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

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Final Report of Inuit Women's Needs Assessment

National Aboriginal Health Organization (NAHO)
Organisation nationale de la santé autochtone (ONSA)
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EXPLORING MODELS FOR QUALITY MATERNITY CARE IN FIRST NATIONS AND INUIT COMMUNITIES: A PRELIMINARY NEEDS ASSESSMENT

FINAL REPORT OF INUIT WOMEN'S NEEDS ASSESSMENT
(November 1, 2004)

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Prepared for the National Aboriginal Health Organization by: Phillip Bird

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 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.[1] 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 complete 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] See Pauktuutit (1995) *Documentation of Traditional Inuit Practices Related to Pregnancy and Childbirth, Draft Final Report*. 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).

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) in terms of the cultural and social context of birthing in the North, and (3) in terms of 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 in terms of 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 and First Nations 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 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 Puvirnituq 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 postnatal 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.[2] These progressive facilities are not paralleled elsewhere in the Arctic.

[2] See the Nunavik Regional Board of Health and Social Services' Internet site: http://www.rrsss17.gouv.qc.ca/en/vivre/professions/sages_femmes.aspx (last accessed October 2004).

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, the youngest was 16 years old. Three (60 percent) had not completed high school. Four (80 percent) made less than $10,000. The other woman made $45,000 or more a year. Forty percent stated they were single. Another 40 percent stated they were single but had a partner. The remaining 20 percent were married. When asked about living arrangements at the time of the 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 had a baby born within the last three years.[3] All 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. For most women this was their first pregnancy (80 percent). Two of the women indicated they were 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 percent knew they were pregnant within one to four weeks; 20 percent knew by the sixth week, and 40 percent do not recall when they found out they were pregnant. Though the determination of pregnancy was variable, four of the women (80 percent) gave birth in a hospital. The other gave birth at home.

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

[3] This study targeted mothers of children below that age of 3 since their pre-natal, post-natal, newborn experiences are recent and timely.

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.

TABLE 1:
Inuit Evaluation of Prenatal Care Services Received

During the Pregnancy The Number of Times Visited or Talked to:	0 times	1-3 times	4-6 times	7-9 times	10 plus times
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%

A review of the Inuit respondents to the questionnaire clearly supports this lack of access to support and information. Sixty percent of respondents never spoke with a family doctor or general practitioner during their pregnancy. Eighty percent 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 percent stated yes; the remainder stated they were somewhat happy. Eighty percent indicated they received their care in their community; none stated they left their community for prenatal support.

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 percent 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 then 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.

TABLE 2:
Inuit Access to Community-Based Medical Services and Professionals

Access to Community-Based Prenatal Care Services:	Not available	Sometimes available	Always available
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	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 percent indicated counselling and support is always available.

TABLE 3:
Inuit Access to Counselling and Support

Access to Community-Based Prenatal Care Services:	Not available	Sometimes available	Always available
Counselling or Other Info	0%	20%	80%
Availability of Written Material	0%	20%	80%
Availability of Breastfeeding Counselling & 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 percent indicated it is occasionally available and 60 percent indicated such support is never available. Similarly, 60 percent indicated traditional medicines are not available though 20 percent indicated it is always available. Access to midwives is polarized – either it was available or it is not. Forty percent indicated that the support of midwives was always available.

TABLE 4: Inuit Access to Midwives, Cultural Support, and Traditional Medicines			
Access to Community-Based Prenatal Care Services:	**Not available**	**Sometimes available**	**Always available**
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 support can be linked, in part, to jurisdictional differences. Obviously, Puvirnituq's midwifery program offers services and support for Inuit women that are not reflected in the medical services available in other jurisdictions that are 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.

TABLE 5: Inuit Access to Facilities and Infrastructural Support			
Access to Community-Based Prenatal Care Services: Counselling	**Not available**	**Sometimes available**	**Always available**
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.

TABLE 6:
Professional Key Informants Rating of Community-Based Maternity Services

	(1) Poor	(2) Adequate	(3) Average	(4) Good	NR
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 depends upon where the mother lived. Ultrasound tests, for example, are not readily available in smaller remote communities. Overall, about 36 percent 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).[4] 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 percent 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 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.

[4] 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.

TABLE 7: Professional Key Informant Assessment of Available Care During Pregnancy			
Care Available	**Yes**	**No**	**NR**
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 percent indicated physicians and counselling services are available and about 78 percent 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 Nation 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 percent stated that neither midwives nor the use of traditional medicines was available to them (see Table 4).

TABLE 8: Professional Key Informants Rating of Available Prenatal Medical Support					
	(1) Poor	**(2) Adequate**	**(3) Average**	**(4) Good**	**NR**
Rating Availability of Prenatal Medical Support	11.1%	33.3%	33.3%	33.3%	11.1%
Mean Rating:	2.8				
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.

GAPS IN BIRTHING AND POSTNATAL PROGRAMS AND SERVICES

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 ended up putting 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 this may not be necessary in routine cases.

TABLE 9:
Individuals Present at Inuit Women's Last Birth

Present at Birth:	Yes	No
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 percent of the Inuit who completed the questionnaire gave birth in a hospital; the remainder gave birth at home. Sixty percent left home to give birth and this involved flying out of their community. This suggests there was some distance to be travelled. Sixty percent, however, stated they were able to have their partner present during the birth. Similarly, 60 percent reported having a family member present (see Table 9). Most women had a doctor present (80 percent). Midwives were more common than nurses (60 percent and 40 percent 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.

TABLE 10:
Medical Interventions During Inuit Women's Last Birth

Medical Intervention	Yes	No
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 percent 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 percent 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.

TABLE 11:
Inuit Community-Based Access to Postnatal Support Services

Access to Community-Based Prenatal Care Services:	Not available	Sometimes available	Always available
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 percent 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 percent 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.

TABLE 12: Professional Key Informant Rating of Access to Birthing Facilities					
Facility	**(1) Poor**	**(2) Adequate**	**(3) Average**	**(4) Good**	**No response**
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% indicated other specialists were at hand (see Table 13). Midwives were said to be available almost 80 percent 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 o someone trained in obstetrics may be somewhat optimistic for the North. The participation of midwives is overstated in the northern context.

TABLE 13: Professional Key Informant Assessment of Available Care During Child-Birth & Delivery			
Type of Care Available	**Yes**	**No**	**NR**
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 Table 7 and Table 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 consider to be less likely to be available than when pregnant (89 percent when pregnant and 78 percent after) though support groups were rated as more common than when pregnant (44 percent when pregnant and 56 percent 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.

TABLE 14:
Professional Key Informant Assessment of Available Postnatal Care

Type of Care Available	Yes	No	NR
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%

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.

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.

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.[5]

[5] As noted earlier, 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.

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 percent had stated such support was never available to them. Eighty percent 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 percent of the key informants indicated they are somewhat familiar with "Aboriginal traditions or cultural approaches" related to maternity care.[6] 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 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

[6] 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*.

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."

INUIT 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:	Provide classes on what to expect during labour and address physical and mental issues. Class should be more than one day; Explain the stages of labour and show how to breath, etc.; Explain options that are available during labour, such as possible birthing positions and the use of medications; and Ask experienced mothers to provide advice and share their experiences.

SOLUTION / MODEL #3: Support for Young Women	
Type:	Education and Counselling
Rating:	Participants ranked the need to support young women as an immediate priority.
Elements / Components:	More experienced young women need to act as mentors to other young women. They need to be available for counselling and support. 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; Organize other outside agency support (for example social workers)

SOLUTION / MODEL #4: Relationship and Partnership Support	
Type:	Education and Counselling
Rating:	Participants ranked the need for relationship counselling as an immediate priority.
Elements / Components:	Help fathers feel more connected and invested in the childbirth experience; Provide support to be a good parent and husband/partner; and Provide teachings on how to build strong relationships while building a family.

SOLUTION / MODEL #5: Promote Social Wellness	
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.

SOLUTION / MODEL #6: Healthy Lifestyle Promotion Nights	
Type:	Education and Counselling
Rating:	Participants ranked the need to promote social wellness as a short-term priority.
Elements / Components:	Promote healthy lifestyles through presentations, social gatherings, and guest speakers; Design programs with the participation and input of community workers; Invite all community members to participate; and Develop the promotions as an 8-month program ($10,000 to $15,000 in funding).

SOLUTION / MODEL #7: 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 #8: 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 #9: 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 #10: 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 #11: Birthing Centres	
Type:	Administrative and Policy
Rating:	Participants ranked the need for birthing centres as an immediate priority.
Elements / Components:	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.

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 participate 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 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.