants by profession



**Graph 3:** Last region of practice of professional informants

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## Peer/Community Review Team

A participatory action research approach was undertaken for the First Nations and Inuit Maternity Care Needs Assessment Project. In this context a Peer/Community Review Team was established with the participation of First Nations and Inuit individuals with experience and expertise in First Nations and/or Inuit health and maternity care.

In May 2004, the First Nations Centre received responses to an earlier call for expression of interest from a number of individuals from national and regional First Nations representative, health and women's organizations expressing interest in participating as volunteers in the Peer/Community Review Team for the project. These organizations include: the Assembly of First Nations (AFN), the National Indian and Inuit Community Health Representatives Organization (NIICHO), the Native Women's Association of Canada (NWAC) and the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC). The Ajunnginiq Centre also received a response from an official of the Government of Nunavut to participate as an Inuit member of the Peer/Community Review Team.

The Peer/Community Review Team provided guidance and advice to the Centres in carrying-out the project and assisted in developing culturally appropriate and responsive methodologies, structures and processes to undertake the needs assessment. More specifically, the Peer/Community Review assisted the Centres by providing input and commentary on the survey instruments for the focus groups and informant interviews and the methodology and final report of findings.

Each member of the Team was asked to volunteer time to provide assistance and advice on the project. The team will worked via e-mail to review drafted templates and other documentation and provide feedback.

## Literature Review

A literature review on First Nations and Inuit maternity care was conducted and a report on the review was prepared between August and October 2004. The purpose of this literature review was to build upon existing research and information, to retrieve relevant studies related to maternal care in First Nations (on-reserve) and Inuit communities and to provide a context for the needs assessment and to complement the information and findings of the First Nations and Inuit Needs Assessment Project.

In conducting the literature review, particular attention was given to First Nations and Inuit voices, their descriptions of past and present maternal care and on the suggestions and recommendations First Nations and Inuit, and other stakeholders on how to improve maternal care in their communities.

The research looked at how maternal health care was reported in the health literature and used to identify issues, priorities and best practices. The review is descriptive as well as interpretive. It required a comparison and analysis of texts, and thereby created new interpretations and cross-translated studies to enable the reader to understand how the studies are related.

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This literature review process began with footnote chasing or backward chaining and included research on, and a review of, more than 200 citations from reference lists of research reports, government documents, articles, books, theses on First Nations and Inuit women and maternal care, and personal communications.

## **Analysis and Reporting of Results**

A reporting template was designed to establish the format and standardized method of reporting data collected in the focus groups and four separate data bases were developed to assist in the organization and analysis of the data and information gleaned from the focus group and informant interview questionnaires. The four data bases developed were based on the following:

- First Nations focus group questionnaires.
- Professional informant interview questionnaires (First Nations specific).
- Inuit focus group questionnaire.
- Professional informant interview questionnaire Inuit specific).

Based on the databases, aggregate data tables were developed that were used to conduct the analysis and reporting of baseline findings to complement the qualitative information collected as part of the focus groups with First Nations and Inuit women.

The analysis of the First Nations and Inuit –specific data and information gathered from the focus groups, the focus group questionnaires and the informant interviews was conducted separately and is accordingly reflected in the final reports of the needs assessment findings.

This final report of findings is presented in to separate parts consisting of the First Nations (Part I) and Inuit (Part II) findings. Each part consolidates the results and findings of the focus groups, the focus group questionnaires and in the informant interviews. The introductory sections of the report include the objectives and anticipated outcomes of the project; provide highlights from the literature review to contextualize the finding and background information on the First Nations and Ajunnginiq Centres and the needs assessment team; and provide a detailed account of the methods used and activities undertaken to develop and implement the maternity care needs assessment.

## **Dissemination of Research Findings**

Knowledge translation (dissemination) of the needs assessment findings is a key element of the success of this project and the benefit to First Nations and Inuit communities. The final report will be disseminated to participants in the project, to First Nations and Inuit communities, and to First Nations and Inuit health and representative organizations. The final report will also be posted on the First Nations and Ajunnginiq Centres at NAHO web sites and profiled on the web site of NAHO's Information Centre on Aboriginal Health. In addition, there will be opportunities for the First Nations and Ajunnginiq Centres to present the findings of the First Nations and Inuit maternity Care Needs Assessment Project at various conference, meetings and other events on Aboriginal health.

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## Research Involving Human Subjects

The First Nations and Inuit Maternity Care Needs Assessment Project seeks to honour principles and codes for research ethics that have been developed and implemented by Aboriginal Peoples and their communities. This includes the First Nations principles of ownership, control, access and possession (OCAP) as they relate to First Nations health research, the Code of Research Ethics of the *First Nations Longitudinal Regional Health Survey (RHS)*, 2002-03, and ethical guidelines and requirements developed by Inuit communities in respect of research involving the Inuit, as well as, nationally and internationally recognized ethical guidelines for research.

The following are among the specific commitments undertaken for this project:

- The Peer/Community Review Team provided guidance and assistance on the project, including, but not limited to input, advice and commentary in respect of the methods and measurement tools prior to commencement of fieldwork and a review and commentary of the methodology and final reports prior to their release.
- Fully informed individual consent was required and provided by individual participants in the focus groups as well as maternity care and health professionals participating in the informant telephone interviews prior to beginning the needs assessment and data collection activities. First Nations and Inuit women participating in the focus groups were asked to read and sign a consent form prior to their completion of the focus group questionnaire. Women participating in the focus groups, who did not wish to sign the consent form, were asked to provide a verbal consent with the facilitator's signature as witness. Elements of the consent form were adapted from those of the RHS consent form including an emphasis on confidentiality, an option of audio recording, a general outline of the research and any potential benefits and risks.
- Individual participants in the project had the right to withdraw from the research process at any point and all information already collected on the individual would be destroyed or returned to the individual.
- No names or other personally identifiable information and data that were collected as part of this project will be released and results of the needs assessment have only been reported in an aggregated and/or de-identified fashion.
- In light of the unique and sensitive nature of the Winnipeg focus group, which gathered information on First Nations women who had lost a child during pregnancy, or soon after giving birth, the session in Winnipeg had an Elder and counsellor on-site to support the discussion and after sessions if required by the participants.
- The First Nations and Ajunnginiq Centres will provide all necessary equipment, supplies and policies to ensure the security and confidentiality of research and consent form data. This includes, but is not limited to:
  - Lockable filing cabinets for the storage of research and consent data; password protection for computers containing confidential data and research information.

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- Controlled and restricted access, by lock and/or computer password of all data and research information, either in hard copy or electronic format.
  - A firewall, or similar software or hardware to protect data and research information that is stored on a computer from which there is direct and indirect access to the internet, intranet or any other type of data sharing networks.
- The record level data gathered from the First Nations and Inuit focus group participants and the professional informants (First Nations and Inuit –specific) will remain under the respective possession and control of the First Nations and Ajunnginiq Centres.
  - Focus group participants and professional informants will receive a copy of the final report of findings.

## **PART I: FINDINGS OF THE FIRST NATIONS MATERNITY CARE NEEDS ASSESSMENT**

### **1.0 Profile of the First Nations Participants**

#### **1.1 Where were they from?**

Focus group discussions with First Nations women were conducted in Vancouver, Saskatoon, Winnipeg, Ottawa, Wendake and Mashteuiatsh. These facilitated discussions included a total of 33 participants from 14 different First Nations communities in Canada, located in seven provinces and one territory, including: British Columbia; Alberta; Saskatchewan; Manitoba; Ontario; Quebec; Nova Scotia; and the Yukon. Of the 33 women who participated in the focus groups, 29 were eligible to complete the focus group survey questionnaire and were all members of a First Nations Band.<sup>17</sup> While relatively small, the sampling incorporated input from women from diverse First Nations cultures, some of whom resided in suburban reserve communities, others from rural or remote communities.

#### **1.2 How old were they?**

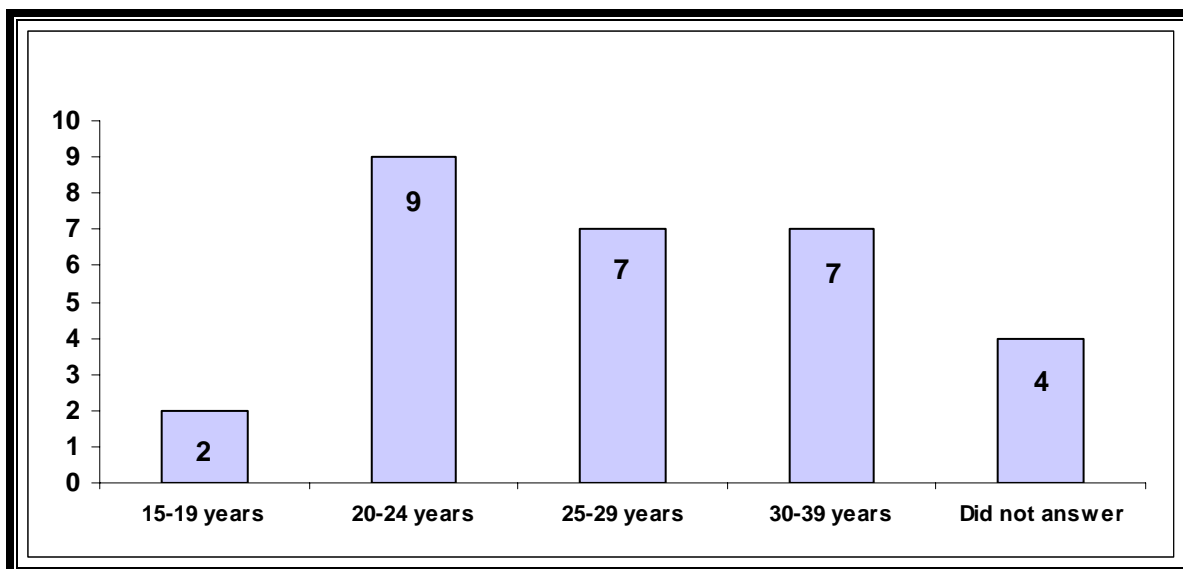
First Nations respondents in the focus group questionnaire ranged from 17 to 38 years of age. (See Chart 4) Most were between 20 and 24 years of age (9 out of 29, or 31 per cent).<sup>18</sup> Two of the women were between 15 and 19 years of age, and an equal number (7 each) reported their age as 25 to 29 and 30 to 39 years respectively. Four participants did not respond to this question.

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<sup>17</sup> In order to be eligible to complete the focus group questionnaire participants had to: be 18 years of age and over; have given birth within the last three years; be First Nation (reserve-based) in decent; and be selected from each of the four directions (north, south, east and west locations) within a particular region.

<sup>18</sup> Percentages that are fractions are rounded to the nearest whole number.





**Chart 4:** Total number of First Nations questionnaire respondents by age group

### 1.3 About Their Birthing Experiences, Babies and Families

Of the 29 First Nations women who completed the focus group questionnaire, 27 respondents reported that they had given birth within the past three years.<sup>19</sup> For 6 of the 29 women (21 per cent) their most recent child was under six months of age, including 2 of the women that had given birth within six weeks of the focus group. For an equal number (6 out of 29) their most recent child was between 6 and 11 months of age; 9 of the 29 (31 per cent) had a child between 12 and 23 months; and 7 of the respondents (24 per cent) had a child that was 24 months and over.

Most of the women that delivered babies within the last three years (15 out of 27, 55 per cent) gave birth to average-sized babies weighing between 5.5 and 8.8 pounds. Only one respondent reported having given birth to a low birth weight baby (under 5.5 pounds) and two women reported having given birth to babies weighing over 8.8 pounds.<sup>20</sup> Nineteen of the twenty-seven women (70 per cent) indicated that their baby was full-term.

For 38 per cent of the questionnaire respondents (11 out of 29), this was their first birth. Twenty-one per cent (6 out of 29) had one child and 17 per cent (5 out of 29) already had two children. Two of the twenty-nine respondents had three and four children respectively, while one each reported already having six and eight children. One participant did not respond to this question.

Most of the women that participated in the questionnaire had partners and the majority of the women (23 of 29, or 79 per cent) were living with their partner at the time they gave birth. Of this number, 10 of the 29 women (35 per cent) were married; 14 of the 29 (48 per cent) were living with their partner; one was separated; while four were single. The First Nations women in this study

<sup>19</sup> Two of the twenty-nine questionnaire respondents had experienced miscarriages over the last three years.

<sup>20</sup> Low birth weight babies are considered to be under 5.5 pounds (or under 2,500 grams) and high birth weight babies are considered to be over 8.8 pounds (or over 4,000 grams).

reported that they felt supported. Almost all, 27 of the 29 participants (93 per cent) indicated having family support during their maternity experience.

The majority of women who completed the questionnaire reported giving birth in the hospital (27 out of 29, 93 per cent), with a nurse (24 out of 29, 83 per cent), doctor (22 out of 29, 76 per cent) and family member (22 out of 29, 76 per cent) present. Just over one-half (16 out of 29) of the women’s partners were present as they delivered and two had the support of a doula. None of the women reported having traditional healers present as they gave birth.

Seventeen of the twenty-nine women (59 per cent) indicated that they had left their home community to give birth. Almost one-half (14 out of 29, 48 per cent) travelled to the hospital by car, two participants travelled by plane and one participant reported travelling by ambulance.

## 1.4 About Their Maternity-Related Health

Eighteen of the twenty-nine women (62 per cent) reported having health problems, or specific pregnancy-related health conditions, during their pregnancy, with a noticeable number, almost 35 per cent, having experienced bleeding or problems relating to their placenta. (See Table 1)

Type of Health Problem	Number of Respondents <sup>21</sup>	As a Percentage of Total Respondents (n=29)
Gestational diabetes	2	7%
High blood pressure/eclampsia	3	10%
Bleeding/placenta problems	10	35%
Water break (3 weeks) before due date	1	3%
Premature labour	6	21%
Anemia	2	7%
Other (non-specific)	4	14%

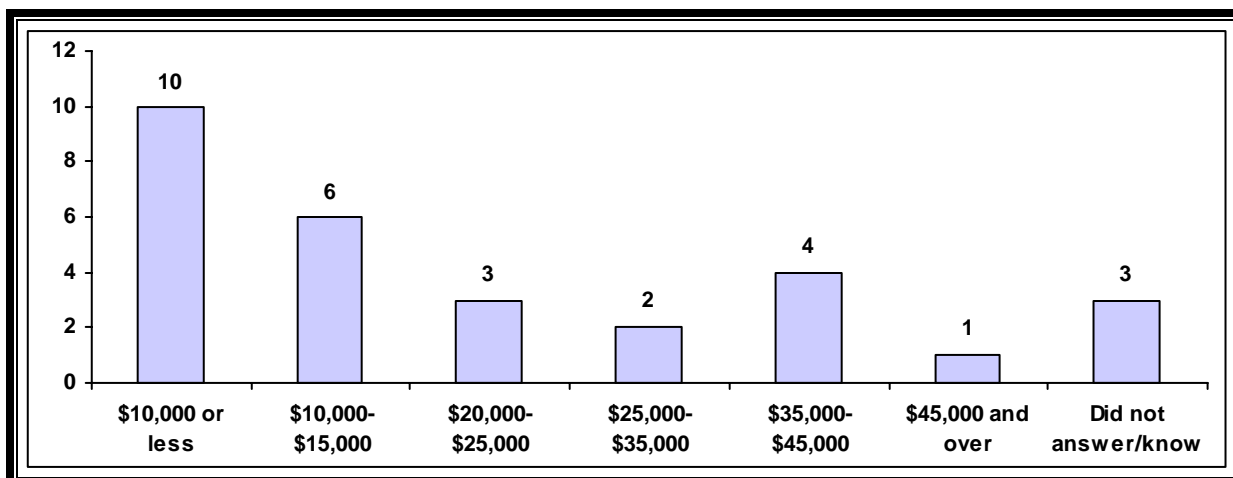
**Table 1:** Type of health problem/condition experienced by First Nations respondents during pregnancy

## 1.5 About Their Schooling and Income

Almost 45 per cent (13 out of 29) of the women that completed the questionnaire had not completed high school at the time of their most recent pregnancy. Five of twenty-nine (17 per cent) reported having completed high school while a combined total of 11 out of the 29 had college (7 out of 29, 24 per cent), or university (4 out of 29, 14 per cent) education.

The participants in this study were economically poor. Over one-half of the participants (16 out of 29, 55 per cent) reported having a net annual income of \$15,000 or less at the time of their pregnancy, while 5 of 29 (17 per cent) reported having an income of over \$35,000. (See Chart 5)

<sup>21</sup> Some respondents reported more than one health, or, pregnancy-related condition.



**Chart 5:** Levels of income of First Nations questionnaire respondents

## 2.0 Maternity Health Care Services in First Nations Communities

### 2.1 Prenatal Care and Services

#### 2.1.1 Availability and Accessibility of Prenatal Care

The vast majority of questionnaire respondents (28 out of 29, 96 per cent) reported that they had received some help with their pregnancy, and 22 out of 29 (76 per cent) reported that some form of prenatal care service was always available in their community. Six respondents (21 per cent) indicated that prenatal care was sometimes available in their community and one participant informed that her community did not have any prenatal care services.

Table 2 provides a more detailed account of the types of prenatal care services that participants reported were “available,” “sometime available,” or “not available” in their communities.

Type of Prenatal Care Service	Availability of Prenatal Care Services Reported by First Nations Respondents (n=29)			
	Always Available	Sometimes Available	Not Available	Did Not Answer/Know
Traditional/cultural supports	7	6	13	3
Nursing services	19	3	7	----
Counselling or Other Information	16	7	6	----
Doctor services for regular visits	12	6	11	----
OBGYN services	18	1	10	----
Traditional healers and medicine	9	3	14	3
Mid-wife/Doula services	4	2	21	2
Birthing facilities	5	1	23	----
Ambulance service	23	2	4	----
Fly-out services	7	6	14	2

**Table 2:** Availability of prenatal care services as reported by First Nations respondents

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The reported availability of prenatal services varied among respondents. Nineteen of the twenty-nine women (65 per cent) reported that nursing services were always available in their community, followed by OBGYN services (18 out of 29, 62 per cent), counselling services (16 out of 29, 55 per cent) and doctor services for regular visits (12 out of 29, 41 per cent). Twenty-three of the twenty-nine women (79 per cent) reported that ambulance service was always available in their community, however, almost one-half of respondents (14 out of 29, 48 per cent) reported that fly-out services were not available in their community. (See Table 2)

Under one-half of respondents in the questionnaire (13 out of 29, 45 per cent) reported that prenatal traditional/cultural supports were “always” (7 out of 29) or “sometimes always” (6 out of 29) available in their community, and an equal number reported that they were not available. However, over 70 per cent (21 out of 29) of the women indicated that midwife/doula prenatal services were not available in their communities. Community-based birthing services were also not available according to the majority (23 out of 29, 79 per cent) of the respondents. (See Table 2)

Eighteen of the twenty-nine women (62 per cent) reported receiving prenatal services in their community, and 10 out of 29 respondents (35 per cent) reported that they travelled outside of their community to receive prenatal services despite the seeming availability of some prenatal services in their communities.

First Nations focus group participants confirmed that physicians were rarely reserve-based, but some women indicated that physicians made community visits at regular intervals.<sup>22</sup> Those focus group participants who were able to access specialized obstetrical prenatal care generally had to travel by car up to 100 miles (or 160 kilometres).

Participants in some focus groups also mentioned accessing nutritionists or dieticians. Others referred to accessing various other caregivers, including:

- psychologists;
- drug and alcohol counsellors;
- a wet nurse;
- prenatal worker;
- dental assistant; and
- crisis intervention worker.

The First Nations women were asked to provide information on the number of times they had visited or talked to a maternity care professional during their pregnancy. The respondents reported visiting or talking to doctors the most during their pregnancy, followed by nurses/practitioners, OBGYNs and social workers. Very few women reported visiting or talking to a traditional healer and none of the women reported visiting or talking to a midwife/doula during their pregnancy. (See Table 3)

Participants that completed the focus group questionnaire were asked whether they were satisfied with the prenatal care services they had accessed. Fourteen of the twenty-nine First Nations women

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<sup>22</sup> This was reported by participants in the Vancouver focus group, which included First Nations women from the British Columbia and the Yukon.

(48 per cent) reported that they were happy with the services they had accessed; 11 out of the 29 (38 per cent) said that they were somewhat happy; and 4 of the 29 (14 per cent) reported that they were not happy with the services that they had accessed.

Maternity Care Provider	Number of Times Respondents Visited/Talked to Maternity Care Providers During Pregnancy, by Number of Total Respondents (n=29)				
	0 times	1 to 4 times	5 to 9 times	9 to 12 times	13 times or more times
Family doctor	11	7	4	5	2
Other medical doctor	6	6	5	7	5
Public health nurse/practitioner	9	12	5	3	0
OBGYN	16	3	4	5	1
Midwife/Doula	0	0	0	0	0
Traditional Healer	26	2	0	0	1
Social Worker	21	6	0	1	1
Other Professional	25	3	1	0	0

**Table 3:** Number of times First Nations respondents reported visiting/talking to maternity care providers during pregnancy, by number of total respondents

### 2.1.2 Pregnancy Awareness – General Information

Focus group participants reported that they had learned about pregnancy in various ways. Some had taken sex-education programs through their high schools, while others had access to pamphlets or booklets through their health units or Community Health Representatives (CHRs) or Community Health Nurses (CHNs).

Written material, which was the most common educational approach offered by health units and medical staff, was not regarded as the most effective method of raising pregnancy awareness. Further, despite their availability, condoms were reportedly seldom used. Information relating to sexually transmitted diseases and Fetal Alcohol Syndrome (FAS), while available, was not taken seriously by youth who engaged in sexual activity. While the participants reported an awareness of risks, information pertaining to sexual health, pregnancy prevention and longer-term pregnancy-related complications was seldom sufficiently personalized to appear relevant to many of the First Nations women that participated in the focus groups, in particular the younger women.

For those with addictions or related problems, the approach taken in the educational materials was reportedly ineffective, given their underlying conditions. As a result, despite the availability of information on risks, many participants considered its actual efficacy in achieving prevention to be somewhat limited.

### 2.1.3 Pregnancy Diagnosis

Although most participants reported that they were intuitively aware of their pregnancy prior to diagnosis, confirmation through diagnostic tests was usually available in their home communities, either through administering blood tests or pregnancy diagnostic kits by the Public Health Nurse. Accordingly, 12 of the 29 respondents confirmed their pregnancy through home pregnancy

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tests/kits (41 per cent); 7 of the 29 women received their diagnosis from a physician or obstetrician/gynaecologist (OBGYN); and 5 of the 29 women (17 per cent) learned of their pregnancy from a nurse or nurse practitioner. In some cases, pregnancy kits were given out by the CHR or, where available, the CHN, or doctor. One participant reported having received her diagnosis of pregnancy from both a home pregnancy test/kit and the community nurse and 4 of the 29 participants (14 per cent) reported that they found out about their pregnancy from both a pregnancy test/kit and a physician or OBGYN.

Eleven of the twenty-nine participants (38 per cent) found out that they were pregnant in their first trimester (between 1 and 4 weeks); 12 of the 29 women (41 per cent) received their diagnosis of pregnancy between 4 to 6 weeks; 5 of the 29 (17 per cent) found out between 6 to 8 weeks; and one participant did not find out that she was pregnant until after her twelfth week of pregnancy.

#### **2.1.4 Prenatal Nutrition**

Obtaining proper nutrition can be problematic for many First Nations women, particularly given their insecure economic status. There are two elements relating to nutritional needs which were raised by participants in the focus groups: information and access. Except for the participants in the Winnipeg focus group,<sup>23</sup> all participants reported that information on nutrition is available in their home community.

The effectiveness of this information relates to both the method of communication and the mother's ability to obtain the foods that contribute to a healthy diet.

According to participants in the focus groups, most communities provide prenatal nutrition programs of various sorts aimed at addressing these needs. Information is conveyed through educational materials, resource people or group activities. One-to-one communication or group programs were reportedly more effective at relaying nutrition information than pamphlets or packaged written materials. Additionally, programs that recognize and ease the expectant mother's financial limitations while simultaneously addressing the need for nutritional knowledge were mentioned positively. According to First Nations women, this approach was taken in a number of communities where they were provided with food vouchers<sup>24</sup>, cooking classes and meals, or various milk programs<sup>25</sup> designed to meet their dietary needs.

In addition to nutritional information, vitamins or supplements were provided in some, but not all communities and some focus group participants complained that the cost of over-the-counter supplements was onerous.<sup>26</sup>

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<sup>23</sup> This could be explained by virtue of the fact that all participants in this focus group were from the same First Nations community.

<sup>24</sup> This was reported by participants at the Vancouver, Saskatoon and Ottawa focus groups.

<sup>25</sup> Focus group participants in the Quebec focus groups reported that communities in that region run an eggs, milk and oranges (EMO) program to assist the mothers.

<sup>26</sup> This was reported by participants at the Ottawa focus group.

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### **2.1.5 Other Prenatal Programs**

Participants described a variety of prenatal programs offered in their communities. The most mentioned program was the Healthy Living Choices Workshop, of which participants in every province spoke.

In three of the focus groups, a number of women spoke of receiving baby bundles for pregnant mothers. However, this was not consistent even within the same community as there were complaints that receiving a baby bundle was contingent upon the time of year a woman became pregnant. Sometimes these appeared to run out early in the fiscal year, while in other communities the baby bundles were a year-end expenditure.

Breastfeeding programs occasionally commenced prior to the birth, preparing expectant mothers for breastfeeding their newborn. Other participants described traditional services taught within the community, such as the red willow bath which promoted easier birthing.

## **2.2 Birthing Care and Services**

When it came time to give birth, the focus group participants' descriptions of their birthing experiences were similar. According to the findings of the First Nations focus group questionnaire, 23 out of 29 respondents (79 per cent) reported that there were no birthing facilities in their community. (See Table 2) Seventeen of the twenty-nine women (59 per cent) indicated that they had to leave their community to give birth. Of these, 2 were flown to the hospital to give birth and 15 (52 per cent) were transported by car or ambulance. Some focus group participants reported that their community provided transportation to the hospital, while others indicated that their community funded, or reimbursed their travel to the hospital. The remainder either did not respond (2 out of 29) or responded that they did not have to leave their community to give birth (10 out of 29). Since 23 out of 29 reported that there were no birthing facilities in their community, the discrepancy is likely explainable by the proximity of the participant's community to an urban centre with a hospital.

While the majority of participants in the focus group questionnaire (25 out of 29, 86 per cent) reported that year-round ground transportation for birthing was available in their community, only 7 out of 29 participants reported that their communities had fly-out services for birthing. (See Table 5)

As previously mentioned, the majority of women who completed the questionnaire reported giving birth in the hospital (27 out of 29, 93 per cent), with a nurse (24 out of 29, 83 per cent), doctor (22 out of 29, 76 per cent) and family member (22 out of 29, 76 per cent) present. Just over one-half (16 out of 29) of the women had their partners present as they delivered. Participants in one focus group indicated that they some had access to midwifery services, but most were either unaware of services in their area or indicated that these were only available at an additional cost. Only 2 of the 29 questionnaire respondents reported having had the support of a midwife or doula during the delivery of their baby. None of the women reported having traditional healers present as they gave birth. (See Table 4)

Individuals Present as Respondents Gave Birth	Total Number of Respondents (n=29)	
	Yes	No
Nurse	24	5
Doctor	22	7
Midwife/Doula	2	27
Partner	16	13
Traditional Healer	0	29
Family Member(s)	22	7
Other	0	29

**Table 4:** Individuals present as respondents gave birth, by total number of respondents

Type of Community-Based Birthing and Postnatal Care Service	Availability of Birthing and Postnatal Care Services by Total Number of First Nations Respondents (n=29)			
	Always Available	Sometimes Available	Not Available	Did Not Answer/Know
Fly-Out Service	7	5	15	2
Year-Round Ground Transportation	25	2	2	----
Postnatal Care Services	16	9	4	----
Written Materials on Baby Care	24	4	1	----
Regular Access to Postnatal Check-Ups	10	14	5	----
Breastfeeding Counselling and Support	18	7	4	----
Breastfeeding Support Outside Community	18	5	4	2
Postnatal Emotional Support	14	10	4	1
Access to postnatal traditional or midwife supports	5	4	18	2

**Table 5:** Availability of birthing and postnatal care services as reported by the total number First Nations questionnaire respondents

As previously mentioned, 19 of the 29 questionnaire respondents (65 per cent) delivered a full-term baby and 16 of the 29 women (55 per cent) delivered their baby through natural childbirth. Respondents in the questionnaire were also asked whether they had received any medical intervention(s) during their labour and delivery, as well as the type of medical intervention(s) they had received. Eighteen of the twenty-nine respondents (62 per cent) received medication during their labour and delivery, and 13 out of the 29 (45 per cent) received an epidural during labour. Eleven of the twenty-nine respondents (35 per cent) had their labour induced and 9 of the 29 women (31 per cent) delivered their babies by cesarean section. (See Table 6)



Type of Medical Intervention Received During Labour	Total Number of Respondents (n=29)		
	Yes	No	Did not answer/know
Medication	18	10	1
Induced Labour	11	17	1
Epidural	13	12	4
Cesarean Birth	9	17	3
Heart Monitor	19	7	3
Other (non-specific)	0	28	1

**Table 6:** Type of medical intervention received during labour, by total number of respondents

First Nations women that responded to the questionnaire were asked whether they were happy with the birthing supports they had received. Of the 29 women, 16 (55 per cent) indicated that they were happy with the supports that they had received; 9 of the 29 (31 per cent) reported being somewhat happy and 3 women (10 per cent) said that they were not happy with the supports they had received. One participant did not answer this question.

### 2.3 Postnatal Care and Services

After release from the hospital, mothers were visited in their home by either, the CHN, the Public Health Nurse or a CHR. Sixteen of the twenty-nine (55 per cent) women reported that postnatal care services were available in their community and 9 of the 29 (31 per cent) said that postnatal care was sometimes available. Eighteen of the twenty-nine questionnaire respondents (62 per cent) reported that they did not have to leave their community to access postnatal care services, and 5 respondents (17 per cent) reported that they “sometimes” had to leave their community to access services. Six of the twenty-nine questionnaire respondents (21 per cent) reported that they had to leave their respective communities to access postnatal care.

Respondents reported that written material on baby care was readily available in their community (24 out of 29, 83 per cent) and that community-based breastfeeding and counselling (18 out of 29, 62 per cent) and outside community breastfeeding support (18 out of 29, 62 per cent) were also available. Ten out of twenty-nine respondents (35 per cent) said that regular access to postnatal check-ups was available in their community and 14 out of 29 (48 per cent) said that access to postnatal check-ups was sometimes available. Almost one-half of respondents (14 out of 29, 48 per cent) reported that postnatal emotional support was available, and 35 per cent (10 out of 29) reported that it was sometimes available in their community. Over 60 per cent of respondents (18 out of 29) said that they did not have access to postnatal traditional or midwife supports in their community. (See Table 5)

One-half of the focus group participants reported that baby care classes were offered in their community. Nutrition programs, milk programs or food hampers were provided to some women. Most were offered breastfeeding support. Those facing the loss of a baby may be offered grief and loss support which included counselling and homemaking. Other programs included foot-care and breastfeeding incentive programs.

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Traditional services and traditional foods were available at the hospital following birth where First Nations hospital liaison workers assisted.

When asked whether they were happy with the postnatal supports that they had accessed, 16 out of 29 respondents (55 per cent) said that they were happy; 7 out of 29 (24 per cent) reported that they were “somewhat” happy; and 6 respondents (21 per cent) said that they were not happy.

### **3.0 Gaps in First Nations Maternity Care**

After describing their maternity care experiences and discussing the types of programs within their communities, the women were requested to identify gaps in the maternity care they received. The women commented and observed that there were a number of key areas where gaps existed in maternity care, which are examined in the preceding sections, and include the following:

- Lack of home/in-community birthing.
- Lack of culturally trained staff.
- Lack of continuity in services.
- Lack of mental and emotional supports.
- Inability to make informed choices.
- Lack of supports for parents and families.
- Failure to integrate traditional practices into maternity care.

#### **3.1 Lack of Home/In-Community Birthing**

The lack of options for home birthing or birthing within the community was described as problematic. Only one community had a midwife in the vicinity that was known to the women but she was booked months in advance. Overall, in-home care was seen as limited.

The number of health care providers with training in maternity care was also seen as limited. In most communities, the health care providers were generalists such that maternity care had to be sought outside the community.

Focus group participants indicated that in some communities no prenatal care is offered on-reserve. For communities that are somewhat isolated, women must leave the community at least two weeks before her due date. These women described their experience as a lonely one, often plagued by insecurity, insufficient or inadequate food, the unfamiliarity of strange surroundings, missing family and other children, and an overall stressful experience.

#### **3.2 Too Few Culturally-Trained Staff**

A number of First Nations participants had negative experiences with health care workers who had expressed views that were racist, insensitive or ignorant of First Nations cultures. For instance, a number of women were subjected to stereo-typical assumptions about alcohol consumption. Others felt that the non-Aboriginal women who were being treated at the same time were listened to, and received better medical attention than the Aboriginal women.

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The First Nations women did not feel respected or listened to by the health care providers. One woman described being rudely brushed aside in a hospital admission area while in the latter stages of labour because clinic personnel did not believe her pleas for urgency based on their assessment of her level of pain. When it became apparent that she was giving birth, she was castigated for not informing medical personnel of her condition earlier. Another described general indifference on the part of hospital staff until they discovered that she had lost a baby earlier. Others described negative bed-side manners by medical staff. A number of women stated that they did not feel listened to by the hospital staff, to the point that one woman described having received medication against her wishes which led to psychotic episodes.

The younger mothers, in particular, reported that they had been treated in a judgmental, negative way by doctors or health care workers. As a result, they avoided seeking medical attention and were hesitant about asking questions or relating information.

While this was not a uniform treatment, some First Nations mothers stated that in some hospitals, the newborn was taken away and placed in a nursery. A number of mothers expressed feelings of anxiety about this because of racist experiences they were aware of in the community. They were concerned that such attitudes would translate into dangerous or substandard treatment, especially for their babies.

### **3.3 Lack of Continuity in Services**

A common complaint of the First Nations participants related to the lack of continuity of care after they were released from the hospital. The CHN was not apprised by the hospital of the treatments given and often the mother was unable to provide a comprehensive description of what medications or treatments had been received. Mothers seldom felt able to ensure that they and their newborn were able to access maternity care immediately after their release from hospital. While family members were often helpful, the mothers did not feel that the full responsibility should be placed on the family which was adjusting to the new baby.

### **3.4 Lack of Mental and Emotional Support**

A need that was consistently identified by the women in the focus groups was the lack of mental and emotional support faced after giving birth. Several of the women had suffered from post-partum depression and shared their experiences with their focus group. One participant noted that post-partum “blues” is not well understood within the community. As a result, it is difficult for women to seek support within their family or within the community. Despite this, very few of the women felt adequately prepared for the experience, and even fewer felt supported by the health practitioners in their community.

### **3.5 Inability to Make Informed Choices**

The women expressed the view that they were not given sufficient information to make informed choices during their pregnancy and birthing experiences. Often they felt pressured to accept treatment without understanding the implications of their decision and without any understanding of other options. Similarly, many felt that they had little or no choice of doctor. Often there were so few doctors in the area, and even fewer obstetricians, that women believed themselves to have no

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choice – even when it was evident within the community that patients were receiving substandard care and were therefore more likely to risk infections. For those who received initial care in the community, this often ceased when they gave birth.

Two First Nations women in different focus groups believed that they had been induced to labour to enable the doctors to leave the hospital. Whether or not this was in fact the case, the feeling of vulnerability behind such a belief must be recognized. In addition, the lack of information had endangered the life of one participant who described that because of her lack of understanding of the risk of hemorrhage she had failed to seek assistance. Another spoke of failure to recognize infection in the sutures following a cesarean procedure.

Others stated that they had not understood the risks for the child associated with the use of instruments such as forceps or suction during the delivery process. Several had been asked to consent to the administration of drugs or a procedure while in labour. In some instances, such as during difficult births, the birthing coach was asked to leave the room, leaving the birthing mother feeling vulnerable, fearful and alone.

### **3.6 Lack of Support for Parents and Families**

Participants stated that parents and families of newborns generally lacked support within their communities. Many referred to the problems arising as a result of the residential school experiences of family members, stating that there were few role models. Most communities suffered from what some described as post-traumatic stress, and families often had multiple problems which often included financial problems, addicted family members, and histories of abuse. Parenting within First Nation communities had considerable challenges and the amount of support available was felt to be inadequate.

### **3.7 Failure to Integrate Tradition into Maternity Care**

Focus group participants reported that the traditionally revered events of pregnancy, birthing and, to some extent, post-partum care had been largely divorced from their heritage and cultures by clinical treatment, systemic interventions and westernized medical practices, whereby pregnancy was depersonalized and dealt with as an ailment. Medical treatment thus overrode longstanding communal concepts of supportive care-giving or care-taking. The facilitators reported that for many, this intervention commenced immediately at or after the initial diagnosis of pregnancy.

### **3.8 Other Gaps in Care and Services**

Participants identified a number of other gaps and weaknesses in current First Nations maternity care and services, as follows:

- Absence of safe houses for women in crisis.
- Too much bureaucracy.
- Proposal-based funding for postnatal services (insecure program funding).
- Lack of attention to babies, toddlers, adolescents and youth (no programs for early childhood development and no on-reserve day care centres).
- Lack of dental care for infants.

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- Absence of continuity in needed gynecological information and care (i.e. cervical cancer).
  - Lack of needed supports for women who experienced the loss of a baby through miscarriage, or shortly after birth (beginning in hospital and after release, including support group).
  - Need for milk storage.

## **4.0 Solutions to Address Gaps in First Nations Maternity Care**

After identifying the gaps in the maternity services offered during their maternity experience, the First Nations participants in the focus groups were asked to think of models of maternity care, or ways in which the gaps they identified could be addressed.

### **4.1 Maternity Care Providers**

#### ***4.1.1 Access to Providers***

Participants often found it difficult to obtain care when they had to leave the community to visit their doctor. These women suggested that where they are not permanently based within the community, physicians should visit the community at least bi-weekly. According to the women in this study, First Nations medical clinics are not always equipped to deal with maternity care. In fact, some women reported that the medical clinic in their community was only open on a part-time basis. They believed that better care could be provided if there was a full-time medical clinic in each community. OBGYN care was considered desirable, but many women expressed the view that the need for referral or pre-qualification restricted access by most women. Some participants felt that OBGYN services should at least be available for birthing and possibly early assessment. Others had given birth in a hospital with only nurses present. For these, the presence of a doctor was perceived as the minimum standard.

The women also recommended that discreet services such as pregnancy tests be available for women at the health centres, as well as tests for sexually transmitted diseases.

#### ***4.1.2 Culturally and Appropriately Trained Providers***

Racism, ethnocentricity or cultural misunderstanding was raised as a key issue in a number of First Nations focus groups. Participants were therefore asked to consider how this problem could be addressed in their community. Some suggested that people from First Nations communities should be trained for positions, such as, midwife or nurse or any other position that provides direct maternity services to First Nations communities.

Some women in the study considered it important that the health care practitioners be screened so only those who exhibit the necessary qualities and essential sensitivities be permitted to work with pregnant women. It was the opinion of many participants that First Nations people would have the best understanding of the problems faced by members of First Nations communities and would therefore be the best suited to coaching First Nations women through their maternity experience.

At the very least, a number of participants felt it important to educate health care providers about the Aboriginal people they were servicing. The women felt that all practitioners should understand

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when they make racist assumptions and should be sensitized to the needs and concerns of the mothers. To do this, the women felt medical practitioners need to get a closer understanding of the First Nations Peoples in their area, their histories and cultures. One solution that was proposed was to have medical staff visit the reserve for cultural experiences.

A number of participants suggested that birthing centres in communities would alleviate a number of these difficulties described by giving control back to the community.

## **4.2 Services to Alleviate the Effects of Poverty**

Participants saw the need for the provision of a wide-range of services to meet the basic needs of pregnant women. They felt that necessities such as, food and housing should be available to pregnant women in the manner as is provided in some provinces or municipalities.

Because many women not only live a distance from their medical doctor and health care providers, a number are in communities that are not serviced by regular public transportation, participants recommended that transportation services should be available without cost to the expectant mothers so they could attend their regular prenatal visits.

A number of women considered the cost of baby equipment to be prohibitively expensive. Given that poverty created complications for many First Nations women during their pregnancy and birthing, a number felt that funding subsidies should be provided to families who need financial support to purchase baby equipment.

## **4.3 Access to Care for Young Mothers**

Participants observed that young women often require assistance to achieve self-reliance. They may need someone to help them in finding an apartment, finding furniture, and in basic home economics, such as how to shop appropriately within their means. Some suggested that a Mother/child centre to provide prenatal and postnatal services could be created for young mothers who do not have supportive families.

## **4.4 Prenatal Classes Aimed at Healthy Living**

A number of participants saw a need for programs that addressed labour and birthing, such as Lamaze classes. Some participants saw a need for comprehensive programming that would include nutrition, education and support to prepare for unexpected outcomes, such as a complicated birth or the loss of a child at birth. They suggested that prenatal classes be conducted each trimester in order to give women who were experiencing their first pregnancy the benefit of a full education while respecting that more experienced expectant mothers may not need the same level of detail of information, but may have knowledge to share.

The women were generally interested in more comprehensive programming that targeted ongoing lifestyle issues such as, exercise and mental health counselling and well-being. The participants of two focus groups specifically mentioned exercise programs to help mothers with their birth and to assist in her recovery. It was suggested that such programs should include the provision of childcare

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to the mothers who attended classes or group support sessions so they could do so without being worried about their children.

Food vouchers for healthy eating were considered a best practice. Cooking classes offered by some communities were also positively regarded. Some participants suggested that Bands organize communal kitchens where families could prepare food together. The participants suggested a meals-on-wheels service that would deliver meals to mothers at home during and after the pregnancy. The increased nutrition and regularity of meals was believed to improve the health of several mothers and babies.

A practice that was considered essential to women's health, maternity care and community health was partner support and programming to prepare and assist men in their parenting role. Although some participants indicated that their communities provided family support and recreation programs for families, many participants saw family recreation programming as essential.

It was also suggested that during pregnancy meetings of women in the same situation should be organized to create a friendship group so that they might help each other during and after pregnancy by sharing their knowledge, their fears and other concerns.

#### **4.5 Community/Band Government Supports**

In some focus groups, the participants spoke frankly about the need for Senior Officers or Directors of community/Band governments to consult more with the Band membership about their needs on a consistent basis and not only at election time. For instance, it was suggested that Bands could distribute an evaluation or surveys on prenatal and postnatal experiences (prenatal courses, home visits, etc.) once a year. They could ask about follow-ups, and learn about the concerns and service needs of pregnant or new mothers, accessibility to community-based maternity care services, or the attitudes of local hospitals or clinics. The women suggested that communities/Bands organize group meetings with members of the nation who are going through the same experiences without distinguishing whether or not they are resident on the reserve.

Because services are sometimes only available to community members who are Band members, some women recommended that agreements be developed between communities to allow First Nations women to receive services in their place of residence.

#### **4.6 Privacy Issues**

Some participants indicated that while home visits are generally desirable, there are situations where the family may prefer to use external resources, either provided by their community/Band government, or in outside communities. Privacy can be an issue, especially where the member or a member of the family is embarrassed about their situation. For example, one participant spoke of a reluctance to use the Band's counselling services because it was situated in a conspicuous place in the community where everyone could take note of who comes and goes. In a small community, this type of gossip can deter members from seeking assistance.

Despite this, participants considered it important to make the medical history of the mother, grandmother, and possibly sisters or aunts available to health practitioners. This was raised as a

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result of some participant experiences with health practitioners who did not seem prepared to accept the First Nation woman's knowledge of her maternal history.

#### **4.7 Birthing Counselling and Advocacy**

Participants did not believe that hospital staff was always primarily concerned with their well-being or that of their baby. Some had delivered by caesarean section or had been induced in their opinion to ensure they delivered at a time that was convenient for the doctor. As such, they felt the need for someone to provide options for delivery and to give them an overview of what is available and what is in their best interest. They wanted birthing counselling, where they could get information on the kind of drug support available during labour, as well as different options for pain management during labour and delivery.

A birthing advocate was seen as a necessity, especially for the younger, less experienced mothers and for those without partners. Even those who had partners and family in attendance occasionally felt mystified when offered treatment or drugs during birthing. They suggested that information on the potential side effects of drugs should be provided to mothers before they are administered and should be explained before the mother is in labour. Participants were of the view that where complications demand that an unanticipated treatment be given, an advocate could assist the mother in making an informed decision and could act as witness and advocate in event of poor or inappropriate treatment.

A service that provides coaching, labour support, general emotional support and follow-up for the mothers and/or the babies who have health problems was seen as the optimal solution for gaps in services related to birthing.

Additionally, some participants reported that they were only allowed to have one person present during the birth. They felt that the mother should be permitted to bring in whomever she wants to her child's birth.

In some hospitals, mothers gave birth in "comfort rooms," which were hospital rooms with a home-like setting. These were described by a number of focus group participants as ideal for birthing, but they were not universally available. At least one group reported this as a model for best practice.

#### **4.8 Neonatal and Postnatal Supports**

The participants had a number of suggestions relating to postnatal programs and services. To begin, some First Nations focus group participants recommended that Bands seek protocols with hospitals serving First Nations women that include discharge summaries to communities. Mothers or their companions were not always in the best position to describe the treatments they or the baby received while in the hospital, but a protocol could ensure that information relating to problems and treatments were noted and passed along so that proper follow-up could be performed when the mother and newborn returned to the community. Health services should include continued medical care after birthing, including counselling. The community health nurse or support person needs to have consistent information and should be aware of problems that may have occurred prior to or during birthing so the care may be continued at home.



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#### **4.8.1 Residential Care**

For postnatal care, a mother and child centre with twenty-four hour support could be created to help young women to plan for their baby's weekly needs and to counsel them on how to grow up while raising their child. Some participants proposed a postnatal residential centre for women in need of protection or young women who need support. Such a centre would provide nursing services, information, a cook and education services on how to care for the baby. This could include the services of a psychologist and/or a social worker as well as education on FAS.

#### **4.8.2 Home Support**

According to the focus groups, new First Nations mothers need home support as a Band program. Some participants believed that communities may be able to arrange volunteer homecare support at least for the first two days home from hospital so the mother could have help with housecleaning, cooking, family care and baby care. Focus group participants noted that new mothers often need support for household chores, meals, and errands but may be reluctant to ask. Homecare support should therefore be provided without them having to ask.

Many participants suggested that mothers of newborns, particularly those who have complicated births or those with little or no family support, should be assigned a mother's aide, either volunteer or other, to provide the needed support and respite so they could better recuperate after giving birth. For mothers with other children at home, one group suggested that longer-term occasional daytime home care would provide relief from the stress of a new baby and allow her to help her other children adjust. Weekly follow-ups from the mother's aide would give the mothers access to independent advice, while helping those who may need to acquire parenting knowledge and skills.

#### **4.8.3 Emotional and Mental Health Support**

A number of participants discussed experiencing varying degrees of post-partum depression. They expressed feelings of isolation due in part to what they perceived as a general lack of understanding by those close to them. The participants suggested that one-on-one psychological follow-ups should be provided to address post-partum blues and assist in dealing with depression. Most agreed that counselling should be available as required, and should be offered without the need for a woman to ask.

Some participants stated that depression may be present prior to pregnancy, but the condition could compound these feelings. They stated that early support is required before, during and after birth for mothers who may suffer from depression. One group made the following recommendations:

- Support shouldn't require diagnosis, since categorization (i.e., mental illness, alcoholism and addiction) often leads to stigmatization.
- Help must be available for the entire family – if the mother needs help, so do the children.
- People need to be able to seek crisis help anonymously – many families live in denial and emotional suppression, so members can't admit sadness and crying or talking about it is not acceptable. Each community should have a crisis line.

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- Depression leads to infant neglect which has lasting effects – to break the cycle, communities should have programs to help depressed parents and should “model” and reward good parenting, i.e.: community family nights; healthy recreation; etc.

A number of the women in this study spoke of low self-esteem caused in part by weight gain following their maternity experience. Many focus group participants felt that the well-being of both the mother and her baby would be improved by programs aimed at assisting in rebuilding self-esteem. For instance, a number recommended health and fitness programs for mothers. Others described incentive programs for new mothers who were breast feeding that included a spa day. Several focus group participants recommended that all mothers with new babies should be given opportunities to have makeovers to help rebuild their self-esteem by getting back into shape and build self-confidence.

Participants in one focus group recommended baby-friendly classes for mothers of newborns to help with job searches, developing life skills, budgeting, resume writing, and job training.

#### ***4.8.4 Breastfeeding and Nutrition Support***

Although most respondents to the questionnaire reported that their communities had some sort of support for breastfeeding,<sup>27</sup> focus group participants suggested that comprehensive in-hospital support for mothers wishing to breastfeed be continued with breastfeeding support in the form of coaches within communities. The provision of breast pumps was considered positive by most mothers, though some wished for the higher quality electric ones. Other participants felt that community/Band programs that included incentives for breastfeeding were examples of a best practice. Some examples were breastfeeding courses where the mother received a spa treatment after one year of breast feeding.

Some focus group participants described the difficulty that some First Nations women have with breastfeeding as possibly rooted in experiences of physical or sexual abuse. A properly trained aide or coach would be able to assess this or other potential sources of the problem and seek appropriate help which the woman may not otherwise seek on her own.

A number of women described themselves as unable to breastfeed. They stated that their unsuccessful attempts and the constant pressure from hospital staff contributed to feelings of despair following the birth of their child, even when the source of the problem had nothing to do with them. These women felt that they received very little understanding from care providers and were often not given any assistance with bottle feeding, despite the fact that it was more complicated and costly. They suggested that rather than penalize or compound the guilt and feelings of inadequacy associated with an inability to breastfeed, care givers should include incentives for all mothers.

A program that was very popular among the First Nations women, but which was not available in all communities, was a series of classes on how to prepare home-made baby food and enriched formula. Not only were the mothers able to make baby food, they were each given a blender to take

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<sup>27</sup> Twenty-five of the twenty-nine participants indicated on their focus group questionnaire that they always or sometimes had access to breastfeeding support in their community. Four reported having no access to breastfeeding support.

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home so they could continue the practice. In at least one community, the ability to do this was a result of creative linkages and partnerships with off-reserve businesses and agencies. In that community a local hardware store donated blenders to augment those purchased with First Nations program dollars.

#### ***4.8.5 Parenting Skills and Family Support***

A number of focus group participants identified residential school syndrome and colonization as sources of many difficulties faced by new mothers. Parenting skills traditionally passed from generation to generation but were interrupted by the unhappy experience of separation and drastic life-style changes. As a result, some focus group participants related stories of abuse or alcoholism within their nuclear family which made it difficult for them to consider their parents as good role models. In particular, men often lacked good role models for fathering. The participants suggested that a solution to this would be programming directed at supporting men. They felt this should be run by men, aimed at helping other men identify and deal with issues relating to their role as father. This should include educating them on pregnancy and teaching them how to be supportive partners during pregnancy. Such things as how long after birth sexual relations can be resumed – what is appropriate and when – could be addressed.

In addition to classes for fathers, the women recommended parenting classes that included First Nations values and principals. Parenting classes could address such things as birth control and family planning support.

One group felt that communities need to break cycles of abuse by introducing training and programs aimed at teaching people to recognize the signals of abuse. For instance, children who are acting out are often in families that need help or intervention. They felt that mothers often need assistance to counter abuse within their home and to overcome their own emotional and psychological issues. Where a child is in crisis, the family is probably in crisis.

#### ***4.8.6 Infant Development***

The focus group participants felt that there was a need for programs directed at infant and child development. They recommended that communities collaborate and partner with Head Start programs to allow children under the age of 3 to use the space and equipment (toys) when Head Start classes are not in session. A number suggested that the Brighter Futures model should be brought on-reserve to provide programming for postnatal care. A moms and tots programming modeled on Brighter Futures could be implemented on the reserve. This could assist parents, who could buy and sell or barter for baby equipment.

Other model programs that were offered in some communities or in urban centres were baby massage, well baby clinics where babies were measured and pictures were taken (up to one year old). One participant described a “Toddler Tuesday” directed at mothers and babies between the years of one through four years where gifts, toys and books were shared.

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## 4.9 Band Administration and Community Planning

The participants of one focus group stated that change is sometimes stalled by Band politics – i.e., participants from one community believed that nepotism prevented interventions and may even prevent hiring the best person for the job. They also felt that it often determines who can access programs or services; obtain treatment; and who is provided with special incentives. This was echoed in the comments of another focus group who used the phrase “Start at the top of the outhouse” to say that the leadership must be aware and supportive.

Some participants complained that they were not aware of programs within their communities. It was suggested that pregnant or new mothers need to be informed of financial reward programs and the kind of support that is available to them. Many felt that maternity care dollars were either too small or were not properly expended. They expressed the view that community/Band administrations need to be more transparent and accountable on funding and programming designated for maternity care.

Some participants suggested that there is a need for training and standards for care providers and staff to increase the level of professionalism of health care workers within communities in order to stress the importance of respecting confidentiality, keeping records secure, and generally behaving appropriately. They felt that sometimes community members may not be the best people for the job, but also noted that there is often a distrust of outsiders.

Establishing a vision for maternity care services in the community was considered important by some. The mothers recommended that communities must be empowered to establish goals for maternity care. One group felt that community support for pregnant women and new moms must be made a political priority. They wanted to see the motto “*It takes a community to raise a child*” introduced into First Nations communities. They felt that the linkages between a high standard of maternity care and community needs should be emphasized. One group suggested the following vision statement: *Building moms builds better kids building better communities resulting in a better world.* Another group suggested the following statement for maternity care and community healing: *“Your life, your children, your responsibility.”*

## 4.10 Supports for Loss of a Baby

While suggestions and resolutions proposed in most of the focus groups were overlapped and were similar, some participants, especially those who had lost babies, had specific recommendations in respect of women who lost babies through miscarriage and after birth. They suggested that grief support be provided to mothers who had lost their babies and that ongoing counselling be provided to family members. They also requested resources to help with funeral costs.

## 4.11 Supports for Special Needs or Troubled Children and Their Families

A program of early assistance for troubled children was identified as a need. The women believed that early intervention is in the best interest of the community as a whole and could prevent the social difficulties that arise later in life for troubled children. In most cases, participants felt that the community recognizes which children are in need of intervention but often community members are powerless to do anything. For instance, one participant told a story of a child in their community

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who had a B-B gun which he used to shoot at animals and children. Recognizing violent tendencies, none of the community members wanted their children to play with this child. When the police seized the gun, his parents purchased a new one for him, enabling him to continue his negative, anti-social behaviour. The women agreed that communities need to have the power and resources to intervene. The women felt that if the parents had parenting training, they may have a better understanding of the implications of their child's and their behaviour. However, even if the parents refused parenting training, there should be intervention to assist the child and any siblings.

Some participants identified the need for programs to support mothers with mental disabilities. They indicated that often mothers are afraid to get help because their children might be taken away (like in the residential school experience).

While focus group participants indicated that counselling was available in most communities for the children of troubled mothers, this is not always the case. They felt that often children of mothers with mental or emotional problems do not have anyone speaking for them. These children would benefit from a program or service that provided child advocacy support.

Children with FAS/FAE or other disabilities should not be treated as sub-standard. Programs directed at assisting parents to raise their special needs child are required. In addition, a program of support is also needed within the school system as some of the focus group participants indicated there was no such support available in their community's school. One focus group referred to the need for proactive and support services for children with attention deficient disorder. They felt that the drug Ritalin was over-prescribed.

A number of focus groups identified smoking as a major problem resulting in health problems such as a growing number of children with asthma. They saw the need for smoke-free spaces within the community and smoking cessation programs for all family members. In addition, incentives should be provided for family/communities to become smoke-free except when using tobacco for spiritual purposes.

#### **4.12 Other Suggestions**

First Nations women participating in the focus groups provided a number of other suggestions relating to neo and post -natal maternity care, including:

- Broader and more flexible schedule for vaccinations.
- More contact with the doctor or (Ministry) Health Nurse.
- Locally accessible and weekly physiotherapy/chiropractic services.
- The availability of trusted day care services within the community.
- Maternity leave.
- Programming for First Nations women in the corrections system.
- Support for homeless women.

## 5.0 Culture and Tradition in First Nations Maternity Care

### 5.1 Traditional and Cultural Practices

Participants were asked to share their thoughts on what cultural and traditional maternity practices are still used today. They were also asked to consider what prevents cultural and traditional practices from being used or blended with maternity care and, if or how this could be resolved.

Twenty-one out of twenty-nine respondents (72 per cent) to the focus group questionnaire reported that they did not follow any traditional or cultural practices during their pregnancy or birthing. (See Table 7)

Traditional Practices During Pregnancy	Total Number of First Nations Respondents (n=29)		
	Yes	No	Did Not Answer/Know
Followed traditional practices during pregnancy	7	21	1
Used herbs and medicines	3	26	-----
Used special foods or drinks	1	28	-----
Participated in traditional ceremonies	4	25	-----
Followed teachings or practices	4	25	-----
Followed traditional birthing practices	-----	29	-----
Ceremonies during birth	-----	29	-----
Followed other traditional practices	4	25	-----

**Table 7:** Number of First Nations respondents who followed traditional practices during pregnancy

As previously mentioned, almost one-half of respondents in the questionnaire (13 out of 29, 45 per cent) reported that prenatal traditional/cultural supports were “always” (7 out of 29) or “sometimes always” available in their community, and an equal number reported that they were not available. However, over 70 per cent (21 out of 29) of the women indicated that midwife/doula prenatal services were not available in their communities. (See Table 2) In addition, over 60 per cent of respondents (18 out of 29) said that they did not have access to postnatal traditional or midwife supports in their community. (See Table 5)

Some focus groups reported that culture and traditional practices are almost lost within their respective communities. In these communities, there is very little talk from Elders to the young people due to the influences of Christianity. These participants also attribute the loss of culture to the failure of communities to actively practice their traditions. Some focus groups were reluctant to engage in a discussion of traditional cultural practices. However, in most instances the questions lead participants to share what they remembered being taught as children about childbirth and the customs and cultural tools used to assist women in that experience.

The following is a listing of some of traditional practices and beliefs discussed by focus group participants as once the norm in maternity care for First Nations communities:

- Medicines were used to purify the blood and induce labour for the women.

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- Expectant mothers were taught to “lie on mother earth” to sleep in order to gain strength and help them carry their babies.
  - If you keep your feet warm and the baby’s feet warm, you will grow to be strong.
  - Traditional food practices - Elders say not to eat certain foods when pregnant due to health risks.
  - Cedar baths help balance and purify - especially pouring cedar water over your head three times.
  - Drink warm water.
  - Rabbit soup was considered a good meal to eat, since rabbits feed on a lot of medicines.
  - Don’t cut your hair.
  - Don’t go to funerals or walk in a graveyard.
  - Lots of physical labour (in the past).
  - If children were in attendance at the childbirth, they were taught to observe quietly.
  - Elders were always present during childbirth.
  - Moss was used to wrap a baby once it was born.
  - Traditional treatment of the placenta.
  - Don’t lose the baby’s belly button.
  - A baby bonnet was placed on the baby will help to keep the family knowledge within the children.
  - Put leaves on the baby’s eyes to promote good dreams.
  - Cedar, sage and sweet grass was used for baths, sweats and purification.
  - Wrap the baby tight and carry it next to you so it feels secure.
  - When a child reaches your waist, he/she shouldn’t sleep with you (adult) anymore.

The reasoning behind the beliefs was discussed in some focus groups where the participants compared traditional teachings with modern practices.

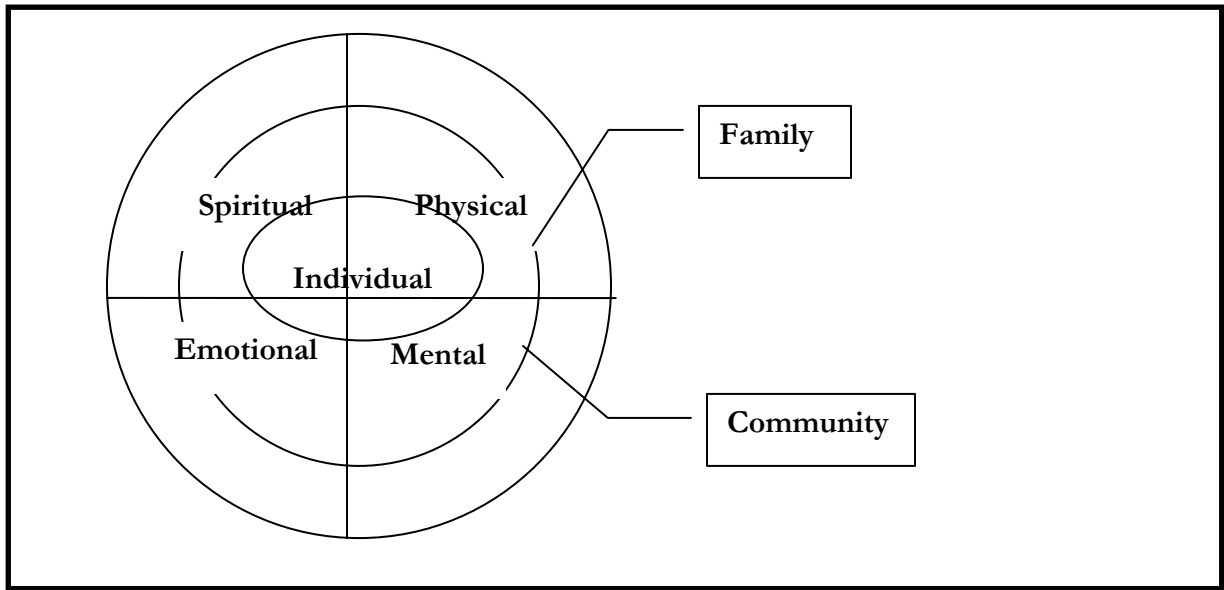
## **5.2 Reinforcing Cultural and Traditional Practices**

The participants were asked to discuss how cultural and traditional practices could be reinforced or introduced into maternity care. This stimulated a number of discussion areas, including in at least one focus group, the idea behind what is culture and tradition given the dynamic nature of these and the experience of First Nations over the past two hundred years.

Parts of these discussions related to the philosophical perspective of First Nations. Women in two different groups designed diagrams of traditional philosophically-based service delivery models. While these focus groups were conducted in different cities with unrelated participants from discrete First Nations, the similarity in design is striking.

### ***5.2.1 A First Nations Cultural Paradigm***

The importance of a more holistic paradigm for maternity care and infant care arose in several discussions. In the Ottawa discussion, the participants drew the following representation of the philosophical basis for maternity and health care.



**Figure 1:** Aboriginal Paradigm for Care – Medicine Wheel

It was explained that wellness includes all the elements of the Medicine Wheel, which provides a model to teach from. Participants felt that the issues relating to pregnancy and maternity care go beyond just maternity care. They were of the opinion that the cultural implications of pregnancy are within the mother’s mind at all times, since she has responsibility for all aspects of the child’s well-being as shown in the medicine wheel.

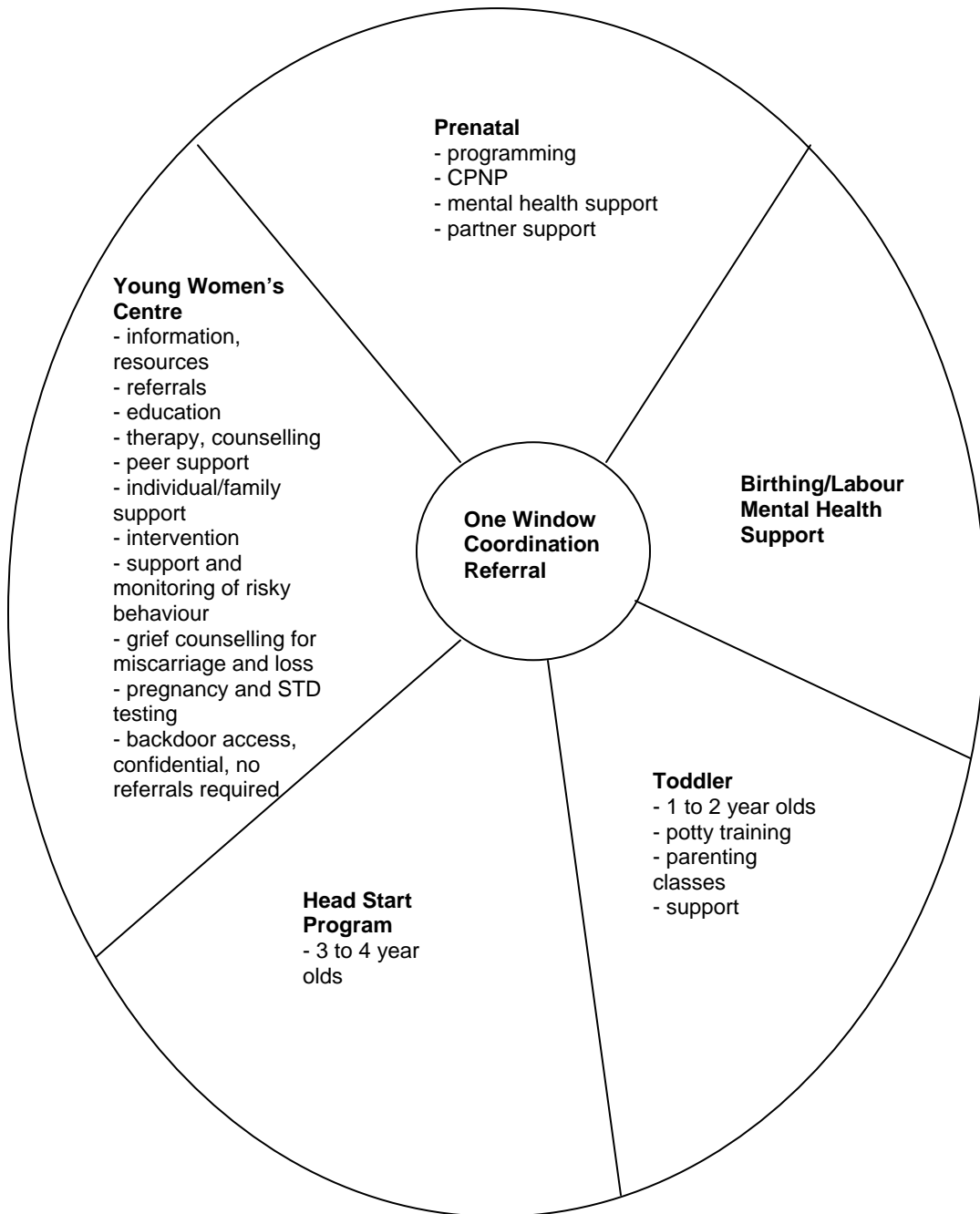
Focus group participants felt that the culture and traditions evoke a more spiritual experience than the western medical model of maternity care, therefore traditional practices and knowledge provides a safe environment for pregnant mothers. As described by some participants, pregnancy represents a life within, which symbolizes a broader context and understanding as symbolized in the Medicine Wheel. The health of the individual cannot be removed from the health of the community. Some First Nations communities are not safe, and the members know this. The women in these groups were of the view that change (rejuvenation) was possible, but it was dependent on the young people. Such things as long-standing family divisions, etc., could be overcome by the young people, who don’t know or care why the divisions came about in the first place.

The idea of holistic care was pervasive in the comments of all focus group participants. A number of participants expressed difficulty in separating the maternity experience from the life experience within the family and the community. As a result, some discussed the impacts of colonization, residential schools and family dysfunction as hindrances to wellness and to perinatal and infant health and felt that these need to be addressed within a model of maternity care.



### 5.2.2 A Cultural Model for Maternity Care

The following is a model designed by participants at the Saskatoon focus group as a way to organizing a holistic approach to maternity care programs and services on-reserve.



**Figure 2:** A Holistic Approach to Maternity Care

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### ***5.2.3 Reinforcing Traditional Values***

Some focus group participants saw the need to reinforce traditional values such as respect through community responsibility for children. They felt that this starts with addressing the parent's issues. Mothers need to be willing to change and they need to have options to change their negative behaviours.

There was a particular emphasis on the need to revive the traditional position of mothers. Mothers were considered as central to the community and children were the community's children and mothers were therefore cherished and supported. It was felt that women had lost their status and it was up to them to revive their traditional roles and engage in supportive activities.

Participants in one focus group observed that in many communities, the traditions are not practiced or taught. Sometimes people may hide what they know out of embarrassment and would share their knowledge if they were in a safe environment. They felt that there should be an opportunity for support and sharing through women's retreats and women's conferences.

This group expressed the view that men are equally implicated in maternity care as fathers. They believed that this role too has been overlooked and undervalued. Men's retreats should also be encouraged to teach the roles and responsibilities of fatherhood as well as how to give care.

They saw the importance of restoring balance within the communities. Both mothers and fathers need to be educated and supported in fulfilling their roles as parents. For instance, the group suggested the need for couples' retreats. They stressed that this should not be labelled as a treatment program. Rather, they felt that incentives could be offered to couples in order to encourage participation.

Women traditionally supported one another, but this had been lost. Women's Talking Circles needed to be revived so women had mutual support and social activity. Women's retreats could be organized. The women Elders would probably be more interested in sharing if asked to attend a woman's retreat. In order to instigate or revive this, women could be surveyed within each community to establish the level of interest in participating in a retreat. They suggested that although they may need financial support, communities could look at fund-raising, etc., to hold an initial retreat.

### ***5.2.4 A Maternity Care Centre***

A number of groups suggested the creation of First Nations maternity care centres. Several described them in some detail. One participant spoke about her dream of a First Nations Maternity Care Institute built like a "keekwilee" (a traditional underground house) where moms could learn about and give birth in First Nations cultural surroundings. She would be supported in her own environment with access to people who had traditional knowledge.

Another group spoke of the need for a Native birthing centre, run by First Nations people where the families would be welcome and mothers would not have to worry about disrespectful providers. This would allow mothers to give birth in comfort and deal with their pain without concern about cultural differences.

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They described the need to select ground that could accommodate a building of the four directions, built in prayer and community consensus. Sweet grass would be provided in the birthing room and there would be a sweat lodge outside. The concept would be respectful of different Nations. There would be Elders residing at the centre and visiting those who required assistance. Traditional foods would be available. The birthing rooms would have music, candles, and water. Mothers would be given options for alternative ways of birthing.

The centre would provide pre and post -natal care. Modern technology would be available if needed, along with traditional medicines. The centre would offer one-on-one birth planning, accommodating what the mother and the family wanted. It would be accessible and affordable (set-aside budget) and would include monies for hiring Elders and giving gifts.

Some groups identified the need for an Early Years Centre on the reserve where the traditional ceremonies such as those celebrating birth, welcoming baby, and the walking-out ceremony would be practiced.

One participant described a positive program that is practiced in some northern communities. There, the expectant mothers can learn to make “Tikanagan” (cradleboard) and moccasins or reinforce traditions through moss bag making or making snugly slings for their infants. It was agreed that this was a practice that occurred in select communities only, but participants saw it as desirable.

Participants in most focus groups agreed with the need to reinforce traditions and culture throughout the maternity experience. Traditional ways of naming meant the community and Elders took a real and lasting interest in the child. Birthing ceremonies and acknowledgements by such community members as the Grand Chief helped reinforce the sense of community and in still strength.

While western medical practices have become the norm, most participants felt that First Nations women should be supported through the use of traditional remedies to treat infants and mothers. This may also build respect for First Nations traditional values by the non-Aboriginal society. One group suggested that this would be assisted if there were more Aboriginal health-care professionals serving their communities. They felt that midwifery services should be offered. They also felt there was a need to obtain information and promote the use of cultural and traditional methods.

## **5.3 Obstacles to Implementing Traditional Maternity Care Practices**

### ***5.3.1 Impacts of Colonialism***

When asked what obstacles prevented the implementation of practices that would promote the traditional or cultural maternity care practices in their communities, participants from nearly all groups identified a loss of culture and tradition as a primary barrier. There was a general lack of knowledge of traditions which participants attributed to the colonial experience. Some felt that the values had been eroded by the philosophy of individualism. Community members lacked confidence in the traditional ways, because in large part they were ignorant of the practices as they are not known or practiced in the community. The proximity of medical care that uses advanced technologies encouraged a reliance on western medicine. There was a fear of taking risks, so it was easier to simply rely on the status quo.

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Beyond this, some participants saw a deficiency in the sharing and communication of cultural and traditional knowledge due to fear of “diluting” the culture. Many traditionalists are accustomed to keeping the knowledge in secret. There is no readily available source where tradition and culture can be found but it is slowly being revived. For instance, language is being taught in some schools, but there is often a lack of community support for language classes. On-reserve programs are often perceived as substandard academically.

Participants saw a strong link between the language and culture, and believe that there are long-term consequences of losing a language. However, even for those who can’t speak the language, often First Nations words are incorporated into English (or French) to describe culturally specific practices. Some participants indicated that occasionally Elders look down on the language, believing it is no longer useful. There is a problem with “phoney” traditionalists.

### ***5.3.2 Community Division***

Focus group participants pointed out that the community has created barriers such as status and non-status due to the internalization of racist definitions. These divisions are often compounded by a population exodus in some communities and the fact that the community is spread out throughout the country, meaning it is difficult to reach, identify or communicate with all the members. The community’s financial limitations often prevent effective communication with the membership and the implementation of successful cultural programming. Furthermore, these barriers reinforce artificial divisions within the membership, such as status and non-status, and on and off-reserve. Dysfunction is internal and sometimes it is a result of family breakdown.

### ***5.3.3 Lack of Resources***

Sometimes the ability to practice cultural events was determined by the resources available to the family. For instance, where welcoming or naming ceremonies were the sole responsibility of the family, those who were financially better off were able to have them, while those with no resources or little family may not be able to afford them.

Additionally, some mothers were unable to access the practices where these required travel or financial expenditure. The lack of funding for Native birthing centres was considered a barrier to the revival of culture and traditional maternity care practices. The lack of properly trained people who understood culture and traditions led to the entrenchment of the status quo – there was a sense that this is the way it has been done, so why change it?

Some participants felt that the decisions and priorities in relation to funding and maternity care tended to reflect the values of an elite bureaucracy, not First Nations members. There was an impression that money was absorbed within a government bureaucracy that did not know the communities. Participants expressed the view that very little money trickles down to the community level and what little money is allocated to social programs within the community is often directed to other pressing priorities.

Participants expressed frustration with the difficulty with funding arrangements that are depended on quantifiable results and evaluation. They felt that when it came to the incorporation of culture and tradition into such things as maternity care, it would be difficult to prove benefits in a quantifiable way.

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## 5.4 Supporting Cultural and Traditional Methods

The focus group participants were asked to suggest how cultural and traditional maternity care practices could be revived or supported within the communities. They had a number of suggestions.

Many felt that there should be a position within the Band infrastructure in charge of enabling the collection and transmission of cultural and traditional wealth. This may include designing interactive community or other forums for the sharing of information by the older people and Elders. They could collect and provide information on what is available. For instance, one mother described a handbook on the language, culture and traditional practices of one Aboriginal nation which she had found useful.

The responsibility of the Band Councils, which many identify as being in control, was seen as essential to the incorporation of culture and tradition in perinatal services. One group saw the need for Band Councils to demonstrate greater involvement through such things as Council member involvement in welcoming the child's arrival.

The participants suggested that it would be most appropriate for the communities to show greater interest in a holistic approach for perinatal care. The entire community should have access to the existing facilities and services such as the long house. Some participants felt that culture and tradition should be emphasised for community healing and growth over and above its utility for economic development such as tourism. Education and information on traditional practices should be encouraged for all community members. This could be done by having the Elders of the community teach community members and those servicing the membership. Wherever possible, Elders could be involved in traditional parenting courses. Information on the services offered by midwives should be generally available and mothers should be educated so they gain confidence in such methods.

Some participants felt that funding should be available for mothers to buy the supplies they need to engage in cultural activities. For instance, beads, hide, transportation should be provided at no cost. One group recommended that the women of the community, rather than First Nations government staff, should plan and implement a program aimed at reviving traditional practices. One method they discussed was a community cultural healing circle (similar to the justice circle).

It was pointed out that many Bands will only help their on-reserve members. Participants felt that resources should be available for all Band members, whether they live on or off the reserve.

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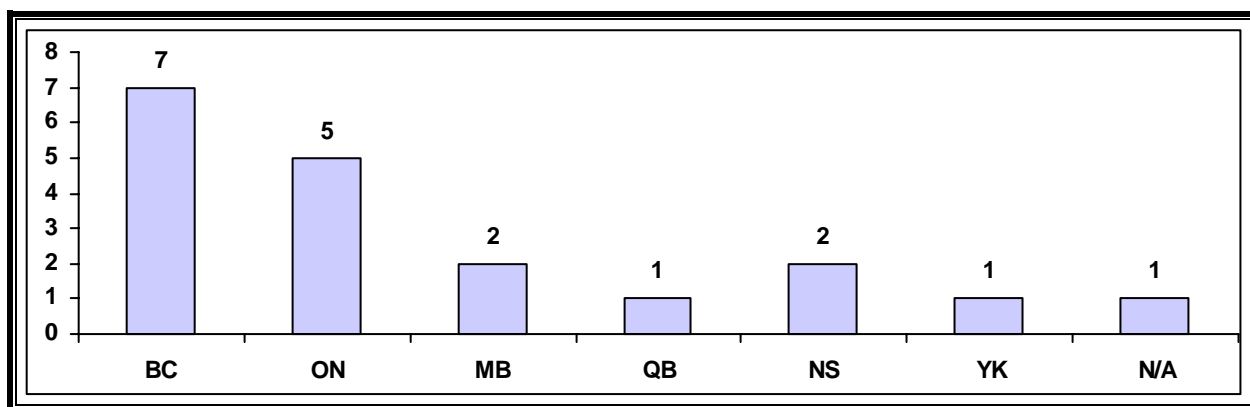
## 6.0 Professional Key Informant Interviews<sup>28</sup> on First Nations Maternity Care

### 6.1 Profile of Professional Informants

The second element of this preliminary needs assessment involved administering a questionnaire to health service providers. A total of 23 health service providers were interviewed and 19 qualified to be included in the report on First Nations maternity care needs assessment.<sup>29</sup> Of the professional informants interviewed, 16 were female and 3 were male. All provided some sort of maternity service to First Nations women living on-reserve. Ten were nurses and three were physicians. Two were prenatal nutrition workers, and one was a dietician. In addition, a breastfeeding promotion coordinator and a midwife were interviewed.

As a whole the informants were reasonably experienced at working with First Nations women. Most (12 out of 19, 63 per cent) had worked with First Nations women for between six and fifteen years. Two had worked with First Nations women for over fifteen years and four had worked with First Nations women for five years or less.<sup>30</sup>

The largest percentage of informants was from British Columbia (7 out of 19) and Ontario (5 out of 19), the rest were from three other provinces, including, Manitoba, Quebec and Nova Scotia, and the Yukon Territory. One professional informant did not indicate his/her last region of practice. (See Chart 6)



**Chart 6:** Last region of practice of professional informants

Sixteen of the nineteen informant interviewees (84 per cent) described themselves as working on-reserve. Just over one-half (10 out of 19, 53 per cent) described their location as rural, while just under one-half (8 out of 19, 42 per cent) said they were situated in remote communities. Six (32 per cent) were in urban settings, one in an Inuit community while one stated “other.”

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<sup>28</sup> The terms “professional informant,” “informant,” “practitioner,” and “respondent” are used interchangeably in this section of the report.

<sup>29</sup> The four professional informants that were excluded from the telephone questionnaire pertaining to First Nations maternity care needs assessment had worked exclusively within Inuit communities and are included in the Inuit maternity care needs assessment under Part II of this report.

<sup>30</sup> One professional informant did not respond to this question.

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## 6.2 Rating Community-Based Access to Maternity Care

When asked how they would rate the access to community-based maternity care for First Nations women, 2 out of 19 found it to be good (11 per cent), one said it was adequate to poor (5 per cent), 4 informants said it was poor (21 per cent) while 7 of the 19 (37 per cent) said it was adequate to average. (See Table 8) By way of comparison, 25 of the 29 First Nations focus group respondents (86 per cent) indicated that they were sometimes or always happy with their prenatal care. Similarly, 25 out of 29 were sometimes or always happy with the support they received while giving birth and afterward.

Rating Access to First Nations Community-Based Maternity Care	Total Number of Respondents	As a Percentage of Total Respondents (n=29)
Good	2	11%
Average	7	37%
Adequate	4	21%
Average to Poor	1	5%
Poor	4	21%
Did not answer/know	1	5%
<b>Total</b>	<b>19</b>	<b>100%</b>

**Table 8:** Rating access to First Nations community-based maternity care by professional informants

In elaborating their answer, these maternity care providers cited the shortage of maternity care professionals or specialized maternity training as a key reason for their response. One informant stated that there is sometimes only one CHR available in the community. Others referred to the lack of maternity training for care providers, a shortage of facilities and services within the community and a lack of maternity/perinatal care programs (i.e. prenatal health) in the community. Women in some communities are flown out to give birth. In these circumstances, they don't know the doctor and may be unfamiliar with the hospital.

Hospitals were not always culturally sensitive to First Nations women so some health care providers were reluctant to rate access as good. For those describing the access as good, the maternity care providers stated access to professionals, services and programs was good in urban centres; however, First Nations women were sometimes unable to access care in a timely fashion (i.e. few physicians deliver and few take new patients). Accessibility to professionals, services, and programs was described as better in non-isolated communities than in more isolated and/or remote communities.

## 6.3 Medical Diagnosis of Pregnancy

In general, the professional informants reported that the availability and quality of diagnostic services for First Nations women vary from community-to-community based on geographic location and degree of isolation.

Almost one-half of informants (9 out 19, 47 per cent) described First Nation women's access to medical diagnosis of pregnancy as good. (See Table 9) Informants, noted however that in some communities it is difficult for the woman to visit a doctor and in most rural or remote communities, the First Nations women must travel to gain medical diagnoses. In other situations, the women must

be referred to specialists out of town. Often First Nations women who are referred off-reserve for diagnostic services do not access these services due to reasons usually relating to cultural differences, ill-treatment, or racist attitudes by health care providers which make the women uncomfortable. Sentiments such as these were raised by the First Nations focus group participants.

Rating Access to Medical Diagnosis for Pregnancy	Total Number of Respondents	As a Percentage of Total Respondents (n=19)
Good	9	47%
Average	4	21%
Adequate	3	16%
Poor	3	16%
<b>Total</b>	<b>19</b>	<b>100%</b>

**Table 9:** Rating access to medical diagnosis for pregnancy by professional informants

In most communities, CHNs at nursing stations are available for diagnostic services. The midwife informant indicated that her services were accessible on the reserve but First Nations women seldom use them. The focus group participants echoed this in their responses, with a majority of the women (21 out of 29, 72 per cent) stating that midwife, doula or traditional birthing assistants are not available in their community.

Some maternity care workers stated that pregnancy tests/kits are given out at health centres/local clinics, or the community health nurse can administer pregnancy test. The registered nurse and nursing station are the primary means of diagnosis. This perspective was confirmed in the focus groups but is reflected less in the questionnaires.<sup>31</sup> Some health care providers commented that it is difficult to get in to see a doctor due to shortages and the resulting long waiting times.

Six informants felt the diagnostic tools available to medical practitioners treating First Nations women during pregnancy were good compared to twelve who rated these as average, adequate or poor. (See Table 10) Practitioners indicated that tools and equipment are unavailable (i.e.: Doppler, monitors, ultrasound) especially in small and remote communities, and where they are available, they are outdated, or the staff lacks the proper training to use the tools and equipment. As a result, women must usually travel outside their communities, even for fairly routine tests, such as ultrasound and genetic testing. Sometimes funding for transportation for women to travel outside of the community for treatment is an issue. Beyond this, practitioner interviewees noted that First Nations women do not have choices in relation to medical personnel and treatments, or their choices are very limited.

Most practitioners regarded the medical facilities available to practitioners treating First Nations women during pregnancy as average. Four said they were good in their community while two did not respond. (See Table 11)

<sup>31</sup> The focus group participant questionnaire indicates that most respondents confirmed their pregnancy with self-administered home pregnancy tests/kits.



Rating Availability of Diagnostic Tools for Pregnancy	Total Number of Respondents	As a Percentage of Total Respondents (n=19)
Good	6	32%
Average	5	26%
Adequate	3	16%
Poor	4	21%
Did not answer/know	1	5%
<b>Total</b>	<b>19</b>	<b>100%</b>

**Table 10:** Rating the availability of diagnostic tools for pregnancy by professional informants

Rating Availability of Medical Facilities for Pregnancy	Total Number of Respondents	As a Percentage of Total Respondents
Good	4	21%
Average	7	36%
Adequate	2	11%
Fair	1	5%
Average to Poor	1	5%
Poor	2	11%
Did not answer/know	2	11%
<b>Total</b>	<b>19</b>	<b>100%</b>

**Table 11:** Rating availability of medical facilities for pregnancy by professional informants

One respondent noted that many facilities were being closed. This informant indicated that there was a lack of doctors and specialists in small towns, thereby affecting access to facilities by many First Nations women. In some communities, there were few or no facilities. One practitioner commented that frequently even when reserve communities have health facilities, they often are not geared to pregnant women. There was not only a lack expertise in providing maternity care services, but a lack of facilities and equipment. It was noted that the availability and quality of facilities vary by community. However, one practitioner noted that even where services and facilities were available in urban centres, they did not often reflect indigenous sensitivities.

## 6.4 Prenatal Medical Support

Most practitioners (9 out of 19, 47 per cent) felt that prenatal medical support for First Nations women was adequate to good. (See Table 12) They noted that nursing stations and CHNs provide most services on-reserve – “nurses are the cornerstone to the care of Aboriginal women.” Geographic barriers often prevent women from getting to prenatal classes and support outside community, so if services are not offered in the community, there is little or no access. Health care informants noted the lack of physicians, specialists, and OBGYNs to assist with birth in communities and acknowledged that women must travel, some for long distances, out of communities to access specialists or OBGYNs.

Rating Availability of Prenatal Medical Supports	Total Number of Respondents	As a Percentage of Total Respondents (n=19)
Good	4	21%
Good to Average	1	5%
Average to Good	1	5%
Average	4	21%
Adequate	5	26%
Average to Poor	1	5%
Poor	2	11%
Did not answer/know	1	5%
<b>Total</b>	<b>19</b>	<b>100%</b>

**Table 12:** Rating availability of prenatal medical supports by professional informants

One practitioner remarked that in his/her community, the care was excellent. There the doctors came to the reserve, there was a parenting course, and courses for mothers.

Despite this, some practitioners noted that there was a high turnover and inconsistent qualifications among nurses delivering maternity care. It is likely that basic “medical” support is accessible on-reserve, but for some communities this does not include adequate transportation, food, community, family network, childcare, recreational opportunities and things that lead to overall wellness.

Sometimes Band members living off-reserve are placed on waiting lists for family physicians, jeopardizing the opportunity for early diagnosis of complications.

Information needs are usually met through a nutrition counsellor, videos and pamphlets. According to informant interviewees there is a lot of information available for pregnant women.

## 6.5 Type of Care Available During Pregnancy

When it comes to medical support, all 19 practitioners commented that First Nations women usually have steady access to a nurse during their pregnancy, but their tertiary caregivers seldom have any education about or experience with First Nations. They are not familiar with the culture and may have stereotypical or negative attitudes toward First Nations women. Additionally, nursing is always available in hospitals and on the reserve, but often nurses on the reserve perform a variety of functions and may not be as available as they should for maternity care. Seventeen of the nineteen professional informants (89 per cent) said that counselling was available and 15 out of 19 (79 per cent) commented that physicians were available during pregnancy. (See Table 13)

Type of Care Available During Pregnancy	Total Number of Professional Informants (n=19)		
	Yes	No	Did Not Answer/Know
Counselling	17	2	-----
Support Group	10	9	-----
Nurse	19	-----	-----
Physician	15	4	-----
Midwife/Doula	10	9	-----
Specialist	10	9	-----
Traditional Healer	8	11	-----
Other	13	6	-----

**Table 13:** Type of care available during pregnancy as reported by professional informants

The interviewees observed that in the hospital, the nurses are always there for delivery but they sometimes seem not to trust the judgement of First Nations women. A comment echoed in both the informant interviews and the focus groups was that frequently hospital caregivers do not listen to the women. One interviewee gave the example of a nurse who had refused to believe a First Nations woman when she advised her that she was about to deliver and was only able to get one glove on for the birth. No doctor attended, as he/she had not yet been called.

One interviewee observed that the women see physicians, but not as often as may be needed. As mentioned earlier, babies are delivered at the hospital by the doctors. The medical treatment is good, but there are too few Native doctors and usually the hospital does not try to accommodate the special needs of Aboriginal women. There is normally adequate medical support that is available.

Depending on the community, a variety of specific and non-specific programs are available to the expectant or new mother. Before and after delivery, the mother generally has access to counselling, Canadian Prenatal Nutrition Program (CPNP) workers, as well as information about the effects of drinking, smoking and drugs.

Nursing is always available in hospitals and on the reserve, but not specific to maternity care - nurses on the reserve perform a variety of functions and may not be as available as they should for maternity care. Midwives and doulas are available outside the community in urban centres but not in more remote and/or rural communities. Specialists are available, but sometimes women have to be transported great distances to access specialist care. Traditional healers are available in some communities but according to one interviewee, in other communities, there are strong Christian fundamentalist beliefs which discourage the use of traditional healers.

## 6.6 Prenatal Care and Services

Prenatal care for First Nations women varies depending on the geographic location of the community. While there is often limited access to physicians, interviewees report an array of other programs aimed at assisting pregnant women. A number of comments reflected the lack of stable care from physicians, the CHN, prenatal nutrition workers, and programs such as NNADAP figured

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prominently. Some interviewees also indicated that prenatal classes are available, though not always on the reserve. This was consistent with the comments of the focus group participants.

There were a variety of prenatal programs mentioned including prenatal addiction programs both in urban centres and on-reserve, and prenatal nutrition programs. In one community there is a doula but the practitioner interviewee was not clear how much she is used. One interviewee commented that recently there were pre-birthing sessions with the doula and fathers which went quite well, but the sessions had not yet been readily accepted. Access to traditional healers varied.

One practitioner reported that in his/her community, there were numerous resources for maternity care, including a CHN, CHR, mental health counsellor, alcohol/drug counsellor, and a clan mother who provided informal support group for expectant or new mothers, a doctor visited the community on a weekly basis. Another interviewee indicated that his/her community had three nurses and doctor visits approximately once a month. The community was close enough to town for mothers to visit as required. There is no midwife or doula there, but one could be arranged through the hospital in town, if the mother desired to have her baby at home. In this community, a specialist is available several times a year. There were Elders in the community available if needed. This full compliment of caregivers was not universally available.

In some communities, the interviewees reported a total lack of equipment for neonatal care or high-risk delivery. They stated that these communities lacked the ability to do caesarean sections, had no physician on the reserve, and lacked a maternity worker. Consequently, if an emergency such as early delivery arises, the mother must be medivaced out. This comment was echoed by a number of informants who noted that physicians may not be available in remote communities.

Specialists are only available in hospital settings that have tertiary care. OBGYNs are occasionally available at the hospital and, in some situations there is also a nurse practitioner at the local hospital. If one is considering birthing based only on facilities, equipment and medical personnel, most women have access to similar treatment. As such, women who have to fly-out to deliver in urban centres have access to the same services as those residing in urban centres. They may also have family at birth, but if they have to leave their community this is an issue since only the mother can travel.

Although in urban and some rural areas, women have better access to midwives and doulas, one respondent commented that in some First Nations communities where there have been a number of early deliveries, the same women attended the births. Though not formally trained, these traditional midwives had learned through experience and were recognized as such within the community. In some communities, accredited midwives or doulas are available at extra cost to the mother, but they are seldom based on the reserve. One practitioner interviewee indicated that there is a doula available in his/her reserve, but coverage for her services is not provided by Health Canada so few First Nations women can afford her.

In some areas, traditional healers could be brought in to assist, and depending on the family's wishes and hospital policies, they may be allowed in at the birth. In some communities health nurses were able to attend the birth at the request of the mother. One interviewee commented that although traditional healers are available in one hospital in which he/she provides service, they were generally not used.

The CHR is also available for labour support and coaching in some communities. Practitioner interviewees described most families as supportive, with sometimes as many as ten to fifteen family members in the delivery room. This was echoed in the comments of focus group participants. A number of interviewees indicated that the drug and alcohol support workers have attended birthing at the mother's request. Some communities have also instigated a program of lay home visitors who provide perinatal support to new mothers providing information and visiting her in her home. The comments suggest that social workers and dietary services are available in most communities and there is an emphasis on diet and nutrition.

## 6.7 Birthing and Delivery Care Services

When asked to rate the medical facilities and equipment available to medical practitioners providing support to First Nations women during childbirth and delivery, over one-half of the practitioners (14 out of 19, 74 per cent) responded that these were adequate, average or good. (See Table 14)

Rating Availability of Medical Facilities/Equipment for Childbirth and Delivery	Total Number of Respondents	As a Percentage of Total Respondents (n=19)
Good	3	16%
Average	6	31%
Adequate	5	26%
Poor	3	16%
Did not answer/know	2	11%
<b>Total</b>	<b>19</b>	<b>100%</b>

**Table 14:** Rating availability of medical facilities/equipment for childbirth and delivery by professional informants

Type of Care Available During Childbirth and Delivery	Total Number of Professional Informants (n=19)		
	Yes	No	Did Not Answer/Know
Counselling	19	-----	-----
Support Group	19	-----	-----
Nurse	17	2	-----
Physician	17	2	-----
Midwife/Doula	12	7	-----
Specialist	11	8	-----
Traditional Healer	4	15	-----
Other	7	12	-----

**Table 15:** Type of care available during childbirth and delivery as reported by professional informants

This was explained in the practitioner comments that childbirth rarely occurs on the reserve. Although one practitioner reported that the women in her community had access to a midwife, none of the reserves had medical facilities or equipment to deal with birthing or pre-term labour. As a

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result, apart from exceptional circumstances,<sup>32</sup> First Nations women give birth off the reserve in regional hospitals. According to the findings of the First Nations focus group questionnaire, 17 of the 29 respondents reported that they had to leave their community to give birth. Of these, 2 were flown to the hospital to give birth and 15 were transported by car or ambulance. The remainder either did not respond (2 out of 29) or responded that they did not have to leave their community to give birth (10 out of 29). Since 23 out of 29 reported that there were no birthing facilities in their community, the discrepancy is likely explainable by the proximity of the participant's community to an urban centre with a hospital.

In some cases, the women must be flown out between 2 to 6 weeks before their due date, but where the woman encounters complications with her pregnancy or risks pre-term delivery, she may have to leave even earlier. While most practitioners considered the regional hospitals to be reasonably well equipped, there were variances in the quality of care based on geographical location – the larger the centre, the better the equipment and facilities. The problem, according to some interviewees, is not with the facilities and equipment, but rather with the dislocation of women from their home and community at this important time. They are placed in unfamiliar surroundings with strangers who often bear negative attitudes fraught with prejudice and racism. Because the First Nations women are alone when birthing such a distance from home, they are totally disempowered.

Even for those less than a plane-ride from their home, birthing can be a negative experience. As one practitioner interviewee explained, the First Nations women are often younger than non-Aboriginal mothers and they are frequently regarded by hospital personnel as too young to be pregnant. The staff therefore treats them negatively. When they are subjected to discriminatory attitudes by those within the system, their birthing experience is tainted with shame and guilt. Furthermore, in the opinion of some interviewees, racism means that the women may not be cared for to the standard that they should be. There are serious trust issues due to racial prejudices, but First Nations women are too polite to say they're not comfortable with a physician. There is seldom a choice of practitioner so women often feel they have to accept the condescending attitude and their treatment.

Because there is a lack of Native doctors and nurses within the mainstream health care system, the women are often left with few hospital caregivers to whom they can relate. A number of interviewees were of the view that if they could give birth within the community, First Nations women wouldn't be subjected to these negative attitudes, would be less stressed, and would ultimately be better equipped for their perinatal experience.

## **6.8 Postnatal Care and Services**

The care available to First Nation women and their newborns varies, but what is clear is that there are a variety of programs geared toward assisting the new mother with nutrition, nursing, and healing. A number of respondents mentioned the Canadian Prenatal Nutrition Program (CPNP) which sometimes includes welcome baskets for the new born including baby supplies and information for the mother. Some programs include vouchers that the mother can bring to the health centre and purchase supplies. Communities occasionally run activity groups such as building a scrap booking for baby where new mothers can get peer support. However, the availability of support groups is dependent on the band. In some communities, the CHR and lay home visitors are

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<sup>32</sup> One respondent reported that there had been a home birth in their community.

key components in the post-natal visits. There are supportive services such as counselling for women who suffer abusive relationships and those with addiction problems.

Most of those interviewed stated that the Community Health Nurse does an initial in-home post-partum visit which may incorporate cultural component. After the initial visit, home aftercare may be left to the CHR or lay home visitors (where available). For programs such as the nutrition or breastfeeding, the informant interviewees found that incentives, such as food vouchers or coupons, were effective in some, but not all cases. Respondents who were medical practitioners noted that compliance is a common problem. Even with incentives, women often miss their appointments.

Type of Care Available Post Childbirth and Delivery	Total Number of Professional Informant Interviewees		
	Yes	No	Did Not Answer/Know
Counselling	15	4	-----
Support Group	12	7	-----
Nurse	19	-----	-----
Physician	17	2	-----
Midwife/Doula	10	9	-----
Specialist	12	7	-----
Traditional Healer	10	9	-----
Other	5	14	-----

**Table 16:** Type of care available post childbirth and delivery

Breastfeeding support is an important component of postnatal care mentioned by both the professional informants and the focus group participants. Breast feeding is encouraged and there are support certificates to help families with food so they don't have to worry about proper nutrition while the baby is breast feeding.

## 6.9 Level of Support Available to First Nations Women

Professional informants were asked to rate the level of support available to First Nations women in their communities. The majority of respondents (14 out of 19, 74 per cent) found the level of support to be average (6 out of 19) or good (8 out of 19). Four respondents (21 per cent) felt that the level of support was adequate (3 out of 19) or poor. (See Table 17)

According to the professional informants, the level of maternity support to First Nations women in their communities varies. In some communities it is good, in others poor. Some have well organized programs, with current, well prepared information for the mothers and they are fun to attend. Other communities do not have any programs at all.

Rating the Level of Available Support in Communities	Number of Respondents	As a Percentage of Respondents (n=19)
Good	8	42%
Average	6	32%

Adequate	3	16%
Poor	1	5%
Did not answer	1	5%
<b>Total</b>	<b>19</b>	<b>100%</b>

**Table 17:** Rating the level of available support to First Nations women in communities by professional informants

In remote areas, support is dependent on the quality of the caregiver. This often depends on the training and the level of expertise of the nurse who is servicing the community. Standards for hiring have been established and there are guidelines for treatment, but maternal care is a specialized area of nursing and few are trained in this area. Additionally, in remote areas, there are fewer professionals available to consult with, so there is less support for the nurse. Despite this, informants noted that the nurses generally do a good job of organizing support for pregnant women.

According to the respondents, while there is an incredible amount of social and family support in communities, medical support is often limited. In addition, there is inadequate financial support to deliver programs. In some cases, the community receives funding for maternity care services and initiatives but this funding is reallocated to address more pressing priorities within the community. The result is variances in levels of maternity care services. Insecure funding plays a major role in determining the level of support offered.

However, this contrasts with the comment of one informant who compared the prenatal nutrition program to the social welfare program stating that the Prenatal Nutrition Program is very good and well used. But the women are not as well supported in the social welfare department. They may not get prenatal allowance because of the discretionary rules that are developed in the administration of the program.

A number of respondents spoke about the great respect for women and children within First Nations cultures. Families play an important supportive role for the mothers within communities that the respondents rated as good. One respondent indicated that families and businesses are good at acknowledging new babies and new families. Several observed that families are very close knit and tend to rally around new babies.

Within all communities, there are varying degrees of programs to support pregnant women or new mothers. Women generally attempt to utilize the services, but they sometimes have logistical problems accessing support. For instance, some lack transportation.

## 6.10 Level of Support to Families

The professional informants were asked to rate the support available to families of First Nations women in their care during their maternity experience.

<b>Rating Support Available to Families during the Maternity Experience</b>	<b>Total Number of Respondents</b>	<b>As a Percentage of Total Respondents (n=19)</b>
Very Good	2	11%
Good	4	21%
Satisfactory	10	52%



Unsatisfactory	1	5%
Poor	2	11%
<b>Total</b>	<b>19</b>	<b>100%</b>

**Table 18:** Rating support available to families during maternity experience by professional informants

Over one-half of respondents (10 out of 19, 52 per cent) considered the support available to families to be satisfactory. Six of the nineteen (32 per cent) thought it was good (4 out of 19) or very good (2 out of 19), while 3 respondents (16 per cent) thought the support available to families was unsatisfactory (1 out of 19) or poor (2 out of 19). (See Table 18)

A number commented that families were their own best support. Families support each other, but there are not always good services like mentorship programs for women who experience abuse or abuse alcohol. It was noted that there is minimal support in some communities. Home visits include the entire family when the family members are present, but little more is offered. One respondent noted that there is a lack of identified needs by families.

Another respondent commented that only one person can be flown out to the birthing centre with the mother. However, not all First Nations women can have someone accompany them. While family support is good at the community level, it is very poor for women in rural and/or remote areas because they have to fly out for delivery and only the cost of the woman is covered. She cannot have a sponsor or family member with her.

Professional informants were also asked to rate the level of support available to First Nations women in the community during their maternity experience.

## 6.11 Challenges to Quality Maternity Care

Informant interviewees identified a number of challenges faced by First Nations women in obtaining quality prenatal care. A key area identified was the need to access care in a non-Aboriginal setting and to travel to receive check-ups.

- ***Lack of Facilities***

Generally, the location of First Nations women - living in rural or remote areas - puts them at risk. Smaller hospitals in outlying areas are closing obstetrics units, so more women are forced to travel further and as a result may not receive proper care. As noted earlier, in some cases the women must leave the community 6 weeks ahead of time to give birth leaving behind their support network, their family and friends. Often the women are young so that being removed from their community and thrust into this situation can be doubly traumatic. How the women are cared for while in the latter stages of their pregnancy depends on the community they are from. When women leave the community to birth they sometimes must board with strangers, other times they stay in a specific wing of the hospital while in other cases, they are placed in a hotel in a strange city for 4 to 6 weeks. As a result, women are often reluctant to admit their due date because they have to leave their family and in some cases are not allowed escorts to assist with their labour and delivery.

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- ***Access to Professionals (Physicians)***

The nurses are very dedicated and provide most of the care, but some respondents observed a degree of apathy by First Nations women toward them. They are not considered as credible by the women, or given the same level of respect as a doctor. However, First Nations women have limited access to physicians and specialists and are thus heavily dependent on reserve-based nursing care. Many women do not drive and have no one to drive them to appointments outside the community. Physicians are seldom reserve-based so physician access and access to specialists is therefore a problem, especially in remote areas.

It is not uncommon for pregnant women, especially the younger ones, not to have a regular family doctor. Due to their youth and inexperience, they are highly vulnerable. They do not often understand their choices and the role that these choices play.

- ***Lack of Continuity***

The lack of continuity of treatment is problematic. The mother may never have met the people who are at the delivery and may never see them again. They do not know their doctor. They choose the doctor while in the community, but don't actually meet him/her until they get to the city. By that time, they are nearing delivery, so there is little time to review or change their mind. In the words of one interviewee, it is an uninformed choice - not really a choice at all.

- ***Social Problems***

First Nations women face complications due to social problems. For instance, teen pregnancy is prevalent in many communities. There are sexual health issues which lead to higher risk pregnancies. There is a high incidence of diabetes, often due to dietary problems. Social determinants of health include such things as financial status and education which impact access to quality maternity care.

- ***Cultural Barriers***

Medical services are driven by the mainstream philosophy of medical care. Accessibility to culturally appropriate care is a great challenge and access to traditional care is extremely limited. One respondent indicated that because of the lack of First Nations health care providers, there are frequently emotional and psychological barriers between First Nations women and their maternity care providers. Women are often intimidated by the health care provider. Often they are not able to communicate in their own language. Language can be a serious barrier since few care providers are able to speak a First Nations language. Aboriginal women may not understand what they are being told and the health care provider may not understand what the women tell them or may be unable to relate to it. As a result, the women often simply accept treatment without question. Others avoid medical care altogether due to fear of the mainstream system and the negative history of interaction.

As one informant stated, mainstream practitioners are sometimes, not always, racist. Cultural differences cause problems due to the stereotyping by mainstream caregivers. The attitude and understanding of service providers is a key consideration. First Nations women are often more comfortable when offered services on a one-on-one basis. More flexibility is needed in the delivery of services and they need to be more culturally appropriate and more respectful of the common

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practices in the community. Although the services are there, First Nations women do not often access these services.

The hospital is not always culturally sensitive. For instance, the mother may want more people in the room, but hospital staff may not allow it. There is a lot of pressure to breastfeed, but as one respondent stated, some mothers have issues with this due to negative experiences.

- ***Childcare***

Although on-reserve delivery is not readily available, having to birth off the reserve gives rise to various non-medical problems. One of the problems of having to leave the community sometimes as early as one month before the due date are the negative psychological effects on the mother and her family. There is no home support or support for the mother who is away. For some mothers without family to baby sit, there could be problems with childcare.

- ***Structural and Systemic Racism***

Maternity care systems for First Nations are based on a colonized model of health care delivery. In one region, maternity care is set up in an old tuberculosis unit and women must travel alone to deliver. The First Nations and Inuit Health Branch (FNIHB) of Health Canada does not provide funding for family members to provide support during delivery and there is no provision for childcare. Things such as family break down, post-traumatic stress, past abuse by people in power, shortage of Aboriginal health care providers, individual/interpersonal racism, geography, and lack of choices are all challenges to First Nations maternity care.

## **6.12 Challenges Faced by Health Care Providers**

The informant interviews were asked what challenges health practitioners face in providing quality care to First Nations women. The responses covered the areas of cultural understanding, compliance and professional support.

- ***Cultural Understanding***

A number of informants raised the lack of cultural understanding, communication and education as key challenges. Aboriginal physicians are not available. As a result, non-Aboriginal physicians are likely to face culture shock and issues relating to trust. The community often does not trust the doctor. Frequently, the doctors do not understand the culture and vice versa. To compound the problem, when it comes to maternity care, there is not enough time for a woman to develop a good trusting relationship with the physician who delivers her baby.

As previously mentioned, language can be a challenge where English is seldom spoken. There are very few Aboriginal physicians and even fewer physicians who speak an Aboriginal language. As a result of the cultural divide, it is difficult for health care providers to build relationships with their First Nations patients. As one informant interviewee stated, repeated phone calls are often ineffectual; the women still do not come in to have the baby checked. House visits are not always welcome. As a result, practitioners won't always know that a woman has returned from the hospital with her baby, and may have no information on what occurred during birthing off the reserve. This

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was also noted by the focus group participants who expressed frustration with the lack of continuity of care.

Some health care providers stereotype Aboriginal women, labelling them in negative ways (i.e., assuming that they drink and smoke). Not all providers understand and accept that the people have the ability to care for themselves. Ensuring that there is awareness of First Nations cultures and an understanding of their history is important to overcome negative assumptions about the lack of a general culture. Health care providers need to know the historical background so they have some understanding of such things as why there is a special relationship. Some lack this basic knowledge and understanding, even though they are treating an Aboriginal community. Sometimes the community members and health practitioners clash due to personality conflicts. One informant advised that retention of health care providers is an issue as nurses leave communities because of cultural differences.

- ***Compliance***

A number of respondents felt a major health care challenge was compliance. Informants noted that First Nations women often do not show up for their appointments, do not attend at the scheduled time, or do not always follow-up with referral appointments. Others complained that the women miss appointments or change them at the last minute. Even though vouchers are provided as incentives, it is difficult to get the mothers to come in. Some respondents were concerned about missed tests, such as ultra-sounds or blood work. Mothers may not always follow the caregiver's advice, engaging in unhealthy while pregnant. Economics and poverty also play a role. There's no point in knowing that you should take folic acid if you cannot afford to buy it.

One respondent pointed out that health care providers need to be flexible and being flexible necessitates a lot of one-on-one work.

There are greater challenges in remote areas, where the community nurse provides most of the prenatal/postnatal care and becomes the main provider for family health care. At each contact, the nurse has to repeat the information covered earlier. There are some serious challenges in the more Northern communities, just dealing with the remoteness and the other issues that occur.

- ***Shortage of Sensitized, Appropriately Trained Health Care Providers***

Multi-jurisdictional issues and the lack of resources often create challenges for health care providers working in remote communities. There is little or no access to specialists and the cost of bringing in specialists is too high for the remote (isolated) community. The cost of transportation is not taken into account in the provision of funding and it is often a challenge just to deal with what is covered and by funding and what is not. As a result there is not enough medical support and health technology and equipment. Several interviewees highlighted the need for midwives. They noted that finding people to assist in maternity care is a great challenge. It is difficult to find professionals who are trained and knowledgeable in obstetrics and who are prepared to come to remote communities. The limited access to other professionals causes health care providers to burn out.

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- ***Women with High-Risk Pregnancies***

One practitioner stated that most pregnancies are high risk due to the lack of specialized prenatal care. Another referred to large babies, pointing out that there is no research or a means to capture data on high birth weight babies. However, if the trend continues, it will mean a rise in cesarean sections. Given the number of large babies among Aboriginal women, some physicians automatically diagnose women as having gestational diabetes, but that may not be the case. The average birth weight is rising, which complicates the birth and may compromise the baby's health.

### **6.13 Gaps in Services**

The informant interviewees were asked to provide examples of gaps in services to First Nations women and the impacts of these gaps.

- ***Access to Care***

A number of respondents identified access as the biggest problem. In some communities, First Nations women are having unnecessary procedures or medical interventions due to the lack of specialists and staff. It is difficult to get an appointment with a physician and the women must often travel to these appointments. There is often no specialist to deal with post-partum complications so women must be taken outside their community to be treated. There is often a lack of access to standard tests, such as ultrasound. Aboriginal women must often settle for a lesser level of care.

Respondents observed that there is sometimes a lack of communication between patients and doctors. Several respondents pointed out an inadequate level of respect for the women's opinion. For instance, women have had infections left untreated to the point that they come to the health centre and have to be sent out with a serious infection. It would have easily been treated if it had been properly diagnosed in their earlier visit to the physician, but all too often they are not taken seriously. The lack of early diagnosis and regular care leads to failure to diagnose problems that could be treated, causing complications that are entirely preventable.

- ***Continuity of Care***

Several respondents identified a lack of family physicians and no continuity of care as a major gap. First Nations women are often shuffled between caregivers causing them emotional distress. Sometimes there is no doctor for delivery, and it is rare to find focused nursing on the reserve.

Distance to seek medical professionals creates problems as the women have to travel leaving their family at home. They may not be able to arrange childcare for their children and it creates additional stress for the mother and family. Lack of transportation sometimes makes it difficult for the mothers to attend workshops, appointments or to seek out medical care.

One respondent observed that the lack of choice in caregivers has implications for a number of areas. Due to the impacts of abuse, many First Nations women would prefer to see female doctors and are reluctant to go to a male physician, which sometimes inhibits their desire to access even routine tests like pap smears and breast exams.

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- ***Jurisdictional Issues***

Because there is both federal and provincial funding involved, there are problems with liaison between the funders and the lack of information exchanges which creates gaps in service. For instance, often after a woman gives birth, she is just sent home without the on-reserve service providers being advised. There is no communication between the hospital and the reserve health care providers.

- ***Addiction***

There is a lack of support for community-based drug and alcohol abuse and mental health. Women may have to go to a service centre (off-reserve) to receive treatment and counselling and this is challenging especially if transportation is required. There is also a shortage of culturally appropriate addiction treatment programs.

- ***Education/Prevention***

Professional informants identified a number of gaps in education and prevention as follows:

- Lack of education on postpartum contraception.
- Lack of availability of genetic counselling.
- Lack of easily accessible pediatric supports.
- Lack of comprehensive and accessible prenatal education.
- Lack of comprehensive and accessible postnatal care education.
- Better breastfeeding support.

- ***Childcare/Family Support***

A recurring theme in the comments and observations of the professional informants was the gap in respect of childcare. The need for First Nations women to travel distances to access maternity care and facilities increases the demand for childcare.

## **6.14 Level of Awareness on Impacts of Health Habits**

When asked to rate the level of awareness of First Nations women about the impacts of their health habits and personal safety on the health of their child, the majority of practitioners (12 out of 19, 63 per cent) felt that First Nations women had an average to good awareness of the impacts of their health habits. Four of the nineteen professionals (21 per cent) felt that First Nations women's awareness was poor. (See Table 19)

In their comments, some respondents indicated that there are many programs in the community to inform women. They noted that knowledge and information is available. Some participants referred to anti-smoking campaigns being taught in school and indicated that information is given out immediately upon diagnosis of pregnancy. In one community, pregnant women are immediately referred to a nutritionist if there is a concern about weight gain. Most of the care is provided by CHNs, some of whom give prenatal classes, but teaching individually can sometimes have the best results. One respondent reported that the women come in early for testing by the nurse, and the doctor and nurse follow-up. The mothers are given information about FAS, folic acid, and high risk

behaviours before pregnancy. One-on-one prenatal counselling, is available, as well as FAS workshops and group sessions with the drug and alcohol counsellor.

Rating Level of Awareness of Health Habits and Their Impacts on Children	Total Number of Respondents	As a Percentage of Total Respondents (n=19)
Good	5	26%
Average to Good	1	5%
Average	6	32%
Adequate	1	5%
Poor to Average	2	11%
Poor	4	21%
<b>Total</b>	<b>19</b>	<b>100%</b>

**Table 19:** Rating the level of awareness of health habits and their impacts on children by professional informants

It was recognized by respondents that while cognitive awareness of the impacts of health habits is usually good, this does not necessarily enable the woman to address the issue. It is often dependent on other factors. Sometimes she is in denial about the impacts of behaviour, other times the ability to change is just not there due to a variety of reasons. Tobacco and alcohol use are prevalent even with the advice of nurses and doctors, and women frequently may not appreciate the impacts. As one respondent noted, sometimes people are entrenched in a lifestyle. They may have the knowledge of good habits, but lack the necessary support and ability to change their habits.

The financial status of the women was considered by some to be a major contributing issue. Some noted a co-relationship between income and awareness, observing that awareness tends to be good where there is higher socio-economic status. People who have fewer social or financial difficulties tend to seek out the information rather than wait for it.

One respondent felt that education levels and age may impact on the ability and attitude of the mother. The residential school experience has resulted in distrust of the system and has widespread negative impacts. Other respondents indicated that often the women are not well informed or may not make note of the consequences of their actions on their baby.

In remote areas with socio-economic problems, awareness tends to be poor in relation to all health issues. But even in remote areas, if the community is otherwise healthy, then the awareness is average to good.

## 6.15 Improving Maternity Care

Professional informants were asked what they thought could be done to improve maternity care to Aboriginal women. Their responses included specific references to program design, such as:

- The need to be more creative in helping women to learn about prenatal care.
- The need for more home visits.
- The need for (community) women to give specialized support to First Nations women in the birthing process (support group).
- The need for birth control education.
- The need for Lamaze classes.

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- ***Midwives***

A number of responses specifically identified the need for midwifery. Specifically several respondents suggested that there was a need for more midwife positions in every nursing station to enable home deliveries. Another suggested that there be more First Nations midwives and First Nation nurses in community. Still another referred to the need for doulas or midwives that could provide the option for traditional birthing practices in the community. Even if not reserve-based, one respondent felt that if midwives could provide a continuity of care by visiting the mother in the community and the regional hospital and be present during the birthing process.

- ***Improved Communication***

One respondent felt that communication should be established between the mother and her health care provider well before the birthing experience. It was noted that a trusting relationship between the expectant mother and maternity care provider could not be established in only 6 weeks. Where fly out was necessary, the women should be placed in a home environment, rather than a hotel. Maternity-type homes, owned by the Band near the birthing hospital, would be better than placing the expectant mother in a hotel. This would be a more natural setting and would probably save money in the long run.

- ***Drop- in Care***

According to many of the informants, there is lack of education among maternity care workers. They do not always adapt to the community culture, but instead expect the community to adapt to their ways. For instance, in some communities, making appointments does not really work. Maternity care workers must allow the women to come in when it is convenient for them. Drop-in care usually works best, but not all health care workers are willing to accommodate this.

- ***Community-Based Birthing Centre***

A birthing centre on-reserve staffed by First Nations health providers was what several respondents considered ideal. The Centre would provide a range of perinatal care from preconception and prenatal care to postnatal care. In one respondent's description, the centre would be a Band-owned facility staffed by community people who would deliver all maternity care.

Another suggestion was to have a doctor-dedicated clinic day committed to prenatal care. The delivering doctor would visit the community so women would not have to travel for prenatal check-ups and could meet the doctor in advance of delivery.

- ***Incorporate Traditional Practices***

The widespread availability of traditional care was raised by several respondents as essential to improving maternity care. One suggested that there should be a paid staffed position for someone whose responsibility is traditional care. A number of respondents suggested that traditional practices could be incorporated into maternity care by training staff at local hospitals, or having more First Nations people trained as nurses or doctors. One respondent suggested introducing cultural workshops at the delivering hospital/institution to sensitize hospital staff. Some suggestions included focusing less on the medical and more on the spiritual traditional/cultural practices in



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childbirth, incorporating drums, songs, involving the Elders, using the language and traditional methods and practices in the birthing experience.

In the experience of one respondent, most hospitals would not have a problem accommodating the incorporation of traditional practices provided they are given advanced notice. For instance, sometimes hospital personnel are concerned about smudging, but they can make arrangements if they know ahead of time. There are Native liaison workers in some hospitals, so a teaching package could be prepared and distributed to raise the awareness of hospital staff. Most First Nations women are not aware that they have options to incorporate traditional practices when they give birth, so it would have to be promoted as an option.

- ***More Professionals and Dedicated Staff***

The need to hire people with the proper qualifications or particular expertise was raised by several respondents. This included: specialized nurses; lactation consultants; prenatal dieticians or nutritionists; and physicians who can see expectant mothers throughout their entire perinatal experience. One respondent noted that there is a lack of qualified people in the community, and there is a high rate of turnover among trained and qualified providers. As a result, there is no real continuity in care. In the opinion of one informant, government bureaucracy does not always acknowledge the importance of the various positions, or Bands may lack the resources to properly staff these positions. Some felt that access to drop-in style care, so no appointment is necessary, would be well received and would address the issue of non-compliance. Others saw the need for a specifically dedicated staff person for maternity care. It was their view that the administrative requirements associated with providing quality maternity care, in addition to the other duties associated with the role, were too onerous for a CHR position. As a result, the CHR was frequently overburdened and could not always offer an acceptable level of care to pregnant women or new mothers.

- ***Community Involvement***

Increasing the role played by the community in maternity care was considered crucial to improving care. Ensuring community involvement was considered key by some respondents to improving care, compliance and follow-up.

- ***Decolonization***

One professional informant placed maternity care in a broader context. Pointing to the relationship between health care and colonization, this respondent endorsed the need to shut down FNIHB, revoke the *Indian Act*, settle land claims and address what has been done to Aboriginal Peoples. Land claims need to be acknowledged as part of the process of empowerment.

Decolonization includes providing support for training of Aboriginal health practitioners, such as nurses, physicians and midwives. However, it was felt that implementing this solution may be problematic in the short-term because people within the system often feel threatened. Beyond that, there may not be enough trained people to plan and run an Aboriginal health system. Information needs must be addressed, such as a way of accounting for First Nations people at birth and how to maintain accurate data over time. At present, hospitals have no way of accounting for Aboriginal

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mothers and babies. Capacity requirements would have to be met. Administrative and political adjustments would be required.

- ***Address Broader Health Issues***

One practitioner identified the need for information relating to lifestyle. Policy changes need to be broadly framed and need to account for lifestyle related issues. Poverty issues need to be addressed. Even with practitioners in each community, without proper food, housing, and necessities for overall well-being, there will not be many improvements.

- ***Non-Prescription Drug Allowance***

One respondent felt that the federal government should allow prenatal supplements to be included in the drug benefits under the Non-Insured Health Program (NIHB) provided to First Nations. Many First Nations women are economically challenged and if they are given a prescription for maternal vitamins, they often simply cannot afford them. Some communities provide these, but in order to ensure that all women, especially those with the most need, are able to get the proper vitamins, they should be provided automatically and subsidized. The cost would be justified over time with healthier mothers and fewer complications for infants.

- ***Education***

More education is needed within the school to inform young women and young men of healthy choices and provide preconception education. There is a general apathy toward health that needs to be addressed. First Nations women need to understand that they can control their own health.

Health care providers need training on possible methods to ensure consistent follow-up during pregnancy and to improve their awareness of addictions and FAS/FAE. While health care professionals may face situations where they need to be persistent, they must also be culturally sensitive. For example, when children need their immunizations, the health practitioner may have to make several calls, but they should not be overly aggressive.

Practitioners also need to recognize when problems stem from the residential schools experience. The consequences are inter-generational, and impact on many who did not necessarily attend residential school. As a result of being separated from their parents at a young age, some First Nations mothers or fathers may not have had a solid concept of parenting; it was not learned, and could not be passed on. For some communities, toddler groups, with modeling parenting, have been fairly successful for. However, to fully address this parenting issues, abuse issues must also be addressed.

- ***Training in New Programs***

Training is needed on how to start-up new programs that are available. A guide or basic suggestions for program start-up would be helpful in launching new programs in communities.

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## 6.15 Implementing Improvements in First Nations Maternity Care

Some respondents felt that their suggestions could likely be implemented within current budgets and authorities by simply increasing home visits, introducing reproductive counselling, implementing outreach pregnancy programs, and implementing parenting classes or cooking classes as well as group activities to support healthy lifestyles. One respondent identified the need for curriculum changes so education on maternity care could be included in the grade 10 curriculum.

In some cases, the health care providers need to connect programming with Elders and traditional people. Additional resources would likely be required to hire a traditional staff person. Another respondent felt that more case management could be implemented with support from the Band. If Health Canada provided the resources, several respondents believed that the Band would hire a midwife immediately. Additionally, one respondent saw the need for a national Aboriginal midwife education program.

- ***Making Maternity Care a Priority***

One respondent felt that First Nations organizations must acknowledge the importance of maternity care and that the government must make accommodations for isolation factors and the particular circumstances arising from isolation. Costs are greatly escalated by remoteness, and qualified personnel are difficult to retain on a long-term basis. This should be taken into account in funding and programming.

- ***Cultural Sensitivity***

One respondent believed that if hospitals recognized the need to learn about First Nations cultures through workshops, a key issue could be addressed. Others suggested that it would be possible to hire more Aboriginal practitioners if there was more funding to educate Aboriginal people in the medical fields. In addition, some saw a need for Aboriginal human resource managers who would be apt to understand the importance and value of Aboriginal staff (particularly in terms of cultural understanding), and the need for maintaining accurate Aboriginal statistics.

In the view of some respondents, a culturally appropriate maternity care system with trained Aboriginal people could be created once indigenous rights were acknowledged. Aboriginal professionals trained to take over all aspects of the maternity and health care system were required including practitioners, policy analysts, and public health specialists.

- ***Social Services Infrastructure***

In some communities, respondents reported that the social services programs did not assist First Nations women in buying healthy foods or vitamins. If maternity care is to be effective, mothers need access to food, adequate and safe housing and resources for transportation to access maternity care providers and services. Sustainable funding to ensure these are available in all First Nations communities is essential to maternity care.

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- ***Funding for Health Facilities***

First Nations women should have the option of being cared for and birthing in their community. For this to happen, some practitioners felt that there would need to be funding to build on-reserve maternity facilities and to properly equip and set standards for staff (i.e., nurses should have a minimum level of qualification/training). This would entail sustainable financial resources to increase the number of staff dedicated to maternity care. On-reserve health services should be structured in a location that could be accessed without scrutiny (in order to avoid issues of privacy). In one respondent's community of practice, health services were situated next to the Band office, which was considered too visible for such a small community. With a proper dedication of resources, maternity health care clinics and more support groups could be organized within all communities. Physicians and nurses who are committed to working with First Nations people are needed.

- ***Community Support***

Several respondents felt that the main determinants in a successful maternity care program were community interest and government support, which would translate into ongoing financial support. Health care workers need community support to do their job. If the community is behind it, the financial resources are more likely to be available. However, few health care workers have the time or the training to do the necessary outreach to rally adequate community support. In most places, dedicated personnel would be required to work directly with the community.

- ***Outreach Team***

In isolated communities where mothers are flown out for birthing, monthly or quarterly visits from a maternity care outreach team would address the issue of continuity of care. Care providers visiting the community would have a better idea of the needs and appropriate care if they could see first hand the housing conditions and conditions of the community - information that is essential to the delivery of health care. They could then adapt programs and services to the circumstances depending on the team's assessment. For instance, in remote areas, the team may need to seek out someone who is experienced at breastfeeding to provide support to a new mother. Community women Elders could be part of the team as essential resources.

- ***Communication/Coordination***

CHNs and all team members have to work in concert to support First Nations mothers. This would require coordination with all health and social support providers, including community support workers.

## **6.16 Priorities to Improving Maternity Care**

The professional informants were asked what they consider to be the greatest priority that should be addressed to improve maternity care to Aboriginal women.

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Their responses ranged from specific maternity care programs to broad topics such as addressing issues of poverty and self-government. Briefly, the broad themes in which more than one respondent identified priorities were as follows:

- Pre-pregnancy, pre-planning and conception education.
- Prenatal care.
- Addressing poverty issues.
- Addressing physician access.
- Culturally-based maternity care.
- Aboriginal governance.
- Accountability.
- Promotion and awareness of the impact of alcohol and drugs.

- ***Pre-pregnancy, Pre-planning, and Conception Education***

Four professional informants noted the need for pre-conception care. One identified life-style (healthy living before pregnancy) and one spoke of the need for more teaching, identifying teenage pregnancy as a big issue. As one noted, young First Nations women often become pregnant before they are ready to be parents, and as a result they are more likely to be unable to care for their baby. Also, many teenage mothers are prone to postpartum depression, which frequently results in the child being deserted as the mother engages in activities designed to escape her depression. Mothers need to anticipate the possibility of this, understand what it is, and appreciate that help is available. They need to know where to go for help. Practitioners generally felt that teen pregnancy could be prevented through education. Young people should be given experiences with parenting and child care before they become pregnant.

- ***Prenatal Care***

Access and consistency in care was considered a priority by many respondents. Several comments identified a need for consistent prenatal care for all First Nations. Trained maternity nurses delivering prenatal care were considered essential as was access to quality prenatal care. One respondent commented that prenatal work provides an opportunity to influence lifestyle and by extension health outcomes.

- ***Addressing Poverty***

Improved socio-economic conditions were considered a priority by several professional informants who noted that poverty impacts on all elements of maternity care. Various health detriments need to be addressed before maternal health can improve. For instance, a safe place to live, food security, as well as emotional/spiritual help must be provided. The health and nutrition of pregnant women, mothers and babies is dependent of the financial support and assistance they receive. To enable long-term positive outcomes, they need to be provided with the necessities, and educated on how to budget in order to feed the child a healthy diet. They also need to be taught about food and nutritional values in light of the rising costs of food and other amenities.

- ***Addressing Physician Access***

Ensuring access to qualified practitioners, especially in remote communities, was identified by a number of professional informants as a priority. Having a delivering physician assigned to each

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reserve would permit better doctor-patient care and would address concerns relating to the continuity of care.

- ***Culturally-Based Maternity Care***

The redefinition of health care to First Nations and First Nations women in a manner that respects First Nations values was prioritized in several practitioner comments. Present care is based on western values and is not culturally adapted to First Nations needs. There is a need to address how to deliver culturally appropriate health care. Teaching mainstream practitioners (nurses, doctors, hospital workers, etc.) about Aboriginal cultures was considered important by several respondents. In particular, it was recognized that there is a need to reconnect traditional practices in maternity care and institutional barriers need to be broken down in order for this to be achieved.

- ***Aboriginal Governance***

One respondent saw the need for First Nations empowerment. The need to break the cycle of colonialism was considered key to maternal and other health issues. Beyond cultural differences, this respondent felt that people need to understand colonialism and its impacts on First Nations societies, families and parenting so they are empowered to end the cycle. First Nations people need to be enabled to make good choices. In order to do so they need to understand why they have been dealing with prejudice and feelings of shame.

- ***Accountability***

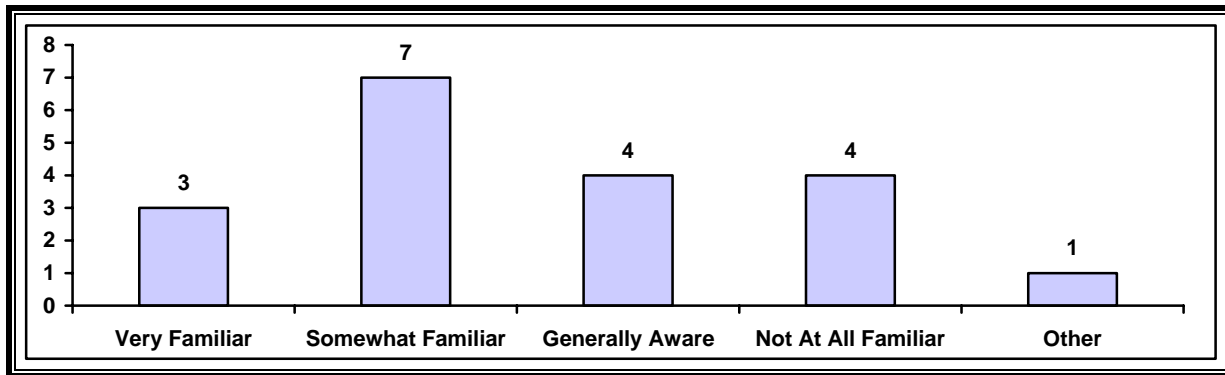
One respondent felt that the biggest priority was ensuring that the CPNP (nutrition program) money is spent where it is supposed to go. Others saw accountability from the federal government as key.

- ***Promotion and Awareness of the Impacts of Alcohol and Drugs***

From the perspective of some practitioners, one of the biggest problems confronting First Nations maternity care is drug and alcohol abuse. However, women with problems often do not want to seek treatment because of fears of being chastised rather than assisted. Addressing the abuse issue should, in the eyes of these practitioners, be considered one of the highest priorities in improving maternity care.

## **6.17 Familiarity with Traditional and Cultural Approaches to Maternity Care**

Professional informants were asked about their familiarity with the traditional and cultural maternity practices of the community they were serving. Although only 3 of the 19 respondents (16 per cent) considered themselves to be very familiar with the traditions and cultural maternity care practice of the community they served, 7 of the 19 (37 per cent) felt that they were somewhat familiar with them. Four respondents (21 per cent) reported having only a general awareness and four were not familiar with the traditional practices. (See Chart 7)



**Chart 7:** Familiarity with local traditions and culture as reported by professional informants

One practitioner self-identified as white but indicated a familiarity with the First Nation community’s traditions. He/she noted a number of cultural beliefs and practices associated with maternity care. For example, families hold a feast for the new baby in what is referred to as an “uplifting”; later, there is a naming ceremony where the baby gets its traditional name. This practitioner observed that women may have different levels of traditional knowledge and within families, views and approaches differ.

There is not just one traditional approach as one First Nation practitioner who indicated familiarity with several cultures observed. To his/her knowledge, none of the women he/she served had accessed their traditional practices. It was observed that the traditions are not being passed on by the parent/grandparents/Elders.

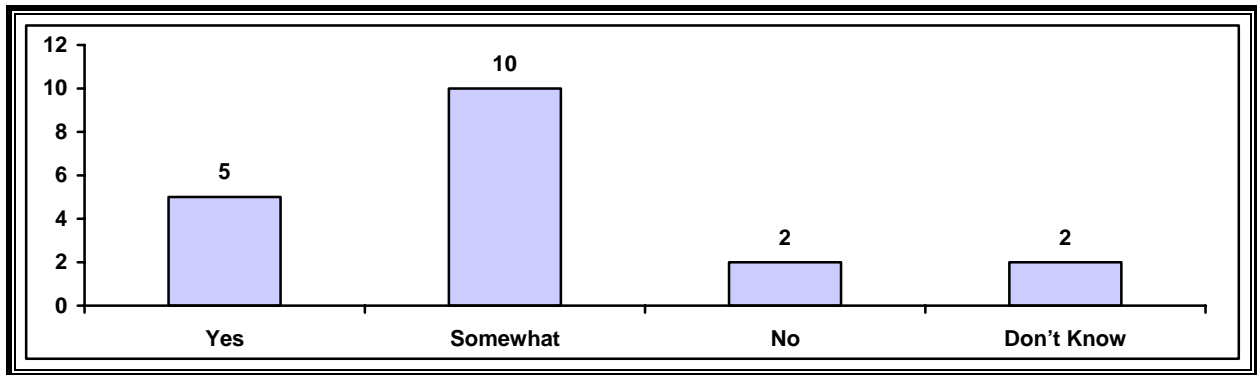
Another practitioner was married to an Aboriginal person and had an Aboriginal child, so had made an effort to learn; participated in ceremonies; and when in need of information, asked the Elders.

One First Nations practitioner was practicing in his/her own community, so was somewhat familiar with the culture and traditions. The community was heavily impacted by Christianity which has changed the values. There is a clash of values between the traditional and occidental values

Another was not very familiar with the traditions and practices in the community she/he services. She/he noted that there is no where to go to find out. While there is a cultural and traditional revival, the practices are not well known within the community and knowledge was not very available. Some cultural tendencies were apparent to this practitioner, such as the preference to have family nearby during the birth. He/she also observed that children are considered blessed so pregnant women are respected and cared for by the community. This is demonstrated in various ways, such as everyone feeds pregnant women - if they visit a house, they are always offered a meal; people often drop-off wild meat at the home of a pregnant woman.

## 6.18 Incorporation of Traditional and Cultural Practices

Professional informants were asked based on their experience whether traditional and cultural approaches have been incorporated into First Nations maternity care.



**Chart 8:** Opinion of professional informants on whether traditional/cultural approaches have been incorporated in First Nation maternity care

Five of the nineteen professional informants felt that traditional/cultural approaches had been incorporated into First Nations maternity care. Ten respondents felt that they had been somewhat incorporated and 2 respondents felt that they had not. One respondent reported that he/she did not know. (See Chart 8)

Several respondents noted that the degree to which traditional and cultural practices are incorporated into maternity care is often dependent on the family. Some have very strong cultural roots in the family, in which case, the cultural practices continue. Some ceremonies are quite expensive and are dependent on how much money the family has. For instance it is quite expensive to have a feast, and not everyone has the money to have one. In some communities, important elements of the culture and traditions are maintained, for instance all babies in some communities get their apron (girls) or vest (boys) with their clan's crest. This is not, however, true in all communities.

### **6.18.1 Institutional Recognition**

One practitioner referred to a (maternity care) teaching curriculum that is culturally designed for community health nurses. Some communities do not practice locally at the institutional level but some cultural practices have been incorporated into prenatal classes on-reserve. The incorporation of traditional/cultural practices into maternity care is also dependent on whether the women want cultural/traditional practices interwoven into their care. In some communities, there is a growing availability/awareness of traditional cultural components of maternity care, whereby women are eager to learn and Elders are eager to teach.

It was also noted however, that in other communities there is not much traditional/cultural revival. Traditions have been suppressed by racism so First Nations people do not have knowledge or are not familiar with their own traditions, and some may have a negative attitude toward these approaches.

### **6.18.2 Specific Practices**

The level of knowledge in respect of traditions and culture, and whether or not these are practiced, depends on what the family has taught. Some respondents estimated that, based on their experience, only about 10 per cent still practice their traditions and this varies from community-to-community. The



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health care providers have to make a deliberate concerted effort to seek out information on cultural and traditional maternity practices and often have to rely on the CHR. Nurses do not usually remain in the community for very long, to access information on traditional and cultural approaches and practices. Professional informants also noted that in many instance, informal knowledge is available for those who observe. Pregnant mothers are told how to behave, where they can or cannot go, and what they should or should not eat (traditional food). For example, in many communities, pregnant mothers will not attend funerals. They are told to eat various types of meat or berries (depending on the location and time of year) and when not to eat certain kinds of food.

## **6.19 Barriers to Cultural/Traditional Maternity Care**

The following barriers were identified as preventing the implementation of cultural/traditional approaches to Aboriginal women maternity care.

- ***Need to document and develop traditional/cultural teachings***

Given the general lack of knowledge, some felt the lack of written documentation prohibited a wider knowledge and acceptance of cultures and traditions.

- ***Lack of confidence***

Aboriginal women may not have confidence in traditional/cultural ways and may prefer the western medical approach.

- ***Residential Schools Syndrome***

The residential schools experience has had inter-generational impacts on the social behaviour and attitudes of First Nations parents. Many young mothers are residential school survivors, or children of survivors and many suffer from the residual effects of the residential schools experience which is embodied in destructive behaviour, such as alcohol, drug or physical/sexual abuse.

- ***Institutional Barriers***

Existing institutional barriers affect the ability to engage in cultural or traditional practices. For instance, it is not always possible for First Nations mothers to arrange a smudge in hospitals. In addition, traditional practices may be frowned upon by the Christian churches so First Nations mothers may be hesitant to engage openly in them.

- ***Legal and Statutory Requirements***

Regimented legal processes, such as the registration of babies, do not allow for cultural differences. In some First Nations cultures, babies are not named for some time after birth, but Canadian laws requires that they be named within a matter of weeks.

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- ***Family Knowledge***

Some practitioners felt that culture or traditional knowledge is only available to those whose family has somehow managed to maintain it. As such, it was not openly accessible to all. Given the closed nature of the knowledge, practitioners are not able to offer traditional/cultural practices as part of routine maternal health care services.

- ***Non-Native Maternity Care Providers***

Most maternity care providers, nurses, physicians, etc., are non-Native. First Nations women are apt to be more culturally open with a Native nurse or doctor. In the view of one respondent, non-Native practitioners do not have the same outlook on life as those who are Native. For First Nations health care providers, it is usually wonderful to work on-reserve, but for those who first come here, especially for non-Native providers, it is a culture shock

- ***Lack of Human Resource***

There is a lack of Aboriginal human resources to practice traditional/cultural approaches. The best place to implement culture/tradition is at the community level.

- ***Insensitivity of the Health Care System to Cultural Values***

The health care system is not sensitive to cultural values. It is almost impossible to incorporate First Nations traditional/cultural practices in the current western health care system. Too often physicians treating Aboriginal women do not take note of the differences of Aboriginal women and as a result, fall short in their treatment

- ***Cultural Breakdown***

In the view of some respondents, cultural breakdown is the greatest barrier to incorporating culture and traditional practices into First Nations maternity health care. Parents do not pass on information, or individuals are simply not interested in learning about it. The health system supports the western (white) culture. The readiness of people to learn is often based on their prior connection to, or dislocation from their culture. In some cases, the community is now closely connected to suburban life and many First Nations people are leading lives that do not include learning about their culture and traditions.

- ***Language***

For some, language is a barrier, since it prevents access to or full comprehension of Elders knowledge. For many, language and tradition has been stripped away by experiences beyond their control. Many do not fully appreciate this, and those that do lack the means to address it. Some communities are trying to promote their language, but people do not have time to learn everything. The women are working and their lifestyle is not geared to practicing a traditional lifestyle.

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## 6.20 Addressing Barriers to Traditional/Cultural Maternity Care

Professional informants suggested that barriers to the implementation of cultural and traditional approaches and practices to First Nations maternity care could be addressed through the following:

- *Using Elders as a Resource and in the Documentation of Traditions*

It was the opinion of some that traditional/cultural practices need to be documented with the help of Elders before they are lost. In some communities, language and culture is being taught in the school. Elders are involved in virtually all the activities of the community health centre. Some indicated that the goal should be to involve Elders in everything. Several commented that initiatives to revitalize and record traditional birthing information need to be supported. Oral history projects, Elders visiting prenatal groups, and access to traditional healers have been introduced in some communities and must be more generally available.

- *Cultural Revival*

There is a need for coordinated efforts within communities to reinstitute traditions and cultural practices. Health care providers should work with the Elders and the community membership. Since they are valuable expert resources performing invaluable services, Elders and participants should be paid.

- *Hiring and Training Community Members*

Some practitioners believe that First Nations need to take advantage of training opportunities to train their own people for positions in health and maternity care. By making sure that their own people are properly trained, they will ensure cultural sensitivity as well as greater retention rate.

- *Empowerment and Ownership*

There is a need for people who work in First Nations communities to understand the history and transition. First Nations need to hire the right people who can plan a vision for empowerment.

- *Cultural Awareness*

Cultural awareness workshops should be held at hospitals and other off-reserve institutions that provide maternity care to First Nations women. Cultural sensitivity workshops and Elder-in-Residence Programs at hospitals have been introduced by some communities. Anti-racism workshops with health care workers and people from the First Nations community should be more generally promoted so that those who are comfortable with their culture and traditions are more readily able to engage in cultural practices.

Some professional informants felt that the Residential Schools Survivor Program will help deal with some elements of the loss of tradition and culture however many other issues remain to be addressed. Systemic changes at the highest levels of government are needed in order to change government attitudes. Some practitioners saw the need for a cultural resource person as part of the maternity health team to assist health workers to deliver services in a culturally sensitive and

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respectful manner. Some practitioners observed that Elders are occasionally willing to teach health workers about plants and medicines so it can be passed on. Some felt that communities need to provide a safe environment for practices to be made known, i.e., some community traditional/cultural practices are not even discussed due to predominance of western medicine.

- ***Professional Training***

Some suggested that health care professionals should be sensitized to First Nations cultures during their professional training, so they will be able to change their practice according to the culture. Others commented on the need for more Aboriginal health care workers.

## 7.0 Conclusions

While this preliminary needs assessment was not sufficiently wide-spread to make conclusive findings, a number of observations are possible:

- Participants noted that the availability/accessibility, level and quality of maternity care services offered to First Nations women vary based on geographic location.
- Knowledge of maternity programs and services varied among the focus group members.
- Participants felt that there was a need for better information and better coordination of programs and services.
- Most participants had experienced some degree of cultural bias by medical officials throughout their maternity experience.
- Participants saw a need for some form of cultural orientation for medical staff providing maternity care to First Nation women. They also saw the need for programs and services that incorporate and revive traditional and cultural practices.
- Participants did not perceive maternity care as separate from the life of the community and saw a need to incorporate First Nations philosophies into maternity care.

While the sampling was too small to firmly conclude that the quality of maternity care available to First Nations women was influenced by geographical location, socio-economic conditions and the overall health of the community, this preliminary assessment gives some indication of this. In particular, it became apparent through the focus group discussions with First Nations women and the informant interviews with health care providers that more maternity care options are available to First Nations women whose community is near an urban centre.

While proximity to urban centres appears to be an indicator of the quality of maternity care, because maternal health care is frequently tainted with negative stereotypes about First Nations peoples, few First Nations women can be considered to receive fully satisfactory care.

The First Nations women in this preliminary needs assessment had minimal choices in their birthing experiences. A number of participants expressed the view that if they could give birth within the community, First Nations women would be less likely to be subjected to negative attitudes, would be less stressed and would ultimately be better equipped for their perinatal experience.

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In addition to the lack of maternity care facilities in most First Nations communities, few had access to cultural or traditional maternity practices. For those from remote communities, this coupled with a lack of continuity in care negatively impacted the overall quality of their maternity care.

While the First Nations women in this study rated their overall maternity care as good, the lack of culturally sensitive care, mental and emotional support, and limited options for care reduced the overall quality of the maternity care that they did receive. Especially for those who were physically removed from their family and community for weeks at a time in order to give birth, the maternity experience was unduly stressful and difficult for the entire community. For the participants in this study, only minimal support was reportedly available to assist in these circumstances.

Accordingly, First Nations participants in the focus groups identified the following gaps in maternity care:

- Lack of options for community based maternity care and in home/in-community birthing.
- Lack of Aboriginal providers and culturally trained maternity care (non-Aboriginal) providers.
- Lack of continuity in maternity care and services.
- Lack of mental and emotional supports, in particular in respect of post-partum depression.
- Inability and lack of opportunity to make informed choices in respect of pregnancy and birthing as a result of the virtual absence of community-based services, programs and facilities for perinatal and birthing care.
- Absence of programs and services to support parents and families, in particular in respect of addressing the inter-generational affects of residential schools and the resultant post-traumatic stress.
- Failure to integrate traditional and cultural practices in the provision of maternity care as a result of the predominance of the western medical model.
- Other gaps and weaknesses, including:
  - The absence of safe houses for women in crisis.
  - Too much bureaucracy.
  - Proposal-based funding for postnatal services (insecure program funding).
  - Lack of attention to babies, toddlers, adolescents and youth (no programs for early childhood development and no on-reserve day care centres).
  - Lack of dental care for infants.
  - Absence of continuity in needed gynecological information and care (i.e. cervical cancer).
  - Lack of needed supports for women who experienced the loss of a baby through miscarriage, or shortly after birth (beginning in hospital and after release, including support group).
  - Need for milk storage.

Focus group participants and professional informants were equally concerned with the quality and inconsistency in care, the latter expressing a desire for more specialized maternity training and more opportunities for cultural awareness.

Maternity care was not considered in isolation by the focus group participants who saw it as part of an overall health and wellness paradigm that could not be separated from the community, the history or experiences of the First Nations. The failure to thrive was associated with broader factors that included community empowerment and choice. Focus group participants expressed the need for women to resume roles of authority and control in relation to their maternity care, with the support of practitioners and government funding.

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The solutions offered by First Nations participants to address the current gaps and weaknesses in maternity care can be summarized as follows:

- Improve access to providers by ensuring that in-community maternity care and women's health services, facilities and providers, including doctors and OBGYNs, are available and accessible to First Nations women. This includes the establishment of permanently based maternity care clinics and birthing centres in First Nations communities.
- Provide support for, and emphasize the recruitment, training and retention of First Nations/Aboriginal maternity care providers (doctors, nurses, midwives, etc.) as a key element in providing quality and culturally responsive maternity care to First Nations women. In addition, ensure that non-Aboriginal maternity care providers are culturally and appropriately trained to provide care to First Nations women, through education and cultural awareness training.
- Establish comprehensive and wide-ranging socio-economic programs and services, including in respect of food security, quality housing, and transportation to alleviate the effects of poverty on First Nations women.
- Target specific programs, services and facilities to support and assist young First Nations mothers in achieving self-reliance, including the provision of community-based perinatal services for young First Nations mothers in need.
- Provide community-based prenatal programs and services that focus on promoting a healthy lifestyle, including in respect of nutrition, food security, exercise and recreation, mental health and well-being, parenting, partner and family support.
- Increase Band/community support for, and consultation on, maternity care issues and needs within the context of community processes, with a view to improving the availability and quality of maternity care for First Nations women.
- Establish community structures and process to ensure the privacy of First Nations women, including in respect of their maternity care information and medical histories, while at the same time ensuring that pertinent information on the health and health history of mothers is communicated to the appropriate health and maternity care providers.
- Establish services that provide birth counselling and advocacy for First Nations women to ensure that information on available drug supports and pain management during labour and delivery, and treatments and medical interventions, etc., is effectively communicated to, and understood by, expectant mothers. Birth counselling and advocacy services could also provide coaching, labour support, general emotional support and follow-up for the mothers and/or their babies.
- As a means of ensuring the continuity of care, Bands should establish protocols with hospitals serving First Nations women to ensure that relevant information on treatment, discharge summaries and follow-up care are provided to community-based caregivers once the women return to their communities after giving birth.

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- Establish community-based programs and services for neo and post –natal care that would provide for: residential care; home support; emotional and mental support; breastfeeding and nutrition support; parenting skills and family support; and infant development
  - Ensure that grief and ongoing counselling and supports are available to women and their families who have lost babies through miscarriage or after birth.
  - Establish early assistance programs and supports for special needs or troubled children, (i.e., including FAS/FAE and attention deficiency disorder), and their families, including in respect of, parenting training, emotional and mental disabilities, family counselling, child advocacy support, and school programs.
  - Other suggestions relating to neo and post -natal maternity care, including:
    - Broader and more flexible schedule for vaccinations.
    - More contact with the doctor or (Ministry) Health Nurse.
    - Locally accessible and weekly physiotherapy/chiropractic services.
    - The availability of trusted day care services within the community.
    - Maternity leave.
    - Programming for First Nations women in the corrections system.
    - Support for homeless women.

The observations made by the focus group participants and those of the professional informants are consistent on most of these points; however, further study would be required before comprehensive recommendations could be made.

## **PART II: FINDINGS OF THE INUIT MATERNITY CARE NEEDS ASSESSMENT**

### **1.0 Introduction**

Inuit maternal care faces all the challenges that limit the availability and quality of health care services in the North but with additional concerns and issues. Isolation, the lack of fully equipped facilities and services in most communities, the lack of staff, and the inability to retain those with medical training are common concerns. Unlike First Nations, however, Inuit claim a common cultural heritage and tradition that covers a vast geographical area that crosses jurisdictional boundaries. Though there are regional differences, there is much that Inuit share as a People. Provincial and territorial government health systems vary and as such, there is a lack of coordinated and consistent health and maternity services available to all Inuit. There is desire to incorporate traditional birthing techniques into routine pregnancies. Currently, support for this varies between jurisdictions.

Inuit share a unique birthing heritage. Birthing has a cultural context that is often disrupted when mothers are removed from their home communities — often to southern cities — for routine births. This can be a highly alienating experience that removes the mother from her family and network of support. Traditionally, the midwife or birthing assistant played an important role in the naming of the newborn. In addition, a boy may give a portion of his first successful hunt to the

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person who assisted in his birth; a girl may give away the first item she sews or knits. Inuit traditional birthing practices are different from southern techniques. Birthing positions, for example, tended to be in a kneeling or squatting position and not on the mother's back. The latter is viewed by some Inuit Elders who have given birth on the land, in small communities, and finally in southern hospitals, as being more for the comfort of the doctor than for the mother.<sup>1</sup> The point being made is that Inuit have a rich cultural heritage and knowledge about pregnancy and birthing that has the potential of being lost, only to be replaced with the inadequacies of modern health care delivery in the North.

In order to conduct a needs assessment of maternity care in the North, a focus group of ten Inuit women was assembled in June 2004 in Iqaluit, Nunavut. To supplement the focus group discussions, a questionnaire was distributed to those participants who had given birth within the last three years. This analysis is based, in part, upon five completed questionnaires. In addition, the results of nine telephone interviews of health care professionals — doctors, midwives, nurses, and a prenatal-worker — are included in this analysis. These key informants are particularly valuable because they all have experience working within Inuit communities. They offered their experiences, views, and perspectives on the maternity care provided with respect to Inuit. Many provided detailed open-ended responses which help in an evaluation of the conditions and needs for effective and safe maternity care in the North.

## 1.2 Key Issues

The key objective of this analysis is to identify issues, priorities, best practices, and suggestions for improving maternity care in Inuit communities. This analysis provides preliminary information on the experiences and needs of Inuit women and health care professionals in the area of maternity care. It will evaluate the care provided to Inuit living in the North in terms of prenatal, birthing, and postnatal support services and programs. At issue are the gaps Inuit have identified in these programs and services and the possible solutions they suggest. An effort will be made to evaluate these gaps and solutions in terms of cultural practices and traditional approaches. This information can help inform new models for quality maternity care programs, services, and strategies.

The material that was gathered during the Iqaluit focus group can be best understood in the context of: (1) what medical services, programs, and infrastructure is currently available; (2) the cultural and social context of birthing in the North; and (3) the jurisdictional differences and barriers that foster uneven and sometimes inadequate maternity care. By conducting a needs assessment in the context of territorial and provincial jurisdictions, in terms of the availability of adequate modern medical services and the social perspective of birthing, a solid understanding can be developed.

Inuit women do not feel health care systems are responding to their needs. Midwifery and maternity care have been an issue for many years. Inuit women are at greater risk for a variety of conditions and complications that arise during pregnancy, childbirth, and postpartum. There are circumstances and conditions that are unparalleled to the North — isolation, teen pregnancies, housing shortages, domestic violence, poor nutrition, the high cost of living, persistent organic pollutants in country

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<sup>1</sup> See Pauktuutit, *Documentation of Traditional Inuit Practices Related to Pregnancy and Childbirth, Draft Final Report* (Ottawa: Pauktuutit, 1995). Pauktuutit conducted a detailed study of traditional birthing with support of Health Canada's National Health Research and Development Program "Community Initiatives North of 60." (File # 6606-4710-T).



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foods, the lack of knowledge about available services, and the general insensitivity of the medical system to Inuit culture are all factors that complicate the delivery of maternity care programs and services. In the North, it is not just an issue of whether a service is available or not. The majority of the 53 Inuit communities are served by nursing stations only. Specialists are located only in a few communities. Expectant mothers, in many cases teenagers, are often re-located to medical facilities thousands of miles from their homes and families. Often they must fly to southern facilities. As a result, language may also be a barrier to effective service delivery. When an expectant mother is flown south she may not understand all that is going on around her.

An exception can be found in Puvirnituk on the Hudson Bay coast of Nunavik in northern Québec where the Council of Physicians, Dentists and Pharmacists of the Inuulitsivik Health Centre employ midwives. Since its creation in 1986, the maternity ward of the Inuulitsivik Health Centre has employed midwives to provide pre and post -natal support and to detect problems early. The midwives make house calls during the weeks after delivery. The health centre works to reconcile traditional practice with modern medical services.<sup>2</sup> This progressive facility is not paralleled elsewhere in the Arctic.

## 2.0 Profile of Inuit Participants

The focus group in Iqaluit was conducted in Inuktitut and English, with simultaneous translation and recording into English. The focus group consisted of ten Inuit women from all four Inuit jurisdictions: Nunavut, Nunavik, Inuvialuit, and Labrador. Five of the participants were from Nunavut with four living in Iqaluit — a large urban centre by northern standards (2001 census population of 5,236). The other Nunavut resident came from a community of about 1,200 people. Two participants came from Nunavik communities that range in size from about 1,300 to 1,900 people. Another two participants came from Labrador communities of about 600 and 1,200 people. The tenth participant came from an Inuvialuit community of about 1,000 people. Community size played a factor in how participants perceived maternal care services. Iqaluit, for example, has a hospital and a greater range of support services.

The average age of the five focus group participants who completed the questionnaire was 23 years. The oldest was 28 and the youngest was 16 years old. Three out of the five participants in the questionnaire (60 per cent) had not completed high school. Four out of five (80 per cent) made less than \$10,000 annually. The other woman made \$45,000 or more per year. Forty per cent (2 out of 5) stated they were single. Another 40 per cent (2 out of 5) stated they were single but had a partner. One of the participants was married. When asked about living arrangements at the time of their last birth, there was an even split between living alone or with a partner of some sort. One woman stated she was, and was not, living with a partner.

Those selected for the questionnaire had birthed within the last three years.<sup>3</sup> All of their pregnancies were healthy. Each gave birth to a single child. The average birth weight was 8.4 pounds; the largest newborn was 9.4 pounds and the smallest was 7.8 pounds. It was the first pregnancy for 4 out of the 5 women (80 per cent) that participated in the questionnaire. Two of the women indicated that their

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<sup>2</sup> See the Nunavik Regional Board of Health and Social Services' Internet site:

[http://www.rss17.gouv.qc.ca/en/vivre/professions/sages\\_femmes.aspx](http://www.rss17.gouv.qc.ca/en/vivre/professions/sages_femmes.aspx) (last accessed in October 2004)

<sup>3</sup> This study targeted mothers who had birthed in the last three years since their prenatal, birthing and postnatal experiences are recent and timely.

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pregnancy was diagnosed by a doctor or physician, one was by a nurse or nurse practitioner, another was self-diagnosed, and the last was diagnosed by her partner. Forty per cent knew they were pregnant within one to four weeks; 20 per cent knew by the sixth week, and 40 per cent do not recall when they found out they were pregnant. Though the determination of pregnancy was variable, four of the women (80 per cent) gave birth in a hospital. The other gave birth at home.

### **3.0 Gaps in Inuit Maternity Care Services**

#### **3.1 Gaps in Prenatal Programs and Services**

Participants in the focus group were asked to identify any gaps they felt existed in prenatal maternity care services. They were asked to focus on gaps that were specific to their community. Particular attention was directed at gaps that may exist for women who may be at high risk or have unexpected outcomes from their pregnancies.

In terms of prenatal care there was an expression of concern that support was not available outside the larger centres. The focus group indicated there was no link, for example, between Iqaluit maternity care programs and the smaller isolated communities. It was suggested boarding home facilities should be available that offered prenatal and maternity care support, classes, and information for clients. There was a comment that Iqaluit should encourage greater community participation in the prenatal services being offered.

Many of the comments focussed upon the need for more support and information. This included information about the medical policies, services, and procedures that a mother might expect to receive as well as more information about traditional Inuit birthing practices. The focus group commented that hospitals should provide more information about what to expect. For example, what were gases and injections used for. The women wanted to have proper counselling about birthing options. They wanted more information about practical things such as parenting skills, healthy living and eating, proper dress, how to travel when pregnant, and guidance at various stages of their pregnancy on how to prevent miscarriages. They felt pregnant women should be able to receive services and information in Inuktitut.

A review of the Inuit respondents to the questionnaire clearly supports this lack of access to support and information. Sixty per cent of respondents never spoke with a family doctor or general practitioner during their pregnancy. Eighty per cent did not talk or visit a medical doctor, a public health nurse, an obstetrician or a gynaecologist, or a midwife. None visited or talked with any other medical professionals, nor did they visit or talk with a social worker, or with a traditional healer. (See Table 1)

When asked if they were satisfied with the prenatal care they received, all the respondents indicated they were satisfied. However, when asked if they were happy with their access to community-based prenatal support, only 60 per cent stated yes; the remainder stated they were somewhat happy. Eighty per cent indicated they received their care in their community; none stated they left their community for prenatal support.

<b>TABLE 1: Inuit Evaluation of Prenatal Care Services Received</b>					
<b>During the Pregnancy The Number of Times Visited or Talked to:</b>	<b>0 times</b>	<b>1-3 times</b>	<b>4-6 times</b>	<b>7-9 times</b>	<b>10 plus times</b>
General Practitioner/ Family Physician	60%	0%	20%	0%	20%
Other Medical Doctor	80%	20%	0%	0%	0%
Public Health Nurse/ Practitioner	80%	0%	0%	0%	20%
OBGYN	80%	20%	0%	0%	0%
Midwife	80%	20%	0%	0%	0%
Traditional Healer	100%	0%	0%	0%	0%
Social Worker	100%	0%	0%	0%	0%
Other Professional	100%	0%	0%	0%	0%

Table 2 summarizes how the Inuit respondents to the questionnaire evaluated their access to community-based services and to professionals who offered prenatal support. In terms of prenatal care services, 60 per cent indicated such services were available to them at the community level. This reflects how the women rated their overall happiness with the support they received (see above). It would seem if the service is available, then they are probably happy with it. Nursing services were the most readily available health professionals followed by doctors and OBGYNs. (See Table 2) As seen in Table 1, however, few of the respondents actually accessed nurses or any other health professional for prenatal care.

<b>TABLE 2: Inuit Access to Community-Based Medical Services and Professionals</b>			
<b>Access to Community-Based Prenatal Care Services</b>	<b>Not Available</b>	<b>Sometimes Available</b>	<b>Always Available</b>
Availability of prenatal care services	0%	40%	60%
Availability of nursing services	0%	20%	80%
Availability of doctor services for regular visits	0%	40%	60%
Availability of OBGYN services	40%	20%	40%

The respondents clearly indicated that they thought counselling services were available to them. For all categories listed in Table 3, none indicated that counselling, information material, or support is not available at least some of the time. Eighty per cent indicated counselling and support is always available.

<b>TABLE 3: Inuit Access to Counselling and Support</b>			
<b>Access to Community-Based Prenatal Care Services</b>	<b>Not Available</b>	<b>Sometimes Available</b>	<b>Always Available</b>
Counselling or other information	0%	20%	80%
Availability of written material	0%	20%	80%
Availability of breastfeeding counselling and Support	0%	20%	80%
Access to post-natal emotional support	0%	20%	80%

The respondents rated access to cultural and traditional forms of support as uneven. None reported it as something that was always available; 40 per cent indicated it is occasionally available and 60 per cent indicated such support is never available. Similarly, 60 per cent indicated traditional medicines are not available though 20 per cent indicated it is always available. Access to midwives is polarized – either it was available or it is not. Forty per cent indicated that the support of midwives was always available.

<b>TABLE 4: Inuit Access to Midwives, Cultural Support, and Traditional Medicines</b>			
<b>Access to Community-Based Prenatal Care Services</b>	<b>Not available</b>	<b>Sometimes available</b>	<b>Always available</b>
Availability of Traditional / Cultural Supports	60%	40%	0%
Availability of Traditional Medicine	60%	20%	20%
Availability of Midwife	60%	0%	40%

Limitations in programs, services, and supports can be linked, in part, to jurisdictional differences. It is obvious that Puvirnituk’s midwifery program offers services and supports for Inuit women that are not reflected in the medical services available in other jurisdictions and modelled after southern medical systems. The licensing of midwives is a provincial/territorial prerogative.

The focus group emphasized the need for more midwife guidance in prenatal programs and services. The knowledge of midwives should be integrated into prenatal classes. They suggested that midwives should be registered. They felt midwife training should support traditional knowledge and practices, and that governments need to acknowledge and support this training. The focus group indicated that hospitals should respect the knowledge of Inuit midwives on delivery and support. As an example, it was noted that certain injections may not be required during routine hospital procedures because of the Inuit diet of country food. Inuit women naturally bleed more after birth.

<b>Access to Community-Based Prenatal Care Services: Counselling</b>	<b>Not Available</b>	<b>Sometimes Available</b>	<b>Always Available</b>
Birthing Facilities	40%	40%	20%
Availability of Ambulance Service	20%	20%	60%
Availability of Fly-Out Service	0%	20%	80%
Availability of Year-Round Ground Transportation	40%	20%	40%

When asked to indicate the availability of birthing facilities and other infrastructural services that pregnant women may need, the responses to the questionnaire indicate the place of residence, and most likely the season, are important factors. None of the services listed in Table 5 are always available, least of all birthing facilities. Transportation services for medical evacuations are also variable with fly-out services being the most reliable.

One focus group comment was about how the LHC in Labrador did not provide financial support to the partners of pregnant women who were re-located for birthing. The funding for such a program would be in the domain of the provinces and territories.

	<b>(1) Poor</b>	<b>(2) Adequate</b>	<b>(3) Average</b>	<b>(4) Good</b>	<b>NR</b>
Rating Access to Community-Based Maternity Care	18.2%	18.2%	18.2%	36.4%	9.1%
Mean Rating:	2.8				

Note: Some respondents provided multiple responses to account for the different communities they had worked in. Percentages are based on 11 responses; the mean rating is based on 10 responses only.

The professional key informants confirmed that access to prenatal and maternity facilities was limited and that some people had to leave their communities. Access depended upon where the mother lived. Ultrasound tests, for example, are not readily available in smaller remote communities. Overall, about 36 per cent of the professional key informants rated access to community-based maternity care as good. The mean rating was just below average — 2.8 on a scale of 4. (See Table 6)<sup>4</sup> These informants, however, also were assessing access in First Nations and Métis communities and therefore this rating may be higher than if it was for just northern communities. A nurse, for example, rated Alderville and Moose Factory as good and Iqaluit as below average with bad equipment or equipment in poor condition. When asked to rate access to medical diagnosis for pregnancy, almost 56 per cent rated this access as good; the mean rating was 2.9 out of four. The professionals suggest that if women went to the hospitals they would find the services for diagnosis

<sup>4</sup> The mean rating indicates what is the average rating or value for all the answers on the scale. It is a useful value for interpreting answers that are provided across a range.

that they needed. A nurse noted that “... a lot of the Aboriginal women are shy to access the services.” Another felt that diagnostic facilities were poor in Iqaluit. She did not think women were well treated. The nurse stated: “there were waiting lists and negative attitudes. Pregnancy tests cost \$40. A lot of women waited until they could feel the baby move and then got tested.”

The reluctance to access medical professionals during the pregnancy is clearly apparent from the data listed in Table 1, above. A midwife noted that many women do not have access to anyone with experience in obstetrics. Professionals were transient and sometimes know little about obstetrics. In addition, caregivers do not necessarily have a good attitude towards pregnant teenagers.

<b>Care Available</b>	<b>Yes</b>	<b>No</b>	<b>NR</b>
Nurse	100.0%	0.0%	0.0%
Physician	88.9%	11.1%	0.0%
Specialist	77.8%	22.2%	0.0%
Counselling	88.9%	11.1%	0.0%
Midwife	66.7%	33.3%	0.0%
Support Group	44.4%	55.6%	0.0%
Traditional Healer	44.4%	55.6%	0.0%

Data collected from the professional key informants indicates support from nurses is viewed as always available to pregnant women. Almost 90 per cent indicated physicians and counselling services are available and about 78 per cent indicated specialists are available. (See Table 7) These figures must be viewed with caution and in the context of availability and access in northern communities. The key informants’ assessments include First Nations and Métis communities and this probably overstates the northern reality. As noted above, Inuit women may not access available health professionals; they are reluctant, less informed about options, and may be in communities with only nursing stations. Table 3 indicates the Inuit questionnaire respondents were aware that counselling services are available to them. Access to the care of a midwife is highly regionalised for Inuit. Sixty per cent stated that neither midwives nor the use of traditional medicines was available to them. (See Table 4)

	<b>(1) Poor</b>	<b>(2) Adequate</b>	<b>(3) Average</b>	<b>(4) Good</b>	<b>NR</b>
Rating Availability of Prenatal Medical Support	11.1%	33.3%	33.3%	33.3%	11.1%
Mean Rating:	2.8				

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Note: Some respondents provided multiple responses to account for the different communities they have worked in. Percentages are based on 11 responses; the mean rating is based on 10 responses only.

When the professional key informants were asked to rate the level of availability of prenatal medical support, the rating was the same – 2.8 out of 4, or average. (See Table 8) Comments were about the lack of access to physicians and about how patients do not always have a family doctor. This is somewhat at odds in terms of the data described in Table 7, above. The key informants noted that those support workers that are available do not have medical backgrounds. One physician noted that prenatal support involved “... *trips out of community and away from family for tests and 3-4 weeks confinement for delivery without family accompaniment.*” Another commented about the difficulty of making such an assessment. A host of factors influence overall wellness besides basic medical support. This includes transportation, food, community and family networks, and recreational opportunities.

### 3.2 Gaps in Birthing and Postnatal Programs

Continuing with the theme of gaps in programs and services, the Inuit focus group was asked to consider gaps in services and programs for birthing and postnatal care. Many of the concerns that were expressed relate to cultural issues. For example, participants continued with the point that little or no support was provided for women who must leave their community to give birth. The resulting lack of family support placed a strain on keeping the family together. Extended periods away from home can foster family break-ups. The women lack social support in the community and in the boarding home. Without family support women who spend lengthy times away from home experienced financial strains, lack of self-esteem, a strain on the relationship with their partner, and a sense of disconnect because fathers often cannot attend the birth. There is no subsidy or compassionate airfare available for family members or partners to attend the birth. Participants noted that Inuit women need to have a good relationship with her partner to support the growth of babies. In terms of programs and services, participants commented that there was a lack of counselling and support for new mothers while they were away.

Discussion also included the question of choice in birthing. Women may want to pursue a traditional Inuit way where they can decide that a midwife attends the birth. The focus group expressed concern that there was a lack of coordination in terms of recording and passing down the traditional knowledge on maternity care and parenting skills. They noted that schools for midwives need to be recognized and certified. The role of midwives and the barriers that limit their participation was a point of concern. The focus group noted that traditional midwives are prevented from providing services in hospitals. If they assist an Inuit woman’s home birth, the local health services may not provide follow-up support to the women. Nurses may even refuse to weigh the newborn. It was noted that birthing centres are not allowed to provide home midwife services because it was against government regulations. As such, midwives are not paid for their services, even if a nurse asks for a midwife’s assistance. For the Inuit focus group, a key gap in birthing services and programs is the lack of policies and standards that support the role of traditional midwives and compensate them for their services.

Other concerns or gaps expressed by the focus group included the lack of education in healthy living and healthy choices related to smoking, diet, alcohol, and drugs. They noted a lack of support for dealing with postnatal depression and a lack of support for very young mothers. Essentially, there is

a lack of aftercare programs and support for mothers living in boarding homes. Reference was also made to the duplication of services and the lack of knowing about what is going on.

The focus group also suggested the medical profession was not sensitive to the needs and desires of pregnant Inuit. This concern is not restricted to pregnancies. The high turn-over of professional staff and the lack of services in Inuktitut are common issues plaguing health care delivery in the North. The focus group suggested doctors should only diagnose special needs conditions and not every pregnancy. For example, they suggested that giving out gas during birthing procedures slowed down the birth/labour and that this may not be necessary in routine cases.

<b>TABLE 9: Individuals Present at Inuit Women's Last Birth</b>		
<b>Present at Birth:</b>	<b>Yes</b>	<b>No</b>
Nurse	40%	60%
Doctor	80%	20%
Midwife	60%	40%
Partner	60%	40%
Traditional Healer	0%	100%
Family Member(s)	60%	40%
Other	0%	100%

Eighty per cent of the Inuit who completed the questionnaire gave birth in a hospital; the remainder gave birth at home. Sixty per cent left home to give birth and this involved flying out of their community. This suggests there was some distance to be travelled. Sixty per cent, however, stated they were able to have their partner present during the birth. Similarly, 60 per cent reported having a family member present. (See Table 9) Most women had a doctor present (80 per cent). Midwives were more common than nurses (60 per cent and 40 per cent respectively). None had a traditional healer present; there was no use of herbs or traditional medicines, no use of special drinks or foods, no traditional ceremonies conducted of any kind, and no traditional teachings or birthing practices were employed. As noted above, however, focus group members expressed a desire for more use of traditions during the birthing experience.

<b>TABLE 10: Medical Interventions During Inuit Women's Last Birth</b>		
<b>Medical Intervention</b>	<b>Yes</b>	<b>No</b>
Full-Term Birth	80%	20%
Natural Birth - Hospital Births Only	75%	25%
Medication Given - Hospital Births Only	50%	50%



Induced Labour - Hospital Births Only	0%	100%
Epidural Given - Hospital Births Only	50%	50%
Caesarean Birth - Hospital Births Only	0%	100%
Monitor Used - Hospital Births Only	50%	50%
Other - Hospital Births Only	0%	100%

As noted earlier, all respondents to the questionnaire reported healthy pregnancies; none reported any complications. Eighty per cent reported their pregnancies were full-term and were natural births. No one had their labour induced or a caesarean birth. When asked about medical interventions during birth, half of those in the hospital received medication; half reported that a monitor was used and half reported that an epidural was given. (See Table 10)

Those who completed the questionnaire were asked to rate the availability of community-based postnatal support services. (See Table 11) Eighty per cent indicated postnatal care services were available to them. All indicated they could get postnatal checks-ups in their community. Though the focus group expressed concerns about the lack of support in the community and the need to leave the community for births, services appear to be available to those who had recently given birth.

<b>TABLE 11: Inuit Community-Based Access to Postnatal Support Services</b>			
<b>Access to Community-Based Prenatal Care Services:</b>	<b>Not Available</b>	<b>Sometimes Available</b>	<b>Always Available</b>
Availability of Postnatal Care Services	20%	0%	80%
Regular Access to Postnatal Check-Ups	0%	0%	100%

The professional key informants were also asked a number of questions in order to rate access to birthing facilities and support. Generally, the professionals rated such access as about average. Access to medical facilities and the availability of diagnostic tools are clearly rated as average. Curiously, over 55 per cent rated access to medical diagnosis for pregnancies as good, though overall the mean rating is average. (See Table 12) This seems consistent with how Inuit women at the focus group diagnosed their last pregnancies; 60 per cent went to a doctor or nurse. It must be remembered that in the North complications during pregnancies result in medivacs to southern hospitals. Access to any specialist is sometimes only once or twice a month only.

One health professional stated the facilities in Iqaluit were below average. A nurse noted that northern facilities and equipment are not adequate if a woman goes into pre-term labour. A physician noted that it is not always a question of the availability of facilities or services, but rather the shortage of nurses, physicians, and midwives. Technically, equipment and facilities may be adequate but socially and psychologically the support may be poor. Health professionals are not always sensitive to aboriginal concerns. One nurse suggested that prejudices raise issues of trust among the patients who feel they have a lack of choice concerning the practitioner so they feel they have to accept what they are told without question.

<b>TABLE 12: Professional Key Informant Rating of Access to Birthing Facilities</b>					
<b>Facility</b>	<b>(1) Poor</b>	<b>(2) Adequate</b>	<b>(3) Average</b>	<b>(4) Good</b>	<b>NR</b>
Available Medical Facilities for Pregnancy	0.0%	22.2%	44.4%	22.2%	11.1%
Mean Rating:	3.0				
Access to Medical Diagnosis for Pregnancy	33.3%	0.0%	11.1%	55.6%	0.0%
Mean Rating:	2.9				
Available Diagnostic Tools During Pregnancy	0.0%	0.0%	66.7%	22.2%	11.1%
Mean Rating:	3.3				
Available Medical Facilities/ Equipment for Child-Birth & Delivery	11.1%	33.3%	33.3%	22.2%	0.0%
Mean Rating:	2.7				
Level of Available Medical Support During Child Birth & Delivery	0.0%	44.4%	33.3%	22.2%	0.0%
Mean Rating:	2.8				
Note: Mean rating based on responses only.					

The professionals stated that doctors and/or nurses are always available during childbirth and about 56 per cent indicated other specialists were at hand. (See Table 13) Midwives were said to be available almost 80 per cent of the time. Again, these figures must be viewed in light of the fact that the professionals were also describing available care in First Nation and Métis communities. Iqaluit has been noted for substandard facilities and the general problem of staffing and the lack of specialists, suggests the availability of someone trained in obstetrics may be somewhat optimistic for the North. The participation of midwives is overstated in the northern context.

<b>TABLE: 13 Professional Key Informant Assessment of Available Care During Child-Birth &amp; Delivery</b>			
<b>Type of Care Available</b>	<b>Yes</b>	<b>No</b>	<b>NR</b>
Nurse	100.0%	0.0%	0.0%
Physician	100.0%	0.0%	0.0%
Specialist	55.6%	44.4%	0.0%
Other	33.3%	66.7%	0.0%

Midwife	77.8%	22.2%	0.0%
Traditional Healer	22.2%	77.8%	0.0%

When asked about postnatal support, the key informants indicated nurses are always available. (See Table 14) The availability of physicians was rated as less than during birthing, and less than when pregnant. (See Tables 7 and 13) This must relate to mothers and newborns returning to their home communities and away from the hospital facilities. Curiously, specialists are considered to be more available than during birthing. Counselling support was also considered to be less likely to be available than when pregnant (89 per cent when pregnant and 78 per cent after) though support groups were rated as more common than when pregnant (44 per cent when pregnant and 56 per cent after). The role of midwives remained constant. This data suggests that professional support is variable between communities. Nursing support is readily available but access to specialists, counselling programs, and even traditional and cultural programs varies between communities and jurisdictions.

When asked to describe challenges facing “Aboriginal women” when obtaining quality maternity care, a physician noted that Aboriginal women tend not to see the same doctor. Doctors are often not located in the community so people lack a family doctor. Another physician noted the lack of comprehensive and consistent programs for care and problems which are further hampered by logistics, distance, and culture. A midwife simply noted the lack of local community facilities. Another commented that remoteness and isolation put pregnant women at risk. The midwife also felt social problems such as teen pregnancies, sexual health issues, and diabetes lead to higher risk pregnancies. The concern about teen pregnancies was echoed by a nurse who commented about pregnant teens having to leave their communities six weeks before their due date. The nurse stated:

In Iqaluit, they go to boarding houses with strangers and there is no choice. Women are reluctant to admit their due date because they have to leave their family and they are not allowed escorts to assist with their labour and delivery.

<b>TABLE 14: Professional Key Informant Assessment of Available Postnatal Care</b>			
<b>Type of Care Available</b>	<b>Yes</b>	<b>No</b>	<b>NR</b>
Nurse	100.0%	0.0%	0.0%
Physician	77.8%	22.2%	0.0%
Specialist	66.7%	33.3%	0.0%
Counselling	77.8%	22.2%	0.0%
Support Group	55.6%	44.4%	0.0%
Midwife	55.6%	44.4%	0.0%
Traditional Healer	44.4%	55.6%	0.0%

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A nurse suggested accessibility to culturally appropriate care was a big challenge. This includes language barriers and a distrust of mainstream medicine due to past experiences. One physician suggested structural and systemic racism were challenges to quality care. The doctor went on to note:

Maternity care systems are based on colonized model of health care delivery.... FNIHB does not pay for family members to provide support during delivery. There is no provision for childcare. Social determinants of health — financial status /education impact on access to quality maternity care. Things such as family break down, post-traumatic stress, past abuse by people in power, shortage of Aboriginal health care providers, individual/interpersonal racism, disparity of outcome geography, lack of choice.

The professional key informants were asked to comment about the challenges health practitioners face in providing quality care. Staff shortages, staff burnout, and a lack of professionals trained in obstetrics were identified. Patients often lack follow-up check-ups with the same doctor. Other issues included the lack of translation services and the lack of understanding professionals had for “Aboriginal cultures.” It was described as a “lack of sensitized, appropriately trained colleagues.” Multi-jurisdictional issues were also identified. A midwife commented that a challenge facing the delivery of quality care by western practitioners was their under-estimation of the expertise of traditional midwives.

When asked about gaps in services, the key informants offered a range of comments. A common topic was the lack of early diagnosis of pregnancies. Women could miss problems that are treatable and could preclude the option of terminating the pregnancy. In part, this must be linked to the lack of family physicians and the lack of continuity in care. Women are rushed through tests (for example, ultrasound) without being informed of the reasons for the tests. There is a lack of counselling about family planning. Western doctors must learn to respect different ways of learning. Women are shuffled between caregivers and this fosters emotional distress. Another gap that was identified was the lack of support for midwives; many women were compelled to spend four weeks away from their homes. In addition, little education is available to women and thus children are at risk. For example, the effects of FAS can be reduced with early education. Stress, crowded housing, and poor diets were also cited as factors that impact Aboriginal maternity care.

## 4.0 Traditional Practices

The Inuit focus group considered what cultural and traditional practices are still in use today and what practices they remember being taught in the past. The intent was to evaluate what traditions and customs can be blended or integrated into modern maternity care services and programs. The majority of participants, however, indicated that such cultural and traditional practices are almost lost in their communities. Now there is little communication between Elders and young people about such things. It was stated the influence of the church and the general loss of culture prevented young people from actively practising traditions. The knowledge of Elders is not being recorded. In addition, it is medical policies and facilities that do not encourage traditional practices.<sup>5</sup>

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<sup>5</sup> As noted earlier, the Pauktuutit Inuit Women’s Association conducted a project to document traditional Inuit birthing practices. Over seventy women were interviewed and over 500 births were described and recorded on audiotape. Though English transcripts were prepared, Pauktuutit has lacked the financial resources to assemble this material into a format suitable for public distribution.

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As noted earlier, none of the focus group participants had a traditional healer present during their pregnancy or labour. There was no use of herbs or traditional medicines, no use of special drinks or foods, no traditional ceremonies conducted of any kind, and no traditional teachings or birthing practices were employed. However, focus group members expressed a desire for more use of traditions during the birthing experience. Sixty per cent had stated such support was never available to them. Eighty per cent indicated traditional and midwife postnatal support was not available to them at the community level.

The participants expressed a desire to document traditional ways. They felt that documenting or recording traditional birthing practices was very important. They also recognized, however, that not all traditions may be appropriate to bring back or encourage. The participants discussed the prospect of a film on maternity care for Inuit women as one way to document traditional ways.

The participants described how traditional skills were taught. A midwife would assist in counselling couples in traditional teachings, approaches, and practices. A midwife or Elder would demonstrate traditional birthing positions. Anecdotal lessons were also provided such as pregnant women should avoid sleeping during the day in order to avoid slowing down labour. Participants indicated that the traditional teaching should be user-friendly and should be geared towards younger people.

Among the professional key informants, a midwife noted that Aboriginal midwives are becoming too old to teach and this is limiting the incorporation of traditional/cultural approaches into maternity care. Another noted that Elders are not comfortable entering maternity wards because they see it as white man's territory. A nurse described how the law and standard hospital procedures are limiting the incorporation of traditional approaches. As an example, the nurse described how traditionally babies may not be named for some time after birth but that the legal system and medical procedures do not allow for this cultural difference. A physician also noted that legal and medical standards for medical delivery systems act as a barrier to incorporating traditional approaches. A nurse explained that there needs to be systematic change at the highest levels in order to overcome the barriers that prevent the use of traditional and cultural approaches. The nurse suggested that someone was needed who can provide information about cultures and traditions to nurses, and doctors, etc. A midwife suggested there should be cultural sensitivity workshops and an Elder in residence or on call at the hospitals. There also needs to be anti-racism workshops.

Almost 56 per cent of the key informants indicated they are somewhat familiar with "Aboriginal traditions or cultural approaches" related to maternity care.<sup>6</sup> A physician noted however, that for those health professionals who work in various "Aboriginal communities," there is more than just one traditional approach to be aware of or familiar with. This is a challenge. Other health professionals expressed the desire to work with Elders but noted language barriers, the need to revitalize and record their knowledge, and the need for resources to get Elders and communities involved were issues that needed to be addressed. As one professional put it, "*...no one does anything without getting paid. Elders get paid, participants need to get paid.*"

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<sup>6</sup> On a scale of three, the key informants' mean average rating on their familiarity with traditional maternity care was 2.6, or between *somewhat familiar* and *very familiar*.

## 5.0 Maternity Care Gaps and Issues: Recommended Solutions

Focus group participants were asked to brainstorm and recommend solutions to problems plaguing Inuit prenatal community care. A variety of solutions were discussed and specific details were included with each suggestion. These solutions were then prioritized in terms of immediate, short-term, and long-term solutions. In broad terms, these solutions range from:

1. Educational programs or classes;
2. Counselling and lifestyle programs;
3. Administrative, policy, and procedural changes; and
4. Improved facilities.

The need for education and knowledge is widespread and can take a variety of forms. The most obvious is the need to provide training and counselling for Inuit who are pregnant or who have a newborn. There is a desire that women within the communities should share their experiences; women who have already given birth should help younger inexperienced women through their pregnancies and help prepare for childbirth. Education and training, however, can extend to the women's partner and to the entire community. Healthy lifestyles needs to be promoted in order to address some of the root causes behind high teenage pregnancies and higher rates of infant mortality, etc. Young women need support. Training and certification should be provided to midwives and traditional knowledge and the role of Elders needs to be promoted.

At the administrative and policy level, the focus group recognized the need for more inter-agency coordination and changes in hospital procedures and protocols to allow greater family participation. They also expressed a need for stronger cultural components in birthing. There is also the need for more birthing centres that incorporate and support Inuit culture.

The following tables summarize the suggestions offered during the focus group discussions on solutions to the gaps and issues facing Inuit maternity care. Many of the solutions are geared towards education. Most are ranked as priority needs.

SOLUTION / MODEL #1 Prenatal Classes	
Type:	Education and Counselling
Rating:	Participants ranked the need for prenatal classes as an immediate priority.
Elements / Components:	Enhanced programs with more intense information about all stages of maternity; Hold classes by trimester with both experienced and inexperienced mothers; Partners should participate in the prenatal classes; Traditional midwives must participate in components of the training; and Community radio services should be used to ask midwives (both traditional and registered) to share their learning and to provide information.
SOLUTION / MODEL #2 Birthing / Labour Classes	
Type:	Education and Counselling
Rating:	Participants ranked the need for birthing/labour classes as an immediate priority.

Elements / Components:	<p>Provide classes on what to expect during labour and address physical and mental issues.</p> <p>Class should be more than one day;</p> <p>Explain the stages of labour and show how to breath, etc.;</p> <p>Explain options that are available during labour, such as possible birthing positions and the use of medications; and</p> <p>Ask experienced mothers to provide advice and share their experiences.</p>
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<b>SOLUTION / MODEL #4:</b> <b>Support for Young Women</b>	
Type:	Education and Counselling
Rating:	Participants ranked the need to support young women as an immediate priority.
Elements / Components:	<p>More experienced young women need to act as mentors to other young women. They need to be available for counselling and support.</p> <p>Young women need support from peers on all stages of maternity: pregnancy testing; support and help in telling their parents; healthy options and guidance; how to deal with their fathers; coaching during labour;</p> <p>Organize other outside agency support (for example social workers)</p>

<b>SOLUTION / MODEL #5:</b> <b>Relationship and Partnership Support</b>	
Type:	Education and Counselling
Rating:	Participants ranked the need for relationship counselling as an immediate priority.
Elements / Components:	<p>Help fathers feel more connected and invested in the childbirth experience;</p> <p>Provide support to be a good parent and husband/partner; and</p> <p>Provide teachings on how to build strong relationships while building a family.</p>

<b>SOLUTION / MODEL #6:</b> <b>Promote Social Wellness</b>	
Type:	Education and Counselling
Rating:	Participants ranked the need to promote social wellness as an immediate priority.
Elements / Components:	Develop broad-based community-level presentations on such topics as: healthy lifestyles; self-esteem; safety; family relations; partner support; and dealing with grief.

<b>SOLUTION / MODEL #7:</b> <b>Healthy Lifestyle Promotion Nights</b>	
Type:	Education and Counselling
Rating:	Participants ranked the need to promote social wellness as a short-term priority.
Elements / Components:	<p>Promote healthy lifestyles through presentations, social gatherings, and guest speakers;</p> <p>Design programs with the participation and input of community workers;</p> <p>Invite all community members to participate; and</p> <p>Develop the promotions as an 8-month program (\$10,000 to \$15,000 in funding).</p>

SOLUTION / MODEL #8: Apprenticeship School - Midwife Certification	
Type:	Education and Counselling
Rating:	Participants ranked midwife training and certification as an immediate priority.
Elements / Components:	Develop a flexible program with no set date for certification; Registered midwives should have mandatory traditional midwife training; Involvement of traditional midwives essential to certification; Traditional midwives lead curriculum development and teaching skill assessment; Curriculum components should include training in baby development, issues around family violence, STDs, and family planning; Midwife training should include skills on how to handle certain high risk conditions; and have schools in each region of the North.

SOLUTION / MODEL #9: Traditional Knowledge	
Type:	Education and Counselling
Rating:	Participants ranked the gathering and teaching of traditional knowledge as an immediate priority.
Elements / Components:	Promote and strengthen traditional teachings with Elders and traditional midwives; Document and record traditional practices and teachings; Traditional teaching approaches should be used to explain, for example, whole family cycles and the differences of raising boys from girls; and Collectively participate to support traditional knowledge with Inuit as one People.

SOLUTION / MODEL #10: Inter-agency Coordinating Committee	
Type:	Administrative and Policy
Rating:	Participants ranked inter-agency cooperation as an immediate priority.
Elements / Components:	Scope of committee limited to municipal boundaries; Committee composed of community workers, possibly government representatives; Conduct consultations between communities, Elders, and midwives to determine what is needed for maternity care; Role of the committee is to share information on programs and services, coordinate programs and services, and address duplication and gaps in the services; and Committee is to provide financial coordination for new or existing programs and services.

SOLUTION / MODEL #11: Hospital Protocols	
Type:	Administrative and Policy
Rating:	Participants ranked changes to hospital protocols as an immediate priority.
Elements / Components:	Shape hospital policies to respond appropriately to the needs of Inuit families requiring maternity care; Allow birthing women to grant permission over who attends the birth — traditionally one person to support the back, one for each side, and a midwife; and Provide appropriate traditional procedures after unexpected outcomes at birth — holding a newborn for no more than 20 minutes, manual peeling of afterbirth from uterus, or cutting board practice to spread pelvic bone to support difficult births.



SOLUTION / MODEL #12: Birthing Centres	
Type:	Administrative and Policy
Rating:	Participants ranked the need for birthing centres as an immediate priority.
Elements / Components:	<p>A birthing centre needs to be located in each Inuit region;            Centre should have community/registered midwife support;            Registered midwives should have mandatory traditional midwife training;            Centres should be staffed with community midwives who speak Inuktitut;            Centres should provide family-centred clinics and women wellness centres;            Provide on-going counselling for young women and provide parenting skills classes;            Support the option of choice and women's rights;            Provide mandatory outside and on-going professional follow-up for mothers and newborns; and            Politics should not interfere with birth centre operations.</p>

## 6.0 Conclusion

In order to improve maternity care key informants suggested education, family planning, and better facilities in the communities. There needs to be better access to physicians. The objective should be healthy mothers. In part this involves a population health approach to address the health needs of entire communities and regions. Healthy communities require adequate housing, nutrition, education, and improved socioeconomic conditions that reduce poverty. The high rate of pre-term deliveries can be linked to stresses stemming from conditions at the community level. Reaching out to Inuit communities and getting members involved in promoting healthy lifestyles and participating in the delivery and support of services and programs is recognized as a key to revitalizing northern health care and improving Inuit community care.

Support for more midwives with training in traditional Inuit culture and in traditional Inuit birthing practises was a constant theme during the focus group discussions. It was expressed that such midwives should actively participate in prenatal counselling sessions and during birthing and postnatal care. Though focus group participants did not have ready access to midwife support and traditional practices during their pregnancies and births, they felt such support would alleviate some of the problems and limitations they encountered within the existing medical system.

Access to health professionals is a constant problem in the North. The lack of continuity, the lack of consistency between regions, the lack of culturally sensitivity and culturally appropriate services, and the inability to retain staff all factor in to describe a system that is not meeting the needs of Inuit. The necessity to fly expectant mothers out of their communities and away from their families highlights the limitations of the existing medical and maternity care system. Training local professionals and incorporating locally trained midwives who are versed in traditional practices would go a long way in solving these limitations. It would also be very cost effective.

As the focus group members suggested, and the professional key informants supported, there needs to be a policy shift that allows greater recognition and integration of traditional Inuit birthing techniques. The key informants recognized the value of such a shift. Hospital protocols need to be amended to allow the presence of midwives and to allow birthing women to have some input into who attends the birth. Ultimately, there is a need for more birthing centres. These would reduce the

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number of women who must leave their communities to give birth and could act as a focal point for prenatal and postnatal counselling, as well as for counselling on family planning and parenting skills.

The twelve solutions or models that the Inuit focus group on maternity care developed point to the range of needs that are required to address the current faltering system. Underlying nine of the solutions is educational and counselling support. This highlights the multifaceted need for more knowledge, not just from a modern western medical perspective, but from a traditional culturally-orientated perspective. Inuit have a viable understanding of birthing that needs to be supported, encouraged, and integrated into programs and services available in the North.



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## Executive Summary

In 1996, the *Royal Commission on Aboriginal Peoples* (RCAP) published its report. According to the Report of the RCAP, neonatal and infant deaths were largely the result of Aboriginal living conditions and the lack of health care choices of Aboriginal pregnant women and new mothers. Frequent barriers to health were also identified, such as: the lack of access to health care and transportation; shortages of food; the lack of appropriate and affordable housing; the absence of culture-based prenatal outreach and support programs for Aboriginal women; and the mandatory evacuation of birthing mothers to distant hospitals, regardless of their medical risk. In addition, RCAP noted that fathers, siblings, grandparents and extended family were excluded from the birthing process, and traditional rituals to name and welcome newborns were delayed or abandoned, with vital contributions of traditional Aboriginal midwives to health promotion and family bonding lost as well. The issues raised were described as having “profoundly negative consequences” for Aboriginal women, their children and families (RCAP, 1996: Volume.3, Chapter 3, Section 1.2, Part 2).

Now, twelve years later, this review shows that the same issues are still being discussed surrounding First Nations and Inuit maternal health care.

In 1996, RCAP reported that stillbirth and perinatal death rates among Indians were about twice the Canadian average; and among Inuit living in the Northwest Territories (NWT), the rate was about 2.5 times the Canadian average (RCAP, 1996). According to Health Canada’s *Statistical Profile of the Health of First Nations in Canada*, 2003, the First Nations infant mortality rate remained 1.5 times higher than in the Canadian population in 1999 with 8.0 deaths per 1,000 live births (based on 65 deaths) among First Nations (0 to 1 year), compared with 5.5 for Canada as a whole (Health Canada, 2003).

There are regions in Canada that are doing their best to provide optimum care to expectant mothers. Studies by Dawn Smith, 2002, *A Comprehensive Maternal Child Health Care for First Nations and Inuit Communities* and the *Secondary Research/Environmental Scan for Health Canada’s Aboriginal Healthy Pregnancy Initiative* by the Learning Methods Group, 2003, contain a wealth of information on maternal child health care.

The Smith study outlined that comprehensive maternal child care was important to the vitality of First Nations and Inuit communities. The study identified structural and policy problems and detailed the implications of medical evacuations on families and communities. Smith, 2002, also presented evidence linking maternal care with the long term health status of the child, as well as a number of effective interventions and recommendations (Smith, 2002).

The study by the Learning Methods Group, 2003, offers: a plain language document describing barriers to healthy pregnancies; promotional suggestions for health prevention and education; where to obtain resources; and best practices for healthy pregnancy initiatives by province. Also included is an Australian best practice health promotion program entitled “Strong Women, Strong Babies, Strong Culture Program” (The Learning Methods Group, 2003).

The National Aboriginal Health Organization (NAHO) produced a paper entitled *Midwifery and Aboriginal Midwifery*, 2004. It too called for a comprehensive maternal health program, described birthing centers and the critical need for more Aboriginal maternity care workers and training

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programs. It includes a listing of midwifery education programs at the university level, the status of midwifery in Canada by province and describes the emergence of Aboriginal birthing centers in Quebec, Nunavik, Nunavut and Ontario.

The Safe Motherhood Inter-Agency is a partnership of national and international agencies and identifies components of an enabling environment:

- A clear policy commitment linked to mechanisms that include women and community members in the design and implementation of health programs.
- Availability of necessary supplies and equipment.
- Functioning systems in place to refer and transport women with complications to health centers or hospitals.
- Effective education programs, supportive supervision and ongoing monitoring and evaluation.
- Legislation that both protects and allows maternity care workers to carry out all life-saving procedures in which they are competent.
- The development of national standards and guidelines for maternity care that are updated regularly based on clinical evidence, and developed in collaboration with key stakeholders including policy-makers, representatives of professional groups and the community (Safe Motherhood Inter-Agency, 2002).

It is clear from the literature that aside from providing a functioning system to refer and transport women to health centers or hospitals, and perhaps the availability of some necessary supplies and equipment, components of an enabling environment are lacking for First Nations and Inuit women and families. First Nations and Inuit know what must be done to improve maternal child health care in their communities. What is needed now is less government rhetoric and full collaborative partnerships between and among equals.

## Purpose

The purpose of this literature review was to build upon existing research and information, and to retrieve relevant studies related to maternal care in First Nations (on-reserve) and Inuit communities. In conducting the literature review, particular attention was given to First Nations and Inuit voices, their descriptions of past and present maternal care and on the suggestions and recommendations First Nations and Inuit, and other stakeholders on how to improve maternal care in their communities.

The research looked at how maternal health care was reported in the health literature and used to identify issues, priorities and best practices. This review is descriptive as well as interpretive. It required a comparison and analysis of texts, and thereby created new interpretations and cross-translated studies to enable the reader to understand how the studies are related.

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## Method and Findings

This literature review was conducted between August and October 2004. The review process began with footnote chasing or backward chaining and more than 200 citations were reviewed for relevance from reference lists of research reports, government documents, articles, books, theses on First Nations and Inuit women and maternal care, and personal communications.

The Bates model of berry picking was used as a framework to conduct these searches. Bates berry picking is an evolving research technique that is not satisfied by a single set of information but a series of selections and is not a straight linear process. It allows for follow up on various leads and shifts in thinking.

This literature review is by no means comprehensive mainly due to the difficulties in retrieving First Nations and Inuit -specific maternity health care literature as a result of scattered repositories, a quagmire of jurisdictions and the paucity of research material. Limitations of this review were due also to key words that were used in published articles in computer databases that might have been inconsistently recorded.

### 1.0 Introduction

#### 1.1 Multiple Issues Related to Equitable Maternal Health Care

In a 2004 report on perinatal care in Canada, the authors Chalmers and Wen used data from the Canadian Perinatal Surveillance System (CPSS) to evaluate morbidity and mortality among mothers and infants. Rates of stillbirth and perinatal mortality among registered Indians were “estimated” to be about double the Canadian average, and rates among Inuit in the Northwest Territories (NWT) were about two and one-half times the Canadian average (5.3 to 8.8 per 1,000 live births in 1990-2000). The report also noted that the World Health Organization (WHO) routinely inflated reported maternal mortality ratios by a factor of 1.5 to take underreporting into account (Chalmers and Wen, 2004).

Health Canada’s *Statistical Profile of the Health of First Nations in Canada*, 2003, acknowledged that Inuit-specific health data is sparse and that the only data available is from the 1991 Aboriginal People’s Survey and university-based research. Quebec, Newfoundland and Labrador, the NWT and Nunavut do not separate Inuit-specific health data. Archibald and Grey, 2000, reported 61.8 pregnancies per 1,000 females aged 15 to 19 years and infant mortality in Nunavik at 25.5 deaths per 1,000 live births from 1990 to 1994. Using the Archibald and Grey figures for comparison, Canada reported that the infant mortality rate in 1990 was 7 per 1,000 live births and in 2001, 5 per 1,000 live births in the United Nations Human Development Report 2003. This would indicate a serious underreporting or under-identification for Inuit and First Nations infant mortality rates.

In its 2002 submission to the Commission on the Future of Health Care in Canada, the Native Women’s Association of Canada (NWAC) highlighted Aboriginal women’s concerns within a holistic framework, noting that the birth rate for Aboriginal women was twice that of the non-Aboriginal population and that Aboriginal mothers are younger (55 per cent are under 25 years of age, versus 28 per cent for the non-Aboriginal population; nine per cent are under 18 years age, versus one per cent among the non-Aboriginal population). In 1996, 43 per cent of Aboriginal

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women aged 15 years and over had incomes below the Low Income Cut-off established by Statistics Canada with 73 per cent of Aboriginal single mothers living below this cut-off, in comparison with 43 per cent of non-Aboriginal single mothers. Access to culturally appropriate and sensitive services were lacking, and jurisdictional juggling resulted in program fragmentation and gaps in services.

In Smith's 2002 analysis, types of communities and access to health services are described. While communities are provided with two or more community health nurses who provide primary health care, including urgent care, physician and dental services are provided on a visiting basis to the majority of remote, isolated, and semi-isolated communities. Programs are provided by Health Canada, Human Resources Development Canada, and Indian and Northern Affairs Canada, and include Aboriginal Head Start On-Reserve, Better Beginnings/Brighter Futures, Fetal Alcohol Syndrome/Fetal Alcohol Effects Prevention Program, and Canada's Action Plan for Children. Unfortunately there is no concise reporting or coordination on whether all, or some, First Nations and Inuit are receiving these programs.

According to Smith, 2002, the review of prenatal and postnatal services is described in regional program manuals (Community Health Program Manuals). However, it is interesting to note that the most recent editions were reviewed between 1987 and 1998 as follows: Quebec Region (1987), Manitoba Region (1995), Saskatchewan Region (1996) and the Pacific Region (1998). According to the review, policy development in the 1980s continued to focus on an individual, biomedical and task-oriented approach, and varied from region-to-region. One region used a community development approach; another region had a prenatal screening protocol; one had a program on family-centred care; and another included cross-cultural considerations. Smith, 2002, recommended that the strengths of each regional policy should be integrated into a comprehensive maternal child health policy.

Although there is evidence that progress is being made in reducing maternal and perinatal mortality, more needs to be done. The literature indicates that there is an association between early and regular prenatal care and reduced infant mortality and incidence of premature and low weight births (Mikhail, 1999; Balcazar, Hartner and Cole, 1993; Institute of Medicine, 1988; Kotelchuck, 1994a; Lewis, Mathews and Heuser, 1996; Petersen, Alexander, DiAscoli and Oswald, 1994). According to the U.S. Prenatal Care Index, inadequate prenatal care is defined as entry into the service system later than the fourth month of pregnancy, or receiving less than 50 per cent of the expected number of visits (Kotelchuck, 1994). Pregnant women residing in rural areas with fewer available obstetric services in their communities frequently must deliver outside their communities. Seeking services outside the community is considered an indicator of inadequate access to care (Nesbitt et al., 1990).

The literature also reveals that women at risk of poor pregnancy outcomes have numerous needs other than medical care that often go unrecognized (Affonso, Mayberry, Graham, Shibuya and Kunimoto, 1993; Maloni et al., 1996). Unemployment, single parenthood, substance abuse, family conflicts, including conflicts with the father of the baby, all contribute to women receiving inadequate prenatal care (York et al., 1993; Young et al., 1989). In addition, equal access to health care does not ensure equitable outcomes for Indigenous Peoples. Inadequate patient-health professional communications has also been shown to determine poorer treatment outcomes (Cass, 2004).

In one California study (Mikhail, 1999), roughly one-third of the women who received less than adequate prenatal care were afraid that staff would find out about their use of substances. This



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finding is consistent with what was noted in the literature that women who smoke or use drugs or alcohol often are afraid to seek care because of possible criticism or pressure to modify their lifestyles (Institute of Medicine, 1988; Maloni et al., 1996). The study suggested that women who abuse substances need to be provided with a supportive, non-judgmental, and non-critical environment.

This same study (Mikhail, 1999) outlined that another impediment that significantly influenced women's use of prenatal care services was not having someone to care for other children at home. Women without childcare must choose between caring for their children and caring for themselves. This was also recognized as a problem in other studies (Harvey and Faber, 1993; Johnson et al., 1994; Rogers and Schiff, 1996; York et al., 1993). Although Mikhail's 1999 study was of low income Black mothers, and cautioned its generalization to other populations, his conclusions are relevant to this literature review in that he states that early and continued access to care is imperative if these women are to deliver healthy full-term infants (347).

Archibald and Grey, 2000, evaluated models of health care delivery in Inuit regions. Beneficiaries of health services commented on issues of quality of care, raising a number of issues. *"Firstly, almost every person interviewed remarked on the need for a greater emphasis on prevention, education and health promotion activities. It appears that the majority of human and fiscal resources continue to be devoted to treatment, and chronic staff shortages reinforce this pattern. Simply stated, immediate treatment needs are met first and other activities are undertaken on an ad-hoc basis."* The ability to building a cadre of trained individuals in the North as a means of addressing staff shortages and the capacity to deliver prevention, education and promotion services and activities, is further hampered by too few educational opportunities available in the North. The majority of Inuit interested in pursuing professions in these areas have to leave their communities for education and training, thereby creating a cycle of limited access to health and social services positions.

In 1999 the Vancouver/Richmond Health Board conducted a review of Aboriginal health and services and included the Musqueam Band, the only reserve-based participants to the study within the geographical area of the Health Board. The Health Board used a *"population-based health planning model that contains many of the features of a holistic perspective but excludes the spiritual component."* This framework supported integrated planning across the health care continuum, encompassing the social, economic and physical environments. It included personal health practices, individual and community resilience, including health services, early childhood development (ECD) and human biology, and a long-standing belief in the value of an Aboriginal healing centre.

To establish baseline data, the review began with:

- an Aboriginal resource inventory project;
- a capture/recapture survey method used to estimate the Aboriginal population; and
- ground work for a health survey lead to data collection (timelines included).

The reviewers avoided using the words "need" and "problem" in order to distance the review from a standard needs assessment. They also avoided a medical model approach that focuses on deficits and pathology. The medical model *"lays the ground for service delivery by high-cost, specialized health care professionals...it limits the potential of creating a holistic response to the complex and interwoven experiences of Aboriginal [P]eople[s]."*

Among nineteen community health issues and health planning priorities were identified by community from this detailed study. Priorities included addressing the: difficulty in meeting basic

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food, clothing and shelter requirements; lack of pre and post -natal care; barriers to access; absence of traditional practices with adequate remuneration for accepted Aboriginal healers.

The Learning Methods Group, 2003, noted that pregnant Aboriginal women considered lack of food security to be the key barrier that interferes with a healthy pregnancy. Information provided through the Canadian Prenatal Nutrition Program is great but not sufficient; women need access to nutritional food. One mother was quoted as follows: *“I don’t need to know five different ways to cook chicken. I need the chicken.”* (31) Low socio-economic status includes: increased risk of depression; high levels of stress; low levels of support; increased use of tobacco and other harmful substances; a greater risk for domestic violence and abuse; and increased incidence of teenage pregnancy. (33)

A need for adequate housing and baby supplies, furniture, clothes, and diapers are an additional stressor when you are poor, and many pregnant women may have low educational levels, are not employed, or are employed in low paying jobs. Additional non-judgmental assistance may be needed to help them understand written information, so plain language instructions and an oral explanation should be available (The Learning Methods Group, 2003).

The Learning Methods Group, 2003, also noted that for rural and isolated communities, access to midwifery care and prenatal classes may be non-existent or distant, and that weather and no public transit system may present additional barriers to service access whereby continuity of care is compromised.

Indigenous populations in the United States encounter multiple barriers in accessing health care resources owing to differences in language and culture (Rew, 2004; Fortier, Strobel and Aguilera, 1998). For example, in New Mexico, 44.4 per cent of pregnant American Indian women did not receive prenatal care in the first trimester. Overall, American Indians and Alaska Natives had higher rates of infant mortality between in 2002 than whites, at 8.6 versus 5.8 infant deaths per 1,000 live births (National Centre for Health Statistics, 2004), and because of sudden infant death syndrome (SIDS), infant mortality is higher for them than for the general population (1.7 versus 0.8/1,000 live births) (National Centre for Health Statistics, 2001). Differences in the cultural meaning of health and illness add to difficulty in obtaining health care services that are acceptable and that these populations believe will benefit them. These populations also lack health care providers that represent them. Estimates are that only 0.5 per cent of registered nurses in the United States are of American Indian ancestry (Rew, 2004).

In the United States, low birth weight and premature birth are major sources of infant morbidity and mortality. Preterm birth accounts for the majority of neonatal deaths not associated with birth defects (Healthy People 2010, November, 2000). Long term impairments associated with low birth weight and preterm birth include cerebral palsy, autism, mental retardation, vision and hearing difficulties, learning disabilities and delayed development (McCormick, 1985). Respiratory distress is the most common cause of death among low birth weight infants (Lishner et al., 1999).

Among the many issues regarding access to care and pregnancy outcomes, lack of adherence to prenatal advice prescribed by health care providers in distant locations, delayed hospital arrival following the onset of labour, and the stresses associated with travel and delivery in an unfamiliar setting can contribute to negative outcomes (Nesbitt et al., 1990, 1999).

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A Quebec study by Luo et al., 2003, of Inuit and Indian women concluded the two groups have different risk profiles for adverse pregnancy outcomes, prevention of preterm birth among Inuit women and of SIDS and infection-related mortality in both Aboriginal groups, with important targets for future research and intervention. Pregnancy outcomes included preterm births, low birth weight, small-for-gestational age (SGA), stillbirth and infant (neonatal and post-neonatal) death.

They noted that relative disparities between Aboriginal and non-Aboriginal women changed little over the decade (1985-1987 to 1995-1997). The leading causes of stillbirth (4,903 cases) were asphyxia (2,004 cases at 40.9 per cent) and congenital conditions (667 cases at 13.6 per cent). Immaturity was coded in 548 cases (11.2 per cent) although 36 per cent of those cases were caused by “slow fetal growth and fetal malnutrition.” (12). The main causes of infant death were: congenital conditions (41 per cent), immaturity (24.3 per cent), asphyxia (9.4 per cent) SIDS (9.1 per cent), infection (5.2 per cent), and external causes (2.6 per cent). Inuit infants had a much higher risk of infant death from immaturity-related conditions (6.3/1,000) than Indian women (0.9/1,000); infant death due to infections was much higher among Inuit (2.8/1,000) and Indian women (2.1/1,000) than other non-Aboriginal women.

Luo et al., 2003, state that excess risks of neonatal mortality were observed among Aboriginal infants, both preterm and at term, suggesting *“an urgent need to improve access to and quality of obstetric and neonatal care. The particularly high risks of post-neonatal death among Inuit and Indian infants also suggest much room for improvement in living conditions and child health care for Quebec [A]boriginal populations.”*

Barker, 2001, stated in the British Medical Bulletin, in relationship with Type 2 diabetes, that the growth of a baby is inhibited by the nutrients and oxygen it received from the mother and a mother’s ability to nourish her baby is established during her own fetal life and her nutritional experiences in childhood and adolescence. This position was supported by an earlier study that a mother’s weight at birth and social conditions of her childhood were found to affect her reproductive capacity, suggesting that influences during gestation and early childhood may have lasting effects (New England Journal of Medicine, 1995). The fetus adapts to under-nutrition by changing its metabolism, altering hormone production and sensitivity of tissues to them, redistributes its blood flow and slows growth rate.

Hospital charges for babies with a primary diagnosis of low birth weight/premature delivery average \$75,000 (U.S.) per child. The lifetime cost for children born with one of the 17 common birth defects and/or cerebral palsy is \$8 billion in just one year in the United States (National Governors’ Association, 2004).

High birth rates are a major concern for the Northern Cree of James Bay. They have the highest ever reported mean birth weight and high prevalence of infant macrosomia of any ethnic group worldwide. Infant macrosomia carries an increased risk for operative delivery, birth trauma and injury and infant morbidity (Rodrigues et al., 2000). The literature illustrates that a “one stop” program will not meet specific maternal health care needs and must be determined locally.

Pregnancy outcomes in this Quebec study also included community size, since the researchers noted that community size strongly affects access to quality health care. The Honourable Michael Mittenburger, Northwest Territories, said that his government is working on developing more birthing centers, that he wants women to be able to have their babies in their own communities but that there are problems with the federal government which considers that the population is too

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small to receive the necessary funding (NAHO Arctic Forum, 2003). Access to medical equipment that diagnose breast cancer is another issue; because small communities are not equipped with important diagnostic medical tools, Inuit women must wait six months or more for an appointment then stay in the south for a week or more waiting for results. If cancer is detected, Inuit women must stay for an even longer time to receive lifesaving treatment, away from family at a vulnerable time (Pauktuutit in Network Magazine, 2001/02).

The Honourable Ed Picco, Minister of Health and Social Services for Nunavut expressed concerns for Nunavut residents, including pregnant women, who had to be evacuated to southern health facilities. He noted that Inuit women experienced enough stress and that they should not have to go to a strange city far from their families. To address this, Nunavut is building three new medical facilities where health care will be provided in four languages. He stated that: medivac costs were between \$12,000 and \$25,000 per patient; recruitment, retention and salaries are higher than anywhere else in Canada; and primary health care provided by nurses represented 90 per cent of health care costs (NAHO Arctic Forum, 2003).

Korhonen (NAHO-HC/FNIHB/ITK Workshop Notes, 2003) stated that the purpose of the workshop was to gather information regarding FASD and help HC/FNIHB develop an effective, efficient Inuit-specific FASD policy/program framework; the program design had to be completed before any funds could be released. The notes provided background on funding initiatives since 1999 (FAS/FAE component was included in the Canada Prenatal Nutrition Program to 2003 “Doing it Right” with the focus on First Nations in on-reserve communities).

The Nunavik Regional Board of Health and Social Services recommended the use of midwives and involvement of medical nursing and community wellness services during pregnancy and prevention activities during and after pregnancy; to focus on identification of at-risk families and to provide more support, training and better coordination between all agencies.

Other regions identified: training, professional development for counsellors, CHRs, childcare workers; youth involvement; address the high turnover rates and heavy workloads in medical/educational services; high rates of alcohol/cocaine use but not addressed even when women have several FASD children; lack of services and personnel; address the alarming rates of children with FASD and the need for more culturally sensitive programs and land based treatment; provide alternative supports and sexual health/alcohol effects education in schools. A major recurring problem is deadlines for using the funds (fiscal deadline: March 2004); inflexible time frames that jeopardize effective use of funds by regions.

Over the past decade, there has been a growing amount of attention focused on demonstrating or documenting the prevalence of racial, ethnic, and socioeconomic disparities in health status, utilization and outcomes. These socio-cultural disparities are most commonly described in groups who have experienced and often continue to experience political, social, and economic discrimination. These populations have diverse health beliefs and values, differing prevalence of diseases, and may respond differently to therapies (Lavizzo-Mourey and Mackenzie, 1996).

Carroll and Benoit, 2004, presented detailed information on birthing practices and traditional teachings that are shared and the “*act of helping another woman in childbirth required no sanction from any outside medical, legal, or political authority but instead was seen as the Creator’s work*” (267). The full impact of colonialism has contributed to the demise of many Aboriginal midwifery teachings and spiritual

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connections to birthing, along with legislation in 1949 that classified midwifery as a medical act (270).

In 2001, the British Columbia Centre of Excellence for Women's Health hosted a workshop to discuss midwifery in Canada and future directions for research. The workshop brought multidisciplinary researchers interested in midwifery to begin a dialogue on priorities and strategies to carry out a national program of research. It was noted that on a professional and client level, Aboriginal access to midwifery care has been restricted. For Aboriginal midwives, this was due to practice barriers including: different world views (birth as part of life and death cycle; women honoured for their roles as life givers) different historical trajectories (role of midwife passed from one generation to the next); demise of traditional ways (colonialism, Western medicine, *Indian Act*); and midwifery legislation process (a non-Aboriginal process that was imposed through legislation).

For Aboriginal birthing women a number of barriers exist in accessing midwifery services, including, a lack of culturally appropriate practitioners for Aboriginal communities; the absence of an integrated or holistic model of antenatal care; and political and jurisdictional issues, such as the lack of subsidized midwifery services across jurisdictions (provinces and territories). In addition, it states that Aboriginal leaders in Canada must take a leadership role to prevent losing all maternity care and other health care as well.

It was positively noted by one participant who spoke of a New Zealand model where birth is supported as a community event within Maori communities, with birthing rooms built in longhouses that provide a sacred place for births attended by traditional midwives.

Dion Stout et al., 2001, identified five principle theme areas in this study of Aboriginal women's health: violence and sexual abuse; substance abuse; maternal health; health-seeking behaviour; and access to services. The Government of Canada has funded research in areas of childbearing and childbirth but much research was "*divorced from the broader social and political contexts...with increased focus on patterns of Aboriginal men's and women's usage of formal health systems, with particular emphasis ...placed on the nature and scope of access barriers and means of overcoming [them]*" (SOGC, March 2001).

The Barksdale study (quoted in Dion Stout et al., 2001) found that the definition of health for Aboriginal women is considerably different than that of non-Aboriginal women. Aboriginal women emphasized "*the toxic role played by racism and sexism in undermining their health and well-being, together with detrimental effects of poverty, unemployment and culturally inappropriate or inaccessible health services.*"

Excellent references made to other studies included positive developments to empower and build relationships with other Aboriginal women; identification of issues of access to services (racism, cultural insensitivity, lack of Aboriginal personnel, geography, lack of basic and essential community services, lack of culturally appropriate information, lack of access to traditional medicines (impact of environmental degradation, economic development, private property ownership, loss of traditional lands where medicines were gathered). Future studies should focus on health seeking behaviours that reflect positive coping strategies and resilience (Dion Stout et al., 2001).

Kioke's (1999) thesis provides a wealth of information on the nurse's role in the care of pregnant women as having a significant [negative] impact. Other risk factors included adolescent pregnancy, grand multi-parity, malnutrition, diabetes, poverty, and geographic remoteness. The Western biomedical model was viewed as a "cultural imposition" and that existing literature consistently

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identifies a need for culturally congruent care to be a priority to achieve improved health outcomes (2). A study identified Northern Native women's cultural beliefs and values as differing from other southern groups of women, including Aboriginal urban women; that health promotional goals must be directed towards family-centered care versus mother as primary caregiver.

In a 1988 study by Burke et al., 1988, northern mothers identified changes needed in maternal health care services during pregnancy, labour and delivery. The main concerns expressed were: discontinuity of medical care, poor communication by health professionals, inflexibility of hospital facility and staff, and attitudes of certain health care workers.

Women identified the breakdown in transmitting cultural beliefs (cultural discontinuity) among the women. Kioke, 1999, states that to address the issue of cultural transmission, there is a need to re-conceptualize prenatal care as "traditional cultural wisdom." Many women did not see value in the Western model of prenatal care, and their views were aligned with findings that pregnancy and birth are tightly intertwined with each society's cultural system (Waxman, 1990; 9). These findings are concurrent with those of Smith, 2002, that effective maternal child health programs should emphasize the need for cultural safety and appropriateness, the importance of trusting relationships with primary care givers, and underscore barriers to early maternal care.

Neander and Morse, 1989, discussed the socio-cultural dimensions of infant feeding practices and interviewed twelve elderly women who used traditional ways of childbearing and rearing and twelve women who used present-day practices. The major findings were: changes to childbearing and the removal of childbirth from the household to the hospital resulting in the loss of social support and care from midwives for mothers who felt insecure and afraid. Infant feeding changed from breastfeeding to widespread use of canned milk. For those who did breastfeed, it was only for a short time. Traditional and present day mothers introduced solid foods at an early age but traditional mothers pre-masticated the infant's food rather than use commercial baby foods or a blender.

Kioke, 1999, spoke to northern Elders who noted the changes in the family that have negatively affected breastfeeding patterns. Breastfeeding was previously a cultural norm that no longer, or only minimally, exists and Elders connected this to parenting practices that ensured the continuity of family as the central, holistic unit and that "*children of today are suffering long term negative repercussions from the changes in some childbirth practices.*"

Present day mothers spoke of isolation and distress, feeling scared and shy about asking for information. Nursing services are often in short supply and it is clear that the health care system is not meeting the emotional needs of these mothers. It was recommended that the system incorporate, consult with, and accept recommendations from Elders. It was also imperative that traditional teachings and supports for new mothers be instituted under Native family and community control in all aspects of pregnancy, delivery and child care, and family and community supports; and that there is a responsibility among health professionals to conduct a cultural assessment of a group and devise goals and recommendations in conjunction with the community.

Archibald and Grey, 2000, spoke of the shortages of doctors and nurses in the north as being intensified as a result of current shortages in southern Canada. They stated that the long-term solution is to focus on creating an education system that produces young people with the academic backgrounds to pursue medical careers in the North. The goal of building a pyramid with community people trained on-the-job, modules, partnering with existing institutions like Arctic

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College, offering a nursing program in Iqaluit, College of the North Atlantic in Goose Bay (nursing program in 2005), Kativik School Board and its affiliates, to provide training for nurses, community health representative (CHRs), social workers, midwives, health administrators, laboratory and x-ray technicians, etc. Eventually, with concerted efforts by governments and education systems, more people from the North would fill the top of the pyramid (53-54). Long-term solutions are needed to address the chronic difficulties in recruiting and retaining health professional staff.

For Aboriginal and Torres Strait Islander Peoples (Phillips, 2004), health outcomes are governed more by the historical and social determinants of health, than with Aboriginality. Prior to colonization, Indigenous Australians were healthy and maintained physical, emotional, mental and spiritual wellness. Thus, the prevalence of illness in today's society cannot easily be attributed only to genetic or even behavioural causes. Rather, as supported by the evidence, the preferred view is that current health outcomes result from a range of interrelated historical, environmental, physiological, political and behavioural factors (7). Phillips also notes that in Canada, the USA and Aotearoa/New Zealand, a convincing case has been made that the health and well-being of Indigenous Peoples is strengthened both by having their sovereignty recognized (Kunitz and Brady, 1995) and having control over their own health care service delivery (Ring and Firman, 1998).

## **1.2 In the Absence of Respectful Listening: The System Stays Broken**

In November 1993, Martha Flaherty, President of Pauktuutit Inuit Women's Association made a submission to the *Royal Commission on Aboriginal Peoples* (RCAP) in which she stated that the people did not want to be studied again but to be listened to and have their words taken seriously. In her submission she stated:

The overall health and well-being of our people are intrinsically tied to the social, political and economic development of our communities. We can no longer afford to pay the price of dividing the issues into manageable portfolios, programs and services. A holistic, integrated approach is necessary at every level and in relation to every issue or problem (RCAP, 1996: Volume 4, *Realities and Perspectives*, Chapter 6, "The North").

The RCAP Report recommended that: Aboriginal organizations, regional planning and administrative bodies and community governments, currently administering health and social services, transform current programs and services into more holistic delivery systems that integrate or co-ordinate separate services (RCAP, 1996: Volume 3, *Gathering Strength*, Chapter 2; "The Family", Section 3.3.8). RCAP also recommended that traditional and bio-medical practitioners continue to engage in dialogue, with two objectives: enhancing mutual respect and discussing areas of possible collaboration (RCAP, 1996: Volume 4, *Realities and Perspectives*, Chapter 2, "Women's Perspectives").

Yet, according to an evaluation of models of health care delivery in Inuit regions, quality of care is compromised by the lack of Inuit involvement at all levels of the health care system and the failure to integrate Inuit knowledge, values and culture into the health and social services (Archibald and Grey, 2000; 53).

*To Bring Birth Back to the Communities, is to Bring Back Life: An Inuit Model* (Nunavik Midwifery Working Group, 2002), a document presented to the Quebec Minister of Health and Social Services, states

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how Quebec's Midwifery Act threatens the future of a best practice model of maternity care (1986) at the Inuulitsivik Health Centre (IHC) in Puvirnituaq, Nunavik (northern Quebec).

Despite the fact that the WHO and other prominent organizations have recognized the integrated care and education/training program of the Inuulitsivik Health Centre, and that "maternity" has improved from levels of care that were two to three times poorer than southern regions to levels that are now better than the Quebec average along with concerns expressed by the Quebec Native Women's Association and the Assembly of First Nations-Quebec and Labrador to Quebec's National Assembly and the Standing Committee on Institutions (George, 1999), the government of Quebec failed to include the Inuit in the consultation process prior to the passing of Bill 28.

Archibald and Grey, 2000, also noted that it is imperative that Inuit are involved in participatory decision-making and informed debate to provide a clear vision for their communities and their regions. Decisions about health care budgets are primary and decisions concerning short-term needs and long-term goals can have huge political implications and can cause public outrage leading to a destabilized environment.

Current research is also becoming increasingly critical of existing structures (Pauktuutit, quoted in Dion Stout et al., April 2001). To address problems in existing structures, the Inuit Tapiriit Kanatami Summary Report (2003-2004), stated the position that discussions should be from the perspective of developing an overall Inuit Specific integrated policy strategy, connecting *"the cross cutting relationship between health, housing, education, economic development, the environment and government accountability...If these issues are addressed independently, or in the absence of holistic or Inuit Specific policy approach, then we will be no further ahead, and the system will remain 'broken'"* (8).

Pauktuutit (in Network Magazine, 2001/02) participated in many national health policy discussions and design of initiatives until the organization lost its small health consultation funding in October 1999. Inuit women lost their ability to voice their concerns and direct health matters that affect them the most.

The Pan American Health Organization (PAHO, 2002) reviewed documents retrieved from 1990 to 2000, and included 48 countries and territories, including in North America. The review was an in-depth look at: models of care (medical and primary health care); the health status and health risks in the Americas; components of care (providers, location of services, types of programs, health concerns and issues); implications and priorities for the new century; and educational barriers and needs. The review recognized that *"over-arching determinants of preventable illness and death are often the result of poverty, unemployment, and lack of participatory development, not biological/physiological determinants...Policies devoid of the values embedded in society...can negatively affect health status on an individual and community level"* (1).

In a 2002 Abstract, Lauer et al. commented on the World Health Organization's published health system performance ranking 191 member countries based on fixed weights common to all countries. Based on a framework outlining a set of social goals, Lauer et al., 2002, stated that health systems should contribute to:

- improving population health;
- being responsive to the people they serve; and
- being financed fairly.



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Five outcome indicators include: level of population health; inequalities in health; the level of responsiveness, inequalities, unresponsiveness; and fairness in financial contributions.

Lauer et al., 2002, found that criticism and controversy surrounds the use of fixed weights, common to all countries because it ignored people in different cultural and social settings who value individual health system goals in different ways and because fixed weights were based on expert opinion from largely health system professionals to a WHO survey. Lauer et al., 2002, conclude that by building in the flexibility of varying weights might yield greater benefits in terms of respecting individual circumstances by allowing them to assign greater importance to indicators that are meaningful to their countries rather than by the experts whose judgments formed the basis of the original WHO weights.

The Millennium Development Goals (MDG) is a compact among rich and poor nations to end human poverty. In 2000, the adopted United Nations' Millennium Declaration committed world leaders to work together to reduce poverty and advance development by 2015 or sooner. One of the three sets of issues that countries debated during the 1990s was "the need for social justice and involving people in decisions that affect them and their communities and their countries" (1). In 2004, MDG continues to state that:

Underlying many of these synergies (improving health and education requires related interventions in schooling, family planning, health care, nutrition and water and sanitation) are agency and equity. When poor people have political power protected by civil and political rights, they can be more effective in pressing for policies that create social and economic opportunities. Such power is especially important for women, as well as for ethnic and racial groups that face discrimination (69).

The United Nations Development Program, 2004, defines capacity development as:

the ability of individuals, organizations and societies to perform functions, solve problems, and set and achieve goals...entails the sustainable creation, utilization and retention of that capacity, in order to reduce poverty, enhance self-reliance, and improve people's lives...builds on and harnesses rather than replaces [I]ndigenous capacity. It is about promoting learning, boosting empowerment, building social capital, creating enabling environments, integrating cultures, and orientating personal and societal behaviour.

It is clear that without the participation of Indigenous Peoples in the development of health care policies, programs, educational opportunities and legislation affecting them, Indigenous Peoples will struggle to achieve capacity development as defined by the United Nations Development Program.

In a comprehensive discussion paper on maternal child health care in First Nations and Inuit communities, Smith, 2002, reviewed the literature by Klein et al., 2002, who identified the synergy between general and specialist physicians, nursing and regulated midwifery. Each profession contributes to an adequate and safe maternity service. She continues by stating that role modeling from the many health professionals involved in communities would be a *"positive step toward building a cadre of Aboriginal health professionals, and a long term goal of self-reliance."*

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Under its strategy for health care renewal Health Canada states that the “*health care system is a reflection of our values as a nation, and embodies a commitment to equality, fairness and access based on need and not ability to pay, regardless of place of residence*” (Health Canada, 2004). During their meeting in February 2003, First Ministers committed to universality, accessibility, portability, comprehensiveness, public administration and jurisdictional flexibility.

Unfortunately, the First Ministers commitment runs counter to the findings of *A Statistical Profile on the Health of First Nations in Canada* (Health Canada, 2003), which refers to the impact of demographic trends on communities, such as the rural-urban migration, and sees the impact in terms of decreasing the population base entitled to non-insured health benefits (NIHB), whereas, Aboriginal populations would see this trend as portable benefits since rights to health benefits do not stop at the borders of reserves, settlements, regions, provinces or territories.

On a positive note, in 2002, the Committee of Deans of Australasian Medical Schools (CDMAS) partnered with the Office of Aboriginal and Torres Strait Islander Health (OATSIH) to establish and implement the CDAMS Indigenous Health Curriculum Development Project. CDAMS proposed to the Australian Medical Council (AMC) that this framework be included in the national accreditation guidelines. The AMC formally approved the guidelines as part of their regular national accreditation requirements. What this means for Aboriginal Peoples in Australia is medical schools are provided with a set of guidelines for success in developing and delivering Indigenous health and well being content in core medical education (Phillips, 2004). Physicians from Canada have shown an interest in the project and Aboriginal Peoples in Canada can learn much from the project to obtain similar institutional reform.

In the United States, the federal Indian Health Service, state and local health departments, are working with Native American communities to develop programs that will meet these health challenges (unintentional injuries, cirrhosis, homicide, suicide, pneumonia, domestic abuse, FASD, and complications of diabetes, which is 230per cent than the general population...). By recognizing and incorporating American Indian and Alaska Native traditions, culture, and values into community health care programs, health care providers are becoming more effective in meeting the needs of this very diverse minority (National Library of Medicine, 1996).

In Canada, the First Ministers Meeting on Health, held in September 2004, resulted in a federal blueprint commitment to sustainable financial support in key areas of First Nations and Inuit health with an investment of \$700 million for: integrated primary and continuing care; health human resources; healing and wellness; and information and research capacity.

## **2.0 Elements of Effective Maternal Health Care Programs**

Smith, 2002, submits for evidence that effective maternal child health care programs emphasize:

- community control or involvement;
- cultural safety or appropriateness;
- the development of a trusting relationship with a primary care giver; and
- home visiting/a multiple intervention approach.

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## 2.1 Community Control and Involvement

Archibald, 2004, participated in a study of teenage pregnancies in Inuit communities. The study involved over 50 Inuit adults and youth who participated in focus groups and interviews, with several recommendations including that all strategies must be initiated, developed, delivered and controlled by Inuit and implemented in a culturally appropriate manner, with Inuit youth actively involved at all stages. Steenbeek, 2004, suggested several avenues to engage youth in empowering health promotion activities by altering structural power inequalities. Prevention services that employ adolescent outreach workers who closely reflect target clients in terms of age, ethnicity, language spoken, and experience have proven effective in a number of areas.

Carroll and Benoit (in Bourgeault et al., 2004) noted that legislation restricted Aboriginal midwifery in British Columbia and the lack of Aboriginal midwives on regulatory bodies limited their ability to impact decision-making. They concluded that community-based involvement is needed to merge traditional Aboriginal ways of knowing and modern science and that one of the struggles facing Aboriginal community-based midwives was how to standardize midwifery services to meet community needs and allow full autonomy and control.

Interesting questions were raised around what resources were needed to build a viable infrastructure, what degree of public education was required to overcome dependency on Western medicine and pinpointed the need for viable research to look at what communities required to build capacity. Primary data was gathered from two focus groups held by the British Columbia Ministry of Health and involved Aboriginal Elders and CHRs in Kamloops and Vancouver in 1993. Secondary data was gathered from Aboriginal and non-Aboriginal midwives throughout Canada and included current developments in Aboriginal midwifery in their respective provinces and territories (265).

At the international level, lack of community control or involvement resulted in the failure of the Experimental World Literacy Program sponsored by UNESCO and several governments. Sociological problems (feelings of inferiority, increased repression) arose when “*questionable translations were done only in majority languages or official languages, ignoring the diverse multiplicity of other languages within these countries*” (Wendell, 1982; 51 in Watters, 2003).

Watters, 2003, in her review of literacy and health education programs, noted the significant difficulty these programs had on vulnerable populations. A one-language and one-culture approach to literacy and health education has historically prevailed. Because of the inability of health care providers and educators to speak local languages, understand silence and be open to cultural differences of priority populations, modern health care services and family planning have often failed in these communities (Karan and Ishii, 1996, in Watters, 2003). A Canadian study by Breen, 1993, found that partnering literacy and health stressed the importance of collaboration between the community, health, and literacy experts.

Dion Stout et al., 2000, also stated that research initiatives must be reflective of Aboriginal women’s linguistic and cultural diversity. Reading and writing convey meaning of speech and thought and is therefore “*paramount for health practitioners and educators to not only understand the relationship between literacy, health, and culture but also the varying levels of literacy from preliterate to functionally literate [in a second language].*” Their review of the literature noted the relationship between literacy, health, and culture, and that collaborative development is “*crucial to accuracy and acceptability of materials.*”

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*“The lack of accessible information and low literacy levels mean that many Inuit women do not have basic health care knowledge. We need educational material in our own language, Inuktitut, and in plain English.”* (Pauktuutit, in Network Magazine, 2001/02).

## 2.2 Culturally Competent Health Care

Ross (1998) discussed the historical events surrounding midwifery in Canada, and north western British Columbia in particular. The current medical birthing model was shown to have a history of professional and masculine dominance and that the feminist-revisionist natural childbirth movement did not challenge the ideology of medical-technology based birth, and both were deficient in their exclusion of cross-cultural social realities and histories of childbirth (25). Through interviews with Elders and other stakeholders, Ross advocates the following:

- traditional knowledge must be protected and promoted;
- prenatal care must not only be accessible but culturally sensitive;
- socio-economic barriers should be addressed in all programs, including one-to-one counselling and home visits;
- develop culturally sensitive resource materials;
- establish awareness strategies, such as birth is not a medical event, that traditional childbirth is an entire community event;
- promote choice by establishing community birthing centers;
- promote awareness of midwifery as a profession;
- provide southern centers and hospitals with culturally-based programs when evacuation is necessary, by providing language interpreters, cultural foods, medicines and recognition of spiritual practices;
- establish birthing group homes to allow families to stay together and be in the company of others in similar situations; and most importantly
- enlist the help of Elders to teach in workshops and programs (pages 119 to 124).

Browne’s thesis, 2003, states that health care delivery to Aboriginal Peoples continues to be influenced by internal colonial relations. The purpose of her dissertation was to address the present research gap relating to how First Nations women and nurses relate to each other and to *“more fully understand (a) the socio-political and historical contexts of relations between nurses and First Nations Women, and (b) the extent to which these relations shape routine interactions between nurses and women.”*

Colonialism continues to affect Aboriginal women in a myriad of ways that are distinct from that of the dominant culture (for example, continued racism, sexism, *Indian Act*, the continuing impacts Bill C-31, under employment, denial of political rights and residential schooling). Negative images of Aboriginal women continue to be highly prevalent. Currently, the determinants of Aboriginal women’s health demonstrate major discrepancies when compared with other Canadian women.

*“In this study, three overlapping discourses informed nurses’ practice with Aboriginal women: (a) theories of culture, (b) liberal notions of egalitarianism, (c) and popularized discourses of Aboriginality.”* Cultural sensitivity has assisted nurses in understanding how culture intersects with health and healing. However, stereotypical negative images reframed as cultural characteristics tend to be applied as markers of “otherness” in practice. Additionally, “culture” has become politically correct language for

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discussions of “race” to take place. Canadian society and its institutions (including health care) are premised as egalitarian, just and fair with equal treatment representing a shared ideological discourse and professional script among nurses.

In direct conflict with these principles, images and discourses of Aboriginal Peoples as dependant, addicted, undeserving and unclean are pervasive and become benchmarks of “otherness”. *“Historical positioning, past experiences, and power differentials inevitably come into play and shape relations between nurses and First Nations.”* The current climate of health care and the corresponding structure of nurses’ work (high patient loads, staffing shortages and long shifts) have limited the amount and quality of time nurses and patients interact, socially distancing the nurse from the patient. This exacerbates the relationship of “otherness” already experienced by Aboriginal women patients and influenced the way nurses related to Aboriginal women. Patients are also affected by social and historical positioning, attempting to fit themselves into existing health care dynamics in order to improve the care they received. The author recommended:

- recognizing the limitations of cross-cultural training;
- introducing cultural safety into Canadian health care practices as an alternative to cross-cultural training;
- that nursing education should situate social determinants of Aboriginal health within the historical and structural context of colonial relations, including basic knowledge of the *Indian Act*; fostering an understanding of the political nature of nursing practice, particularly as it relates to groups who are marginalized by politically mediated social conditions;
- developing linkages with Aboriginal communities to teach content on the above; and
- developing training modules on the above for practicing nurses and providing opportunities for nurses and students to interact with Aboriginal communities or groups as a way of challenging myths and stereotypes.

In a journal article by Wittig, 2004, cultural beliefs and values profoundly influence the actions of Native American Peoples. Wittig, 2004, stated that culturally competent nurses need to understand, respect, and demonstrate sensitivity to the values of Native American cultures. Culturally competent nurses could then be able to appreciate the importance of adjusting health interactions to make them more readily accepted (Plawecki, Sanchez and Plawecki, 1996). She noted that the concept for health as defined by Native American Peoples is often based on traditional beliefs, that human kind has an intimate relationship with nature by living in harmony with the spiritual, environmental or the individual.

Wittig, 2004, also noted the work of Hutchens, 1991, and Weslager, 1973, who found that the spiritual and physical health of Native Americans is dependent on harmony with nature, and to heal physically, nature must be in balance. For many Native Americans, all of nature is considered related and interconnected. In other words, if the land is healthy, the people are healthy. Wittig, 2004, cites similar findings in Leninger, 1991, who found cultural values of harmony between the land and the people, the importance of spiritual guidance and acceptance and use of folk healers.

Data from several common research findings identified seven dimensions considered essential by Native Americans. The dimensions identified include: (a) caring; (b) traditions; (c) respect; (d) connection; (e) holism; (f) trust; and (g) spirituality. Wittig, 2004, notes the work of Plawecki, Sanchez, and Plawecki, 1996, who identified the health and illness beliefs of Native Americans.

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Their work identified five great values that guide Native American clients: generosity and sharing; respect for elders; respect for nature; choice; freedom; and courage.

Wittig, 2004, states that the focus of previous studies centred on trans-cultural nursing and Native Americans but none produced specific research on knowledge, skills, and attitudes of nursing students and cultural competency.

A study by Weaver, 1999, which is considered as important because it surveyed Native American nurses, student nurses and social workers from 23 different tribes in the United States, who provided meaningful data regarding cultural competency. Weaver, 1999, identified four knowledge themes, four skill themes, and three attitude/value themes, and found that nurses must know about, and show respect for, the cultures and histories of the Native American Peoples. This would include culturally-specific health beliefs and healing practices, such as, smudging and the traditional use of sweat lodges.

Weaver, 1999, found that:

- many Native Americans felt it was important for nurses to practice listening and being quiet as a style of communication;
- respect for diversity and traditions was identified by the survey as being critical to serving Native Americans; and
- being open-minded and non ethno-centric were viewed by the nurses as fundamental values that enhanced their work with Native American Peoples. Although prior research has documented the importance of giving culturally congruent care, these studies lacked information regarding the perception of nursing students in particular.

Weaver's 1999 survey was originally developed and designed for use with Maori helping professionals in New Zealand regarding culturally congruent care and was refined and pre-tested in the survey with Native American nurses. The survey found that classroom cultural content identified possible gaps or missing information, in that:

- The nurses identified knowledge of the basic beliefs of some groups (i.e., Native Americans).
- The need for awareness and appreciation of all groups as an emphasis in the classroom;
- students thought it would have been particularly helpful to have guest speakers from a tribe visit the classroom.
- The students said more information that related specific cultural aspects to health care practices would have been appreciated.
- The students expressed a strong desire to become culturally aware and competent in their clinical practices.
- Knowing the status of nursing students regarding cultural knowledge, skills, and attitudes is an essential responsibility of nurse educators and institutions of higher learning.

Wittig, 2004, noted that students did not specifically indicate the need for a cultural assessment, but recommended the introduction of a cultural assessment tool in the classroom for student use, with suggested published resources for student use relating to cultural assessment and care and a tool that measures cultural competency:

- Geiger and Davidhizar, 1999, in *Trans-cultural Nursing: Assessment and Intervention*;

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- *Trans-cultural Concepts in Nursing Care* by Andrews and Boyle, 1999; and
  - *Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals*, Campinha-Bacote.

**Other findings included the following:**

- The study provided nurse educators with better information regarding the status of students' cultural competence.
- The study suggested that the current nursing curriculum supports the development of cultural competence among the newest nurses
- The study provided positive feedback that students are becoming more culturally aware, sensitive, and appreciative of diversity;
- The goal of culturally congruent care is supported by the students' responses in the demonstration of a theoretical understanding of the concepts necessary to provide culturally competent and meaningful care.

Geiger, 2001, wrote in the Canadian Medical Association Journal of the need for cultural competency based on reviews of peer reviewed literature in the United States that provided overwhelming evidence that African American, people of Hispanic origin and American Indians are strikingly less likely to receive life saving surgery and treatment compared to white patients matched for education, age, income, etc.

Basic elements of clinical care such as physical exams, history-taking and lab tests and adequacy of medication for pain were identified as disturbing, with speculative explanations that include patient-physician communications problems, lack of cultural sensitivity and competency on the part of physicians and other health care workers and mistrust of the health care system. To address the problem, distinguished organizations are reviewing the evidence and will make recommendations for change; proposals are underway to make cultural competence a requirement for health professional schools at the undergraduate and graduate levels (Geiger, 2001).

Eschiti, 2004, writes of a holistic approach to resolving American Indian/Alaska Native health care disparities by providing culturally appropriate education, promoting educational opportunities in nursing for American Indian/Alaskan Native people and mentoring Native nursing students. The Salish Kootenai College credits a 93 per cent pass rate by infusing the curriculum with American Indian culture (talking circles, interactive learning format and Elders). To increase retention for Native youth to become teacher/educator nurses and server as mentors they promote "plant the seed early."

Te Kaunihera Tapuhi o Aotearoa, Nursing Council of New Zealand (2002) developed Guidelines for Cultural Safety, the Treaty of Waitangi and the Maori Health in Nursing and Midwifery Education and Practice to set and monitor standards and competent care for the public. The model has three parts that include the definition and content of cultural safety education, links between the Treaty and its principles; and the Treaty informs students about Maori health and nursing/midwifery practice, with emphasis on its contribution to achieving positive health outcomes for individuals, families and communities. The guidelines caution that Maori health is specialized teaching and should be delivered by nurse/midwife staff that have a solid understanding of the Treaty and Maori health issues.

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Ananeh-Firempong, 2003, advocates for a new framework for cultural competency that would include organizational, structural, and clinical interventions based on evidence of socio-cultural barriers to care and the levels of health care delivery, noting an often overlooked and important cultural competence intervention of providing interpreter services and culturally and linguistically appropriate health education materials.

Writing in the *Western Journal of Nursing Research*, Kirkham, 2003, states that both structural forces (inappropriate or inaccessible health care) and individual actions (racism by health care professionals) contribute to inequities in health outcomes. She notes that particularly in Canada, health care and nursing literature has been silent on matters such as inequities in health, marginalizing practices, racialization and racism, and a pervasive tendency to focus on culture as an influence (or barrier) to health and illness in an effort to account for differences in health outcomes. Kirkham states that to focus on culture as a panacea or solution to health care problems leaves unexamined deep-rooted institutional and structural forces that perpetuate inequities.

A similar model of cultural safety education such as the Maori model may be considered for Canadian institutions, and can be nation/tribe/community-specific. An introduction to the history of Indigenous health and knowledge past and present and would be an opportunity to share Indigenous worldviews.

### **2.3 Development of a Trusting Relationship with a Primary Care Giver**

A birth in Rankin Inlet: Surrounded by her boyfriend, older daughter, three nieces, two nephews and sister-in-law:

They were excited. My boyfriend was so speechless, he was crying. With my first daughter down in Churchill, I was all alone. I didn't want to be there and I swore and cursed at the male doctor. This time the care I got from my midwife was the best. If I got pregnant again, I'd hunt her down to be my midwife again (Eastern Arctic Birthing Workshop, quoted in Lowell, 1995).

I thought I'll never survive the loneliness and fear of waiting. Everyone here at home I know, no one over there is familiar. Everything is different-moving stairs, white people talking English and checking me all the time, no normal (traditional) food, and no wide open spaces on the land. My kids sent me drawing with tears dripping down the page. I cried on the phone to my husband every night. There is no one (no one who is Inuit) over there (From Eastern Arctic Birthing Workshop, quoted in Lowell 1995).

Two different childbirth experiences, one birthing experience was frightful and stressful, the other, was joyful, with family and a midwife to provide cultural safety. Cultural safety is but one component of achieving cultural competency and is a standard of professional nurse/midwifery practice for the Maori of New Zealand as previously mentioned.

Northern Native women felt an *"overwhelming need for many changes in health care services during pregnancy, labour and delivery."* They identified problems in discontinuity of medical care, poor communications with certain health care workers, inflexibility of the hospital facility and nurses and attitudes of certain health care workers (Kioke, 1999). Several other studies referenced evacuation and communication with professional staff as a critical issue that creating distrust (Webber, 1992), communication with health providers were described as "rushed and authoritarian"(Sololoski, 1995),



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and BC Native women did not perceive nurses as a part of their health care system and that addressing communication problems and cultural competency was recommended (Clarke, 1990).

Health care providers should give more attention to interpersonal communications with pregnant women to reduce their anxiety about the medical examination and gain their trust. The women's cultural beliefs, traditions, and lifestyles should be respected and considered in any communication with them. Continuing education programs on communication skills, cultural diversity, and women's psychosocial needs must be provided to all health care workers (Mikhail, 1999).

## **2.4 Home Visiting/A Multiple Intervention Approach**

Home visiting was deemed most effective as one part of a multiple intervention program that included components such as community level breastfeeding education and advocacy, hospital and clinic based support and interventions, nutrition support and education, and referral to other community resources. The effectiveness of home visiting varied: effective and cost effective with high risk populations with high dose, high intensity of prolonged duration; less effective with low risk populations (Smith, 2002).

In a review of U.S. In-Home Visitation Programs (Rapoport and O'Brien-Strain, 2001), best practices were identified from five nationally recognized models of home visitation based on empirical evidence. A best practice was based, among others, on the following factors: philosophy and culture; home services provided; target population; nature of client participation; attrition; credentials of staff; and duration and frequency. (See Annex A, Best Practices in In-Home Visitation Program).

## **3.0 Birthing in Inuit and First Nations Communities**

Unfortunately, the debate we often find ourselves engaged in is premised on disrespect for our history and for the knowledge and skills which many of our elders still possess. We often find ourselves on the defensive, endlessly declaring that we, too, are concerned about maternal and infant mortality rates. We have not been allowed to engage in this debate as equals....Changes [need to be] made to the health care system to allow women to regain control of pregnancy and childbirth. In many areas, this may mean the development of regional birthing centres; in others, it might mean providing nursing stations, with the necessary staff and equipment to safely accommodate childbirth. In all cases, it means utilizing the skills of Inuit elders as teachers and midwives and setting up training or apprenticeship programs. (Submission to the Report of the *Royal Commission on Aboriginal Peoples*, 1996, Volume 3, Chapter 3, by Martha Greig Vice-President, Pauktuutit, Ottawa, Ontario, November 1, 1993).

Dr. Elizabeth Wilson's 2003 study presented at the First National NAHO Conference involved twenty Elder women ages 60 to 89 years young who spoke of their birthing stories. She found that the women did not distinguish between pregnancy and birthing which was viewed as a continuum with the focus of their birthing process beginning at conception. The Elders spoke of their care during pregnancy, locations for birthing, family birthing support, the items used for birthing, medicine during birthing, infant and mother's care after birth, and bindings used for infant and mother. Wilson noted that historical documentation of First Nations' birthing is scarce to non-existent, with sparse documentation available on infant care.

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Pauktuutit, 1995, asked Inuit midwives why they had stopped practicing and they revealed that since the nurses took over birthing: they were no longer invited to assist; that many women have to leave town (to deliver); and that they are afraid of being reprimanded by the nurses for practicing midwifery, and threatened with legal charges (13).

Hospitals and nursing stations contribute to alienating factors associated with childbirth and include language barriers, a mother's sense of loneliness, shyness and stress (Pauktuutit, 1995).

Alex Wilson's 2004 research project was undertaken by the Aboriginal Women's Health Research Committee and supported by the Prairie Women's Health Centre of Excellence. Results were gathered from group discussions and individual interviews with Aboriginal women in Manitoba and a review and analysis of current research relevant to Aboriginal women's identity and wellness.

The women's identities are inseparable from their family, history, community, place and spirituality and that health care practitioners, providers and policy makers, including federal and provincial governments, need to assist Aboriginal communities in the development of the infrastructure, human resources and administrative structures needed to create and control health care services that are rooted in the cultural practices and values of Aboriginal women and men they are serving. It recommended that further research that focuses on the identity and well-being of Aboriginal women in remote communities will enhance understanding of the connection between well-being and identity of Aboriginal women. A traditional person described childbirth as one of the sacred ceremonies. Women have so much to offer. (16)

The *Indigenous Women's Health Book, Within the Sacred Circle*, (Asetoyer et al., eds., 2003), describes all aspects of women's health in plain language, from menstruation to menopause, to detailed information on pregnancy, diabetes, contraception and more. The book deals with pregnancy and "Revisiting the Customs of Birth" and explains the customs of the Uto-Aztec traditions of birth and the role of Elders and midwives; early traditional midwifery practices developed knowledge of nutrition, assessing appropriate fetal growth and position, and knowledge of, and techniques for, managing complications of pregnancy, childbirth and post birth. The midwife is concerned with the mother, their families and the community. The authors state that this is where Native midwifery is differentiated from non-Native midwifery and medical care—they were concerned with all the factors needed for the health of birthing families.

The authors suggest that support is needed to integrate traditional knowledge into the health care system and encourage Native women to study midwifery by providing them with access to traditional community and institutional education and training. Other topics covered are nutrition, breastfeeding, teen pregnancies and infant mortality, informed consent, issues surrounding sterilization of Native American women in the 1970s, problems of access to and delivery of health services (availability, accessibility and affordability, acceptability).

Pauktuutit, 1995, documented the role of the husband in traditional births, that it varied from being present but uninvolved, to supporting his wife's back or legs during labour, to providing skilful assistance. Often, however, he provided crucial physical and emotional support. Another woman recalled that her husband made sure she ate well and that he "hunted for my cravings." There is also a suggestion that a formal practice existed for men to build a birthing shelter (12). Males were not sheltered from birthing knowledge. They gained experience from watching their mothers, wives, and daughters give birth (13).

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A community health representative (CHR), Winnie Greenland, spoke of the role that CHRs play in prenatal and nutrition. Other speakers spoke of food equity and expectant mothers, babies and children who don't receive adequate nutrition (lack of traditional foods) are at risk. Traditional healer, Be'Sha Blondin said Aboriginal Peoples are working with hospitals to put in healing centers so they can combine modern medicine with traditional healing (NAHO, Arctic Forum, 2003).

The newsletter, Suvaguuq, 1995, issued a Special Report on Traditional Midwifery, an edited version of the report on Pauktuutit's traditional midwifery research project conducted between October 1992 and January 1993. Elders from ten communities were interviewed and there is a wealth of traditional Inuit midwifery life stories, traditional midwifery techniques and how the education of Inuit midwives was transferred from one generation to the next.

Many Elders stated that many skills and knowledge were required to become a midwife and that childbirth was seen as a normal part of family and community life, not an isolated medical event; childbirth and family and the role that Inuit men played in childbirth was mentioned as key elements that could lead to strengthening family ties and reducing social problems. With the gradual displacement of Inuit midwives, fathers, and family members playing pivotal roles in childbirth and maternal care, that *"...without an ongoing midwifery practice in the north, the vast knowledge base of Inuit elders is threatened with extinction."*

McGrath conducted an interview with Regilee Ootova about traditional midwifery and contains profound knowledge waiting to be passed on to the next generation of Inuit midwives. Regilee Ootova shares her experiences as a midwife and says that an Inuk woman in labour can *"be guided to give birth using Inuit knowledge alone"* and that birthing and labour are not an illness. Working with a traditional Inuk midwife, she discovered the high level of skill required, that knowledge was gradually acquired with wise advice. Not wanting this knowledge to be lost, she has collected information from Inuit midwives and from women who gave birth before the North had doctors. She presented a paper to the NWT legislative assembly in 1989 that Inuk midwifery should not be lost, that Inuit must have the opportunity to give birth in their own homes and should be done while Elders are still alive.

Traditionally, Inuit women were guided throughout their pregnancy. They were advised to keep active to promote quick labours, to eat nutritionally, including what broths to drink to stimulate lactation and to get adequate rest. The physical health and well-being of pregnant women in Inuit society was a shared responsibility. It was the personal responsibility of the pregnant woman and family responsibility of the husband, parents and in-laws (Pauktuutit, 1995).

Teenage pregnancy in Inuit communities was identified as a priority issue at the Inuit Health Workshop held at Pauktuutit's annual general meeting in 2000 and in a survey of Inuit community health centers conducted in 2002. For this study, over 50 Inuit adults and youth participated in focus groups and interviews. A holistic approach must involve federal/ provincial/territorial governments, Inuit organizations, communities, health and social services boards, schools and education authorities, Inuit youth, Elders and parents; more time must be devoted to Inuit men, their parenting roles and responsibilities and how they perceive themselves as husbands, fathers and partners, both traditionally and in the contemporary world; all strategies must be initiated, developed, delivered and controlled by Inuit and implemented in a culturally appropriate manner, with Inuit youth actively involved at all stages.

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As early as 1984, Medical Services Branch, Vancouver in partnership with the Native Infant Education class at Malaspina College (Duncan, British Columbia) produced a book on traditional child birthing knowledge of the Salishian and Nuu-chah-nulth Nations of Vancouver Island. Using images and traditional teachings passed down orally from Elders, it describes how women and their families must prepare to have a child, describes dietary and behavioural restrictions for pregnant women and their husbands, that birth is holistic. The teachings continue into the post-partum period, early childhood and adulthood (Ross Leitenberger, 1995).

Kioke, 1999, spoke of northern First Nations and the high rates of adolescent pregnancies. She spoke of the historical behaviour codes that were needed to continue to exist in a harsh environment, where men and women had to acquire survival skills prior to planning for a child. These skills provided a greater chance for survival for the child and the family but since the people have been settled in static communities, young people no longer need to delay childbirth and this may be a factor for high rates of adolescent pregnancies.

Specific resources and needs were identified by Kioke, 1999, throughout the document: i.e. the need for community resources; prenatal care; CHRs; midwives; address Inuit-specific issues; including community size; to learn from Elder's experiences and wisdom.

Although this document did not identify Inuit-specific information, Inuit have been dramatically impacted by their findings. Ford and Van Wagner, 2004, reported on the many Aboriginal communities who spoke to the Equity Committee (late 1980s and early 1990s) about their experiences in forced medical evacuation of all pregnant women to southern health facilities, where many women experienced overt anti-Aboriginal discrimination; they stated how these forced evacuations were linked with problems such as substance abuse, sexual abuse, and family violence. In addition, it undermined women's self-esteem and relationships between men and women; the loss of common knowledge about pregnancy and childbirth and the loss of transferring birthing skills from one Aboriginal midwife to the next generation. The authors found that there was strong support for midwifery services in every community visited (to preserve Traditional midwifery and to have services that combined access to and knowledge of "white" medicine.

Dr. David Miller, 2005, a general physician in Puvirnituk, spoke of his appreciation in working with midwives from the Inuulitsivik Health Centre. He liked their design of pregnancy and childbirth and his experiences have been positive. He acknowledged that some southern doctors have conflict with Northern midwives to illustrate Inuit midwives' knowledge of maternal care: *"We had an emergency of prolapsus cord. By the time that I call[ed] Montreal, the midwife had already regulated the problem. In the south, one would have made a Caesarean"* (Miller, 2005).

In Taloyoak, Lowell, 1995, reported a women's group working hard to return Inuit childbirth to the community and had developed a birthing program modeled after the Puvirnituk Maternity Centre in Quebec. They have developed strong support within the community and from the Kitikmeot Regional Health Board.

At present, there is no birthing center at the Judy Hill Memorial Health Center and provides basic health services to community residents. All women are flown out to Yellowknife, NWT though there are nurse-midwives. Ella Subramaniam, a nurse-midwife said that more support is needed for Inuit to make the health care system work for the people. Inuit women have a difficult time and need to feel good and equal, that having a baby is a joyous time. She was very happy that more Inuit

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women are breastfeeding and feels that working more closely with the Community Health Representative would be a positive step to promoting healthy maternity care in Taloyoak (Personal communication, September 23, 2004).

Ford and Van Wagner, 2004, state that in Northern and remote communities, women described serious problems of: lack of facilities, long distances to obtain childbirth services, lack of control over birth experiences; how many people leave to train in health professions but rarely return. They mentioned that incentives were needed to change this: grants, special funding, more health programs in the north, distance education programs and alternative teaching methods. Many non-Aboriginal women were also accepting of having home births and midwives trained to handle home births in isolated conditions. Primary concerns in Aboriginal and non-Aboriginal communities were continuity of care, informed choice and choice of birth place.

In 1990, the Inuit Broadcasting Corporation and Pauktuutit Inuit Women's Association produced a film entitled, "Ikajurti, The Helper". The film deals with Inuit birthing issues in the North and talks with Inuit midwives, mothers, doctors, nurses, regional health authorities, and the NWT Minister of Health. NWT policy, similar to other northern regions throughout Canada, was to evacuate all pregnant mothers because "*hospitals are better to handle the risks of childbirth.*"

High risk mothers were identified as being: young, older mothers, severe hypertension, diabetic, or had abused drugs/alcohol. Inuit state that they have weighed the risks and many are choosing to give birth in their communities. Inuit midwives spoke of their responsibilities to ensure the pregnant mothers are supported from pre to post-natal care; eating more country foods, family involvement, breastfeeding support, and birthing education. Younger Inuit midwives are asking elders to help them because they are important. As Inuit discuss how they want their births to take place, they have asked themselves: Do we want our babies delivered in regional hospitals? Smaller hospitals? Nursing stations? What kind of training is necessary for midwives? Nurses? Doctors? Mothers and fathers? What other kinds of backup support is necessary? They end with "The answers are beginning to emerge."

#### **4.0 Defining Maternity Child Health Care**

Smith, 2002, provides four definitions/visions of what maternal child health care is from the New Zealand Health Funding Authority, 2000; Health Canada, 2000; the International Conference on Population and Development, 1994; and UNICEF's International Guidelines for Safe Motherhood, 1999.

An operational definition was provided by Smith, 2002:

Maternal child health care includes interventions at individual, family and community levels aiming to improve capacity for safe and healthy pregnancy, birth and transition to parenting. It occurs from the preconception period until several months past birth, when women, infants and families are integrated effectively with early childhood programs and services. Women of childbearing age are the key target for programs and interventions, but neonates and infants, families and communities are also the foci of interventions (10).

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Perhaps one of the first tasks of First Nations and Inuit communities is to define, for themselves what maternal child health care means to their peoples, what it entails, what traditional values and beliefs are important (or not) as an important first step to developing a maternity care policy that sees fragmented service and program delivery integrated into an integrated holistic model of care (9).

Smith's 2002 Discussion Paper on Maternal Health Care in First Nations and Inuit Communities was prompted by the evacuation policies and practices and to determine:

- What are the values and issues related to maternal care in rural and remote on-reserve and Inuit communities?
- What opportunities and challenges are suggested by the evidence and the structures for delivering high quality culturally safe maternity care?
- What can we learn from the experience of other jurisdictions?

Her analysis found that current maternal child health care in First Nations (on-reserve) and Inuit communities falls short of national and international standards, relies heavily on evacuation of women in late pregnancy for medically safe births and minimized attention to key factors influencing perinatal health and development.

It was determined that maternal child health care can be improved when program design was community driven, culturally safe, delivered by a multidisciplinary team, focused on early recruitment, development of trusting relationships, adequate resources, ongoing training and support, effective information management, well developed protocols for transfer between health care organizations and community involvement. The study emphasized health promotion and prevention from preconception to post partum should be supported by evidence and stakeholder values.

Policy was hampered by an unstable workforce, poorly developed management and health information system, as well as the challenges of isolated communities, increased prevalence of perinatal risk factors in the Aboriginal population and a current shortage of health professionals. Adequate resources, ongoing training and support, effective information management, well developed protocols for transfer between health care organizations and community involvement were necessary for effective program implementation and evaluation.

The work by Smith, 2002, is a comprehensive, well researched document that is still relevant today. Smith noted her study as lacking in the *“involvement of women, families, community leaders and front line care providers in rural and remote Aboriginal communities, but considered their perspective as integral to development beyond this initial policy synthesis phase”* and *“limitations for Aboriginal [P]eople[s] were not applied as this significantly reduced the pool of evidence available for the review. As a result, the majority of the evidence synthesized has limited generalizability to the specific culture and context of on-reserve communities.”* This finding supports the need for a qualitative and quantitative meta-analysis research study that involves First Nations and Inuit Peoples directing, defining, and analyzing any future maternal health care research.

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## 5.0 Best Practices in Inuit and First Nations Midwifery Models of Care

### 5.1 Inuulitsivik Health Centre

Since 1986, the Inuulitsivik Health Centre has provided a community-based, apprenticeship model of midwifery education and practice in Nunavik. It is unique for its success in integrating Inuit culture with the present health care system and working in an interdisciplinary team with other health professionals and regional health authorities. It was noted that “the front-line nature of midwifery services in a remote area and the reality that all women—not simply those at “low-risk” or those who choose—are followed for at least part of their pregnancies by midwives, require a larger scope of practice than that of southern regions (To Bring Birth Back to the Communities, is to Bring Back Life).

The system recognizes midwives at two levels:

- Community midwives who attend births with a certified Nunavik midwife or OSFQ (Quebec permit) midwife and care for women and babies during normal pregnancy, birth and postpartum, in addition to their active roles in community health, well-women care and well-baby care.
- Nunavik Midwifery Act as team leaders for maternity services for all women and extended roles in emergency care and community health and education.

In addition to the midwives role in prevention and support care, this comprehensive model of care includes walking with the women long after the defined perinatal period. After a first visit to the doctor, Inuit midwives follow women with medical conditions, deal with multiple forms of violence and abuse, special needs of adolescent women while emphasizing self-care, nutrition, rest, group and family counselling, teaching sex education and nutrition in schools and through local radio stations, family planning, running Pap and STD clinics, and much more.

#### 5.1.1 The Perinatal Committee

A subcommittee of the Council of Doctors, Dentists, Pharmacists and Midwives, the Perinatal Committee whose members are doctors, nurses, midwives, student midwives and for important policy decisions, community representatives. The Committee meets weekly to review each woman’s chart at 31-34 weeks from a multidisciplinary perspective. The Committee jointly decides on the plan of care and intended place of birth, with Inuit midwives adding a valued socio-cultural aspect to the assessment.

#### 5.1.2 The Training and Education of Inuit Midwives

**Direct Entry:** Midwives first serve as “anniasurtiapiit” (health care workers), or as postpartum maternity workers. This allows individuals to learn the basics. Individuals that wish to continue may apply for the intensive midwifery training.

**Apprenticeship/Experiential:** Midwives are involved in the care of at least 50 pregnant women before becoming a primary caregiver; under the supervision of a senior midwife, the trainee will be

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responsible for 60 women, including team leader at birth. Before completing the course of studies, each midwife will have cared for up to 200 women, with a minimum of 1240 supervised clinical hours. Training weaves traditional knowledge and social points of view into the theory and practice of Western medicine.

**Perinatal Committee as Model for Evaluation:** Each midwife trainee will have attended the case review discussions of at least 200 women at the interdisciplinary Perinatal Committee meetings and have prepared and summarized the obstetrical chart for each woman under their care.

Inuit vision of having their Inuulitsivik midwifery education process accredited to ensure that Nunavik midwives who learn in their communities can legally practice in Nunavik and to grant certification to both levels of midwifery (community midwives, Nunavik midwives).

The midwifery program is culturally appropriate, delivered in the language of Inuktitut, a non-degree certification, competency-based program and founded on principles of apprenticeship/ on-the-job training, with core competencies consistent with both Quebec and Ontario and adapted to the needs of northern practice. It was noted that there are seventeen U.S. states that have approved competency based programs for certification.

### 5.1.3 Obstacles to Overcome

To continue delivering the Inuulitsivik midwifery education program, structural and financial barriers needed to be addressed, including:

- funding needs for developing teaching resources;
- costs associated with the accreditation process;
- funding to hire teachers who will deliver the program modules at Inuulitsivik Health Centre; and
- the elimination of legislative restrictions in obtaining educational accreditation.

Quebec's *Midwifery Act* 1999, (Bill-28) has presented serious consequences for the future of the Inuulitsivik Health Centre and Inuit midwifery services in Nunavik. The Act:

- Ignores the fact that Nunavik midwives actually work with and within the infrastructure of the regional health establishments (hospitals and the Centres de loisir et services communautaires - CLSC's).
- Disrespectfully rejects Inuit maternal child health care knowledge essential to transmitting Indigenous knowledge to future midwives and extending Inuit midwifery services to other villages.
- Defines midwives in such a way that denies Inuit definition of midwives as defined by Nunavik communities. As a consequence, Inuit women will no longer be permitted to provide maternity care services.
- Exposes community midwives and their employers, (Inuulitsivik Health Centre and the Nunavik Regional Board of Health and Social Services) to civil liability should problems occur while providing maternity care services.
- Under Article 208, guarantees that future coordinators of midwifery services be members of the Order of Quebec Midwives (OSFQ), thereby implying that southern midwives with little or no



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understanding of Inuit community and cultural dynamics, history, and scope of practice to run their services are better able to provide service. (The current coordinator is an Inuk, a locally educated midwife recognized under Bill 28).

- Under Article 259.2, allows only midwives who are members of the OSFQ and have insurance to be hired by a CLSC and hold administrative positions.
- Under Article 225.1, determines that only members of the OSFQ can sit on the Council of Midwives, effectively keeping Inuit midwives from decision-making positions that determine competency and employment criteria, and directs midwifery care to those outside of Nunavik who lack “an intimate understanding of the context and circumstances of northern practice and of Inuit communities.”

Seventeen years have lapsed since the first request in 1987 to the Quebec Ministry to establish the Inuulitsivik Health Centre as a recognized midwifery teaching center and a budget request to deliver a specialized northern midwifery program.

## 5.2 Rankin Inlet Health Centre

The Rankin Inlet Health Centre began as a two-year pilot community birth project (1993-1995) in response to Inuit women wanting to deliver their babies closer to home and with their families. It was initially staffed with nurse-midwives by the NWT Department of Health. Later it accepted registered direct entry midwives from other jurisdictions due to difficulties in recruiting experienced nurse-midwives in Canada. It is now an established program under the Nunavut Department of Health, with positions for three midwives, two Inuit maternity workers, a translator, and a project coordinator who provides prenatal, delivery and postnatal care and well-baby clinics. The role of the Inuit maternity workers is health promotion. An Elder from Rankin Inlet facilitates small prenatal groups in teaching traditional birthing and local women prepare country foods to teach about food groups and nutrition (NAHO, 2004).

The Rankin Inlet Health Birthing Centre provides low-risk obstetrical services in the Kivalliq region to the Inuit community in the eastern Arctic. The Birthing Centre offers birthing rooms for women to labour, deliver and receive post-partum care. A choice of birthing bed and birthing stool are provided along with a bassinet for baby. A private entrance offers women and families the opportunity to share the birth experience, have access to a communal kitchen and examining rooms.

Although it is a permanent facility, it operates without a legislative framework due to absence of midwifery legislation in Nunavut. It continues to be plagued with recruitment and retention problems and from time to time is forced to withdraw community birthing services because of staff shortages. The expressed desire of the community to have Inuit primary care providers has never been fulfilled as no comprehensive midwifery training program has ever been provided to local women. Discussions are under way about the development of such a training program. (NAHO, 2004)

In her article Lowell, 1995, found that 88 women came to the Centre, with only 22 delivering there while 66 were hospital births in Winnipeg, Yellowknife and Churchill. High risk factors identified one third of the women as first-time deliveries. Another one-third of women were high risk based on 52 per cent of pregnant women who smoked during pregnancy, which can lead to low birth rates

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and other complications. The first two nurse-midwives left the project and have been replaced. At the time of this article (Lowell, 1995) there were no First Nations or Inuit midwives or birth attendants involved in the project which leads some critics to comment that it was still southern-focussed, medically-based, and non-traditional.

### **5.3 Prenatal Visitation Pilot Program**

Prenatal Visitation Pilot Program uses teleconferencing (using satellite technology to transmit medical images and information between remote communities and medical experts in larger centers) to let expectant mothers in Iqaluit see and speak to their families every week. Nunavut Minister Picco said patients receive consultations in dermatology, internal medicine, orthopedics, cardiology, counselling and psychiatry. [http://www.nunatsiaq.com/archives/nunavut000531/nvt20505\\_12.html](http://www.nunatsiaq.com/archives/nunavut000531/nvt20505_12.html)

### **5.4 Iewirokwas Midwifery Program**

In Mohawk, the word “iewirokwas” means, “pulling the baby out of the earth”. The Mohawk Nation at Akwesasne operates this program, which focuses on education, empowerment, and Aboriginal healing practices.

The Director of the Iewirokwas Midwifery Program in Akwesasne, Katsi Cook, is an internationally recognized leading expert of Aboriginal midwifery education. Her contribution and responsibilities include developing a curriculum for Aboriginal midwifery education and developing collaborative links with individuals and organizations focusing on women’s health and wellness and empowerment to the women and their families. The program informs them of their duties and responsibilities, traditional Mohawk birthing rites.

The Midwifery Education Program is a four-year program with clinical placements with a family physician, obstetrician, hospital, or in one of the birthing centers located in Six Nations, Ontario or Puvirnituk, Nunavik that could provide extended learning sites and broader connections with other Aboriginal midwives. The training schedule focuses on the “normal” in pregnancy, labour, birth and postpartum care; the final year focuses on birth complications. The curriculum covers anatomy and physiology, social and cultural dimensions of health, statistics, reproductive physiology, physical assessment, informed choice presentations to clients, breastfeeding counselling, alternative medicine, pre/post -natal care, physical assessment of the newborn midwifery theory and practical, clinical placements, legislation and much more. Through workshops, one-on-one and group prenatal care, the program teaches pregnant women about their birthing rights along with traditional Mohawk birthing rites so that women can feel educated about her choices and not intimidated by their medical provider.

The program works with local obstetricians, nurses and other health care staff to educate them about traditional birthing practices so both medical staff and mother are better equipped to work together.

Because of the program, more Mohawk women have begun using the birthing stool, smudging, and other Mohawk birthing practices, drumming, singing, uses of herbs and speaking to their newborns

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in the Mohawk language. Iewirokwas has also worked hard with other Aboriginal Peoples to obtain an exemption for Aboriginal midwives in Quebec's midwifery law, Bill 28.

The program trains Mohawk midwives in Akwesasne and in other Mohawk communities

## **5.5 Tsi Non:we Ionakeratstha Ona:grahsta'**

Tsi Non:we Ionakeratstha Ona:grahsta' at the Six Nations Maternal and Child Centre, located at Six Nations of the Grand River, Ontario opened its doors in 1996. Aboriginal midwives and support staff provide traditional and contemporary midwifery services and programs, offering a choice of services that support personal beliefs and customs. Established as a department within the Six Nations Council Health Services, Tsi Non:we Ionakeratstha Ona:grahsta' receives its funding through a formal agreement between the Six Nations Council and the Aboriginal Healing and Wellness Strategy. The three-year training program graduated its first class of midwives in 2003 and as of January 2003, the midwifery caseload has steadily increased from 13 clients in 1996 to 47 clients in 2002, a total of 252 clients (NAHO, 2004).

Midwifery services provided include: complete prenatal care, complete labour and birth care (home and Centre), complete postpartum care (home or Centre) breastfeeding support, Pap Tests, Women and Well-Baby Issues, educational and emotional support, traditional family teachings and traditional medicine, annual birth celebrations and more. Protocols are in place in the event that referrals to obstetricians and hospitals are necessary.

Traditional teachings play an important role in their programs encompassing male and female traditional self-care, traditional workshops in parenting, medicines and foods and women in all her seasons. Other programs are the Aboriginal FAS/E Child Nutrition program, prenatal and exercise classes and access to a family, maternal resource library and the Aboriginal Midwifery Training Program.

## **5.6 Access to Traditional Healers**

Sioux Lookout Hospital, Ontario permits traditional midwives to assist the mother through much of her pregnancy although no actual labour coaching or home births are allowed. A self-help program was initiated to be more responsive to the First Nations community and create better liaison between health care workers and community. Traditional healers may practice in the hospital if services are requested by the patient, while midwives may give prenatal and postnatal counselling to the mothers (Malloch, quoted in Ross Leitenberger, 1998).

Yellowknife General Hospital offers a First Nations Health Program that includes: First Nations Health and Social, Liaison Workers, Child Life Worker, Traditional Diet, Traditional Medicine, Interpretation Services, In-Service Training/Education and Community Liaison Health Promotion.

A Healing Room is available to be with a patient, practice traditional ceremonies and the Coordinator assists families to access traditional methods of healing. Two suites and one sleep room are available to families in times of need.

These are but two examples of hospital settings that offer traditional healers and liaison workers within the health care system. Additional research is required to do an in-depth analysis to determine

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scope of access to traditional healers and other First Nations and Inuit health care providers and liaison workers in hospitals and health centers in Canada.

## 5.7 Alaska Native Medical Centre

The Alaska Native Medical Centre has been successful in providing prenatal care to Indigenous women and their families in 30 remote Alaska Native villages.

A Study described the Rural Maternal Child Health Program as a successful model of prenatal care, providing health care services for Indigenous women of childbearing age who do not have ready access to health care. Prenatal care was initiated in first trimester of pregnancy with the study showing that from 1985 to 1999, improvements to first trimester prenatal visits (91 per cent compared to 31 per cent); 9 per cent in their second trimester (compared to 58 per cent) no woman waited until their third trimester (compared to 11 per cent).

Findings compared favourably with data from Indian Health Services in Alaska (77.4 per cent of women with live births entered care in their first trimester). Dr. Eby, who works for the Alaska Native Medical Centre, said that his team transformed services for Alaska's Indigenous population from the ground up and significantly reduced the pressure on emergency and specialist services. He began by asking the Indigenous community what they wanted. *"What they want, what they prioritize, what's important to them and then we'll provide technical expertise within that context around healthcare issues"* (Baldwin and Stevenson, 2001).

## 6.0 Models of Midwifery Education and Training

Canada is currently facing a shortage of maternity care providers that grows more acute every year (NAHO, 2004, taken from Milne, 2001). The shortage is felt most acutely in rural and remote communities and has fostered an increased acceptance of midwives as appropriate care providers for low risk pregnancies. For Aboriginal communities, this development provides opportunities for the restoration of midwifery and community births (NAHO, 2004).

The present situation of midwives in Canada is a patchwork quilt, with a number of arrangements including:

- Midwifery as a regulated and publicly funded profession.
- Midwifery as regulated but not publicly funded.
- Midwifery as funded but unregulated.
- Midwifery as unregulated and non-funded (NAHO, 2004).

Specific midwifery legislation exists in only three provinces: Quebec, Ontario, and Manitoba. The profession is regulated under other legislation in Newfoundland and Labrador, Saskatchewan, Alberta, and British Columbia. In the Northwest Territories, Nunavut, Yukon, Prince Edward Island, New Brunswick, and Nova Scotia, midwives work without any applicable legislation. In some parts of Canada, Aboriginal midwives are exempt from midwifery regulations. This is true for example, of Ontario, where Aboriginal midwives practice at the Six Nations Birthing Centre (NAHO, 2004).

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Aside from the traditional midwifery way of seeing-doing-learning to be a maternal child care giver, Benoit and David-Floyd, 2004, presented three models of midwifery training: apprenticeship training; vocational training; and university training. The history and characteristics of each training model is given, along with the strengths and limitations of each.

In the 1970s and 1980s, “lay” midwives began to develop educational methods and programs to preserve the sophisticated apprenticeship knowledge system and prevent it being incorporated into universities. Use of a more professional title “independent” or “direct-entry” was used to denote non-nurse midwives.

In 1982, non-Aboriginal “lay” midwives founded the Midwives Alliance of North America (MANA), and developed standards for practice and core competencies; its associate, the North American Registry of Midwives (NARM) then developed a national certification, the Certified Professional Midwife (CPM)—MANA members wanted to legitimize apprenticeship by creating methods to evaluate the knowledge, skills and experience of apprenticeship-trained midwives. This certification is now part of the licensure process in Manitoba.

The authors state that the apprenticeship model remains an appropriate route for Northern midwifery education since it is the apprenticeship training model that establishes the midwifery ideal for continuity of care, an ideal that other training programs can only strive to emulate. The Netherlands vocational model is a four year program with three schools that do not have enough spaces for the number of applicants. Dutch midwives believe their model retains a separate, woman-centred and unique program that protects their special knowledge and autonomy; their program does offer mechanisms that enable midwifery graduates to continue to university if they choose. The authors state that all three models are not mutually exclusive, as many apprenticeship programs include didactic classes and some form of apprenticeship or clinical training, which are also part of the vocational and university-based educational programs.

In support of midwives and home birthing, Tew and Damstra-Wijimenga (1991) analyzed national perinatal mortality rates (PMR) of 185,573 births in Holland in 1986, demonstrating that for all births after 32 weeks gestation mortality was much lower under midwifery care (non-interventionist care) than under obstetrical care (interventionist care). Findings concurred with other studies from Britain, New Zealand and Finland. Statistical evidence is provided in the document. Dutch midwives have no prior qualifications in nursing and are trained and recognized as autonomous practitioners; protection of midwives field of care is encouraged by public health insurance (the Sick Funds). The PMR by birth attendant, place of birth and risk factors for 1986 was found to be higher for doctors in hospital (18.9 perinatal deaths per 1,000 births) than for doctors at home (at 4.5 deaths/1,000 births); higher for midwives in hospital (2.1 deaths/1,000 births) than for midwives at home (1.0 deaths/1,000 births). PMRs were also compared to the weeks of gestation cared for by obstetricians in hospital and midwives in hospital and home.

For all gestations, PMR was higher for obstetricians (18.9 deaths/1,000 births) compared to midwives in hospital and home (1.5 deaths/1,000 births). Perinatal outcome is determined by two or three factors: pre-delivery risk status of the baby; the nature of maternity and neonatal care; possibly the setting in which delivery takes place. The very low PMRs for home births in Holland, even for those in so-called high risk groups, may reflect, not only the competence of the midwife, but also the beneficial effect of emotional security for the mother in a relaxed familiar setting (9).

The WHO accepted the conclusion of the studies and recommended that the contribution of modern technology to childbirth should be reduced (WHO, 1985, 10).

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As previously mentioned in Cass, 2004, it is often assumed that a hospital, by virtue of immediate access to technological support, provides maximum safety. In fact the available literature does not provide conclusive evidence that hospital birth is safer for properly screened clients. Many hospitals in rural and northern communities do not provide on-site operative delivery, and have emergency equipment comparable to the equipment a midwife carries to a home birth. With careful antenatal screening, these hospitals have been able to deliver safe and effective care to women and their babies (College of Midwives of British Columbia, 1992; Ontario College of Midwives, 1994; Baird, A.G., Jewell, D., Walker, J., 1996; Baird, A.G., Jewell, D., Walker, J., 1996; Nesbitt, T.S., Frederick, A.C., Hart, L.G., Rosenblatt, R.A., 1990).

These compelling arguments and facts do not support the medical evacuation of all women from remote, isolated and semi-isolated communities to secondary or tertiary care centers at 36 weeks. The need for comprehensive maternal health programs was highlighted from data collected from the First Nations and Inuit Regional Health Surveys Report (AFN, 1999). Included were components of an enabling environment; the need for organizational support for Aboriginal midwives; and a human resource strategy (including training initiatives) to dramatically increase the numbers of Aboriginal midwives and related maternity care providers, as access to services is a grave concern. The Safe Motherhood Inter-Agency Group, that includes groups such as UNICEF and WHO, has advocated a partnership between the health system and communities to ensure services respond to local needs and address barriers that limit Aboriginal women's access to care (NAHO, 2004).

The issue of who determines that someone is qualified to be a midwife warrants exploration. In Canada, some Aboriginal midwives want to be exempt from midwifery regulations for reasons of culture and self-determination – for individuals, families, and communities. These midwives believe that Aboriginal culture, with its effective healing and life cycle traditions and knowledge, can be practiced and protected through Aboriginal midwifery. The sacredness and safety of the birth experience is of paramount concern (NAHO, 2004).

In some Aboriginal nations, birthing practices were shared and midwifery was not viewed as a profession with specialized education and training. For these reasons, some Aboriginal midwives and pregnant women see the medicalization of childbirth as yet another manifestation of colonialism. Other Aboriginal midwives prefer to work within established professional associations of their respective provinces, such as the Colleges of Midwifery in Manitoba and British Columbia. These midwives believe that by integrating contemporary midwifery and traditional best practices, they are able to provide the best quality care possible to Aboriginal women. They also enjoy the flexibility, portability and financial rewards of an accredited health profession (NAHO, 2004).

## 7.0 Conclusion

An overview of the current status of maternal and child health care in Aboriginal communities by Smith, 2002, identified that the cornerstone of maternal child health care for Aboriginal communities has been the medical evacuation of women from remote, isolated, and semi-isolated communities to secondary or tertiary care centers at 36 weeks. The women give birth in major urban areas, separated from their families and communities (Smith, 2002; NAHO, 2004).

Smith demonstrated that the following evidence does not support this practice:

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- When women are separated from the support of families and friends, there is an increase in small, premature infants, as well as maternal and newborn complications, even though the majority of women have come to maternity centers with a good standard of care.
  - Postpartum depression is more likely in women experiencing high stress and low support during the perinatal period.
  - The ability to successfully establish breastfeeding may be compromised.
  - Family relations are strained and paternal attachment during the critical first week is negatively impacted.
  - Communities and extended families are denied the opportunity to celebrate birth (Smith, 2002; NAHO 2004).

## 7.1 The Issues

Retrospective analyses of recent publications in large databases have confirmed disparities in birth outcomes between Aboriginal and all other groups, but there is a paucity of prospective data. There are few comparisons between specific Aboriginal groups (Inuit, Métis, First Nations, or between First Nations), or comparisons of Aboriginal groups with the general population.

In the United States, underestimating American Indian/Alaskan Native infant mortality rates because of misclassification of race on death certificates hinders assessment of unmet needs and progress toward national health objectives and few studies link American Indian/Alaskan Native mortality rates nationally and stratified by residence location using data linking birth and death certificates (Baldwin et al., 2002). Archibald and Grey, 2000, noted that the overall health status of the Inuit falls far below rates in Canada (17) and that geographic variations and differences among sub-populations limit the comparison of regional data (10). Further research is needed collect and respect these variations and differences for Inuit and First Nations Peoples to assess their unmet needs.

Although small improvements have occurred, the issues have not varied. What remains static is:

- Less than adequate, often inconsistent maternal child health care (lack of continuity of care, informed choice, choice of birthplace, access to quality of care)
- Impact of community size and geographical location as a barrier to access to care, limited programs and services, long distances, lack of medical equipment
- Recruitment and retention problems of physicians, nurses, specialists in remote/isolated and sparsely populated areas
- Extremely high costs associated with health care delivery (i.e. 90per cent of primary health care delivery budget goes to nurses' salaries, etc. in NWT)
- A majority of pregnant women in rural/remote/isolated areas must still deliver outside their communities (medical evacuation of 'at risk' pregnancies in some areas, in others 'all' pregnant women); major mental, emotional, physical distress on mother, family, community and discontinuity of cultural knowledge transmission
- Majority of human and fiscal resources spent on treatment and not on prevention, education and health promotion

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- Serious lack of First Nations and Inuit health care workers because of lack of health career educational/training opportunities in rural/remote/isolated areas and lack of sustained funding to support ongoing training needs
  - Communications difficulties due to language and cultural barriers, hindering cultural safety
  - Lack of culturally and linguistically appropriate health promotion information
  - Lack of culturally competent practitioners in First Nations and Inuit communities
  - Barriers to an integrated holistic model of maternal health care resulting lack of access to and knowledge of First Nations and Inuit midwives and traditional healers, thus a lack of choice
  - Environmental degradation impacts negatively on food and medicine sources
  - Racism
  - Roles and responsibilities of father, siblings, family community in childbirth
  - An integrated holistic maternal health care model that includes traditional teachings, skills and knowledge and western medicine
  - Roles of Midwives and Community Healthcare Representatives (CHR's) can play in pre-conception, pre and post natal care and throughout the lifespan
  - Role of Elders in transmitting knowledge and wisdom on women, men and children's health.
  - Lack of programs to track where midwives are, what services they offer, First Nations and Inuit health professionals, where they are practicing, in what field.

## **Risk Factors**

- Difficulty meeting basic food, clothing and shelter requirements
- Smoking, alcohol and other substance abuse
- Serious overcrowded housing
- Youth unemployment
- Abuse and violence
- Depression
- Poverty
- Teen pregnancies
- Low educational levels
- Diabetes Type 2 and Gestational Diabetes
- Single parenthood
- Lack of adherence to prenatal advice from health care providers
- Stresses associated with long travel and delivery to unfamiliar settings, leaving other children behind for lengthy periods of time

## **Structural Issues**

- Concise data on First Nations and Inuit maternal, prenatal and infant health care is difficult to retrieve, with statistical information gathered and stored in various provincial/territorial and federal departments.
- Lack of maternal and perinatal surveillance system that would address the underreporting and under-identification of First Nations and Inuit found to occur in provincial/territorial reporting; and, to identify special needs of rural/remote/isolated communities, frequency of access to maternal child health care programs and services, number of birthing centers and locations, number of hospitals, CLSC/health centers and locations who offer midwifery and traditional healing; retention and duration of care, satisfaction of users to produce measurable outcomes,



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ongoing monitoring and develop national standards guidelines for First Nations and Inuit Peoples.

- Lack of participatory development on legislation, policies, programs and services between Inuit and First Nations Peoples and federal, provincial and territorial governments has lead to an outdated, inconsistent policy commitment to pursue a comprehensive holistic maternal health care for Inuit and First Nations Peoples (policy manuals vary across provinces/ territories).
- Education institutions need to commit to change by including cultural competency for all health career programs on a national level.
- Inflexible program funding timelines jeopardize effective use.
- Inflexible hospital facilities and health care providers for meeting the cultural, emotional and safety needs of Inuit and First Nations.
- Lack of recognition that First Nations and Inuit health outcomes are the result of interrelated historical, environmental, physiological, political and behavioural factors; hence the need for a comprehensive holistic maternal health care approach that integrate and coordinate separate services.

## 7.2 Improving Maternity Care in First Nations and Inuit Communities

The literature recommends that Inuit and First Nations communities determine for themselves the relevancy and appropriateness of all programs and services and they alone should determine the needs of their Peoples. The following models identified through the literature review are only suggestions that can be considered by Inuit and First Nations communities and regions.

One model put forth by Smith, 2002, for effective maternal child health care emphasizes:

- Community control and involvement.
- Cultural safety or appropriateness.
- Development of a trusting relationship with a primary caregiver.
- Home visiting/A Multiple Intervention Approach.

These key factors for effective maternal child health care are found in the Inuit and First Nations Models of Midwifery Care. Their success lies in the fact that they are community controlled and have community involvement, by the very nature that First Nations and Inuit are midwives, providing culturally appropriate services and choices to pregnant women. Inuit and First Nations midwives know the culture, the community and the families, and are comfortable and trusting of their care. They provide home visits with the women, take time to talk about their feelings, how they are doing and can develop a trusting relationship with the midwife. As one midwife said, she keeps in contact with the woman and infant long after the birth; a special bond develops between the child and midwife.

Canada provides program funding for nutrition and healthy pregnancy initiatives but it is the midwives, CHRs and Elders that shape the delivery of services at the community level to reflect the specific needs of the people they serve.

The training that First Nations and Inuit midwives receive is a unique marriage between the traditions of their Peoples and western medicine, a competence-based apprenticeship training program that far exceeds the narrow bio-medical model of childbirth. Inuit and First Nations

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women have a vested interest in ensuring the best health outcomes for both mother and infant—they are the continuation of their Peoples.

### **7.2.1 Initiatives, Prevention, and Interventions**

The literature suggests that primary initiatives should include improved access to culturally appropriate prenatal services and screening for and intensive management of diabetes in pregnancy; encouragement of breast-feeding and other programs to prevent obesity in early childhood; and provision of nutrition, physical activity and quit-smoking programs.

Effective secondary prevention should be directed at the control of blood pressure, diabetes and hyperlipidemia. This will require innovative approaches to the delivery of services in remote areas and increases to the resources and capacity of the indigenous, community-controlled health sector.

Macroeconomic interventions will be required at all levels of government to improve education and employment opportunities, to regulate tobacco advertising and to improve access to affordable, healthy food in Aboriginal communities Alan Cass (CMAJ, 2004).

### **7.2.2 Suggested Components for Improved Maternal Health Care**

1. Health care providers should give more attention to interpersonal communications with pregnant women to reduce their anxiety about the medical examination and gain their trust. The women's cultural beliefs, traditions, and lifestyles should be respected and considered in any communication with them. Continuing education programs on communication skills, cultural diversity, and women's psychosocial needs must be provided to all health care workers.
2. Spending more time and effort in educating teenagers and women in general about the importance of early and regular prenatal care and the negative consequences of failure to obtain such care is a worthy investment of health care resources and is strongly recommended.
3. Reduce the waiting time in the clinics to no more than 90 minutes and provide information to the women explaining any additional delay. The waiting time should be used to provide educational services to women. If there are no midwives available, Community Health Representatives (CHRs) can be involved. Patients may benefit from working with people who can help them understand medical discussions with their providers and navigate complex and often unfamiliar health processes. A common approach to break down cultural barriers in medical care is to make use of community health workers, community members who share experiences, language, and a cultural background with patients they serve, and have a solid understanding of their community and its resources. They can be trained in medical interpretation, patient confidentiality, case management, cultural mediation, and community health education and outreach in order to conduct health promotion and education, and instruct people in ways to gain access to services. At an individual level, CHRs are viewed as critical in helping to reduce cultural and linguistic barriers to health care services and information. They also educate providers about the community's health needs, cultural norms, and culturally competent care (Annie E. Casey Foundation, 1998, quoted in Vladeck, 2000).

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4. Transportation assistance, such as bus or taxi vouchers or volunteer drivers, seems necessary to help women receive adequate care. The availability of such assistance should be publicized to all women through the outreach programs and health education messages to the public.
  5. More afternoon and evening appointments with health providers should be made available to women to overcome their difficulties in waking up early in the morning or dealing with morning sickness.
  6. Home visiting should be provided to women at risk of not receiving adequate prenatal care services at the clinic. The major factors influencing non-use of prenatal care were: “Western model” of prenatal care, substance abuse and domestic violence. The reality is that Native American women live in two worlds; as such, prenatal care should be re-conceptualized as traditional cultural wisdom, with the majority of care provided by natural helpers from the community, including Elders, grandmothers and aunts in collaboration with licensed providers (Campbell, DePersio and Lorenz, 1991).
  7. Addressing the women’s psychosocial needs through a comprehensive multidisciplinary program should be considered an essential part of prenatal care. This will result in greater adherence to prenatal care recommendations and improvement of perinatal outcomes. The assessment tools used by health providers must include social and behavioural indicators of risk and not just physical or medical indicators. Substance abuse assessment and risk reduction strategies should be integrated with prenatal care services. Since wide gaps in the science base of existing epidemiologic data in this area are apparent and generalization of this data is limited, improved data collection may provide support for the elevated prevalence rates of FAS (Moffatt, 1994). Arranging for on-site child care as well as providing counselling services regarding family conflicts, single parenting, unemployment, and substance abuse are examples of strategies to meet the women’s psychosocial needs (Mikhail, 1999:348).

### **7.2.3 Indigenous Storytelling for Prevention**

Storytelling to transmit educational messages is a traditional pedagogical method practiced by many Indigenous Peoples. Stories are effective because they present essential ideas and values in a simple, entertaining form. Different story characters show positive and negative behaviours and illustrate consequences of behaviours and invite listeners to come to their own conclusions after personal reflection. Stories have been passed down through tribal communities for generations, so listeners also have the opportunity to reconnect and identify with past tribal realities. Hodge et al., report on a unique research intervention in promoting health and wellness through the use of storytelling. The project utilized stories to help motivate tribal members to once more adopt healthy, traditional lifestyles and practices. Selected stories and techniques were presented for group discussion, including the preparation required, the setting and the involvement and interaction of the group. Although effectiveness in changing behaviours is not known, it has great potential (Hodge, Felicia Schanche, Pasqua, Anna, Geishirt-Cantrell, Betty, 2002).

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### 7.3 Research Needs in Maternity Care

**The Learning Methods Group**, 2003, produced *Secondary Research/Environmental Scan for Health Canada's Aboriginal Healthy Pregnancy Initiative*. The work includes a national overview of the many existing barriers to healthy pregnancy; an analysis of target audiences, the social marketing implications of research findings, Best Practices, a resource listing and advice on helpful/ unhelpful assistance. Additional research should be devoted to adding to this document by methodically finding out how individually communities are presenting the initiative.

**The *Evaluation of Models of Health Care Delivery in Inuit Regions*** by Archibald and Grey, 2000, should be used as a primary reference to this review. Additional research should be conducted to update present health services in Inuit Regions to determine improvement or changes in program delivery. Four years have elapsed with new telemedicine sites that had been planned for 2001-02 and questions from the Arctic Council made several recommendations that included staff training. Has this been done to the satisfaction of beneficiaries of telemedicine? How are the nursing programs progressing with recruitment and retention of Inuit health care students? Can teleconferencing be used to train Inuit by distance education? How has maternal health care improved since 2000?

1. Conduct a meta-analysis of First Nations and Inuit maternal health care in Canada to include both qualitative and quantitative data. Many research studies/reports have been done but information has not been collected in an effective, methodical manner to date and will assist in identify any gaps in research; with the potential to future development of national standards guidelines specific to First Nations and Inuit holistic maternal health care.
2. Conduct research on the viability of developing a databank on First Nations and Inuit maternal, prenatal and infant health care with statistical information gathered and stored from various federal, provincial and territorial departments. Developing a maternal and perinatal surveillance system could address the under-reporting and under-identification of First Nations and Inuit found to occur in provincial and territorial reporting and identify the special needs of rural/remote/isolated communities, frequency of access to maternal child health care programs and services, etc.
3. Conduct research on the viability of using Geographic Information Systems (GIS Mapping), to identify the number of birthing centers and locations, number of hospitals, CLSC/health centers and locations who offer midwifery and traditional healing; retention and duration of care, satisfaction of users to produce measurable outcomes, ongoing monitoring, and identification of future needs.
4. Research the benefits of developing a National Inuit and First Nations Human Health Resource Directory/databank through GIS mapping. Individuals can be identified by profession, area of practice; include all health professions, (legal health researchers, human rights health and health educational trainers, etc.).

## Annex A: Best Practices in In-Home Visitation Program

**Table 4.1 Best Practices from Empirical Evidence**

<b>Philosophy and culture</b>	<p><b>P</b> Recognize families face complex and multiple stressors and establish comprehensive focus to address full range of family needs rather than focus on single domain of functioning, such as increasing birth weight or reducing child abuse</p> <p><b>P</b> Home visiting program need not be comprehensive in and of itself rather can be an integral part of broader early intervention family support program</p> <p><b>P</b> Respect each family’s personal space</p>
<b>Home services provided</b>	<p><b>P</b> Initial focus should be family needs and stressors, before curriculum</p> <p><b>P</b> Curriculum must have clear objectives and structures protocols that are compatible with each family’s culture, language and needs</p> <p><b>P</b> Establish core educational curriculum, with modeling role playing, and observation as key components</p> <p><b>P</b> Services should include frequent assessments of parental alcohol and drug use: if substance abuse is identified, visitor should work to reduce risks to the child and family by emphasizing abstinence and alternative care opportunities if parent is drunk, as well as suggesting initiating formal supports (rehabilitation centres) and informal supports (family, friends, support groups)</p> <p><b>P</b> Promote positive partnership with father or partners</p> <p><b>P</b> Help families develop their own informal support system by assessing existing social network, strengthening social skills, organizing quasi-informed support groups of mothers with similar experiences</p> <p><b>P</b> Promote parental confidence and sense of control by acknowledging commending personal successes across all domains (such as social network relationships, securing employment, dealing with public bureaucracy, as well as teaching communication and conflict management skills)</p> <p><b>P</b> Teach parents skills that serve as bridge to future use of community resources and functioning in social environment</p> <p><b>P</b> Ensure families linked to medical provider and other services as necessary (e.g. child care, job training, FRC, substance abuse, etc.)</p>
<b>Target population</b>	<p><b>P</b> Target services to populations most likely to benefit (as opposed to universal program)</p> <p><b>P</b> Design target group that is based on population/demographic characteristics instead of using screening entire population for individual characteristics</p> <p><b>P</b> Populations that have experienced positive effects through home visitation: teen parents, first time parents, women with low-psychological resources</p> <p><b>P</b> Realize that effects for Families with high levels of existing domestic violence may be limited</p>
<b>Nature of client participation</b>	<p><b>P</b> Voluntary</p> <p><b>P</b> Use outreach programs to build client trust</p>
<b>Attrition</b>	<p><b>P</b> Assess attrition, address specific barriers to continuation in program (such as the perceived needs of mothers, the stigma of participation, time obstacles, values with respect to privacy)</p> <p><b>P</b> Mothers who are healthier and in greater need of social support are more likely to remain in services</p>
<b>Credentials of staff</b>	<p><b>P</b> No clear domination of a particular professional or education discipline, nor trained paraprofessional or nurses</p> <p><b>P</b> There is debatable evidence that nurses have a greater effect than paraprofessionals</p> <p><b>P</b> The type or visitor must [be] well-matched with the goals of the program</p>

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	<p><b>P</b> Select staff on both characteristics (comparison, etc.) and education experience</p> <p><b>P</b> Do not establish multidisciplinary teams of visitors</p>
<b>Duration and frequency</b>	<p><b>P</b> Intensity is more important than duration, thus intensive and short programs are better than less-intensive programs that continue longer</p> <p><b>P</b> Visits initiated prenatally are associated with better outcomes and higher retention rates</p> <p><b>P</b> Continue visits for at least 6 months, or for as long as 3-5 years</p> <p><b>P</b> Intensive – weekly or bi-weekly for families with greatest need</p>

Rapaport and O'Brien-Strain, 2001.

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