

A Report on Best Practices for Returning Birth to Rural and Remote Aboriginal Communities

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Abstract

Background: During the last four decades, policies and practices based on modern obstetrical techniques and knowledge have replaced traditional practices in many rural and remote Aboriginal communities. As most of these communities do not have obstetrical facilities or staff, women often have to leave their communities to give birth.

Objective: To review policies currently in place in Aboriginal communities that recommend evacuation of all pregnant women at 36 to 37 weeks' gestation to deliver in a Level 2 hospital.

Options: Allowing Aboriginal women, their families, and their communities to decide whether it is safe and practical for women to deliver close to home.

Outcomes: Increased opportunities for Aboriginal women in remote and rural communities to deliver within their own communities or closer to home in a familiar environment.

Evidence: PubMed was searched for articles on subjects related to birth in Aboriginal communities, birth in rural and remote communities, and midwifery in Aboriginal and remote communities. The web sites and libraries of the National Aboriginal Health Organization, The First Nations and Inuit Health Branch, and Health Canada were also searched for relevant documents.

In addition, the authors visited three communities that have trained local midwives and that support deliveries within the community to observe and participate in their programs.

Benefits: It is hoped that improved communication between health institutions and remote and rural communities and changes in policies and procedures concerning the care of pregnant women in these communities will contribute to reductions in perinatal morbidity and mortality.

Sponsors: First Nations and Inuit Health Branch (FNIHB), Health Canada.

Key Words: Pregnancy, birth, obstetrical care, midwives, Aboriginal, First Nations, Inuit, Métis, community

Recommendations

1. Physicians, nurses, hospital administrators, and funding agencies (both government and non-government) should ensure that they are well informed about the health needs of First Nations, Inuit, and Métis people and the broader determinants of health.
2. Aboriginal communities and health institutions must work together to change existing maternity programs.
3. Plans for maternal and child health care in Aboriginal communities should include a "healing map" that outlines the determinants of health.
4. Midwifery care and midwifery training should be an integral part of changes in maternity care for rural and remote Aboriginal communities.
5. Protocols for emergency and non-emergency clinical care in Aboriginal communities should be developed in conjunction with midwifery programs in those communities.
6. Midwives working in rural and remote communities should be seen as primary caregivers for all pregnant women in the community.

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INTRODUCTION

The recommendations in this paper are intended to support, to the extent it is practical and safe, the return of birth to all remote and rural Aboriginal communities. However, as the National Aboriginal Health Organization notes, "there is less information available on First Nations and still less on Métis birthing practices than those of Inuit."¹ Partly because of this, and partly because Inuit communities are almost by definition rural and remote, most of the observations and examples in this paper draw on Inuit experience.

It is clear, too, that practices and traditions vary widely, even among communities in a given area. The focus of this paper is not the specific historical conditions of any group or culture but the need to assist communities to retain or restore what is important from their own birth traditions without losing the benefits of modern obstetrical practice.

Until the middle of the 20th century, Aboriginal women in rural and remote areas gave birth in their communities, usually assisted by family members, traditional midwives, or

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both.¹ Studies of traditional birthing practices and midwifery have differed in their findings, but it is clear that despite considerable variations in approach, for most Aboriginal cultures, birth was important to the whole community, and strong traditions governed its conduct.²

In the case of Inuit women, the community was not a fixed settlement but one of several camps that families moved among as seasons changed. When Inuit were moved into permanent settlements, women gave birth at newly established nursing stations, usually assisted by non-Inuit nurses or midwives.³

Changes in training and recruitment meant that by the 1970s, nursing station staff were often reluctant to perform deliveries in remote communities, and women were routinely sent to regional centres (Iqaluit, Yellowknife, and Churchill) or to larger hospitals in the south, typically at 36 weeks' gestation.^{3,4} Although this practice has undoubtedly reduced morbidity and mortality associated with high-risk pregnancies, it has also created hardship for many women, and there is growing evidence that it may contribute to postpartum depression and increased maternal and newborn complications.⁵ Kornelsen et al. note that women need "continuity of caregiver, involvement in decision making, and presence of partners, family, and social support."⁶

EFFECT ON ABORIGINAL WOMEN IN REMOTE COMMUNITIES

These effects are usually even greater for Aboriginal women and for their communities. Douglas et al. report comments from women whose first children were born before evacuation was routine: "they told [other researchers] that only their first children were real Inuit, not the later ones."³

Women who live in remote communities often spend three or more weeks hundreds of kilometres away from home in an unfamiliar place. Language may be a barrier, and cultural norms and expectations may be different. Women may be unable to eat at a time when nutrition is important. Inuit women have traditionally been encouraged to eat more "country foods" (caribou, seal, char, etc.) while pregnant, and they may find southern food unappealing.⁷ If they have lengthy labours, they may find themselves alone on occasion, which one Inuit midwife described as "incomprehensible in our culture."⁸

It is often difficult for physicians and medical staff who live and work in the south to understand why a community would choose to offer delivery without the immediate availability of modern obstetric services. The reasons are complex, but the following quotation from Nellie Tooliguk, one of the senior Inuit midwives working at a maternity centre in Nunavik, offers a vivid analogy.

Just imagine this: You are having a baby. A group of people with PhDs have decided that Denmark's perinatal statistics are better than Canada's. They decide it will improve the medical outcome for you and your baby if you are flown to Denmark three weeks before your expected delivery date. You will remain there, without your family, until your baby is born. You arrive alone in this place where you have never been. You can't adjust to their strange food, so you eat very little for your last weeks of pregnancy. Everything is in a different language. Sometimes an interpreter is available. Your family calls after two weeks to say that your children have been taken to another relative's. The house you know is already over-crowded. The children cry on the phone to you, and you know you can't pay for this phone bill when you return home.

If you refuse this new plan, which has no evaluation of impact, you are considered selfish, undereducated and willing to put your family's health at risk! When you ask if this money could be used to simply improve the health care at home you are told studies need to be done first to see if it is possible. This is just a small piece of what injustice we have been put through by health care policies and policy makers.⁹

Like other women, First Nations, Inuit, and Métis women want control over their birth experiences: they want to choose where they give birth and who provides care for them in the childbearing year, and they want birth to be as safe as possible for themselves and their babies. When policies and practices are formulated, consideration must be given not only to the safety of delivery, but also to family and cultural needs at the time of delivery.^{2,4}

Recommendation

1. Physicians, nurses, hospital administrators, and funding agencies (both government and non-government) should ensure that they are well informed about the health needs of First Nations, Inuit, and Métis people and the broader determinants of health.

MOVING BIRTH CLOSER TO THE COMMUNITY

Clearly women at high risk of complications benefit from evacuation, but for women at lower risk, alternatives to southern hospitals are emerging.

In Puvirnituq, a Nunavik community about 1100 miles north of Montreal, the Inuulitsivik Health Centre maternity ward, known locally simply as "the maternity," has served the communities of the Hudson Bay coast (a total population of about 5500) since 1986.^{1-4,10} In addition to physicians and nurses, the Inuulitsivik maternity has registered

midwives, community midwives, and maternity workers on staff. In 2001–2002, there were 94 births at the centre. Maternity services for the communities of the Ungava coast are provided at the Tulattavik Health Centre in Kuujuaq. Although it does not currently provide a program comparable to the Inuulitsivik maternity's, the centre has a permanent staff of general practitioners, nurses, and other health professionals.

A smaller maternity centre has been operating in Inukjuak since 1998.¹⁰ Care is provided by midwives, with students from the community working under the supervision of a senior midwife. A retrospective review of the centre showed that this team had attended a total of 132 births during the five-year period of the study. The percentage of women giving birth in the community increased, particularly after a policy that did not allow women to have their first baby in Inukjuak was changed in 1998.¹¹

In Nunavut, the birthing centre in Rankin Inlet began as a pilot project in 1993 and is now a regional centre for low-risk births. The centre has Inuit maternity care workers, but as Nunavut has no midwifery legislation—and therefore no midwifery training program—midwives are still recruited (often with difficulty) outside the territory.^{1,3,4}

Women from remote communities may still have to travel to these centres, but the care they receive and the people who provide it are closer to their experience and expectations. Inuit midwives are part of the team, culture and language are understood and respected, and family members may be able to accompany the pregnant woman to the centre.⁴

The development or enhancement of community birthing programs and facilities requires communication and trust between pregnant women and their families, community Elders, political leaders, and medical professionals. Studies of all aspects of prenatal care and delivery are also needed to ensure that rates of maternal and neonatal morbidity and mortality are comparable with (or better than) those associated with evacuation to southern hospitals. There is little recent information in the literature and therefore no good basis of comparison for perinatal outcomes at the existing birth centres.^{3,10,12,13}

Recommendation

2. Aboriginal communities and health institutions must work together to change existing maternity programs.

UNDERSTANDING THE DETERMINANTS OF HEALTH

The healing map, outlined in “Community Healing and Aboriginal Social Security Reform,”¹⁴ shows the determinants of health essential to social security reform. The healing map examines questions such as “Who is responsible for community health and health education?” as well as

risks and benefits of proposed reforms. Physicians, nurses, midwives, and other care providers, as well as pregnant women and their families, need to be aware of the potential adverse outcomes for each woman giving birth in the community and for those providing her care.

Recommendation

3. Plans for maternal and child health care in Aboriginal communities should include a “healing map” that outlines the determinants of health.

MIDWIFERY AND COMMUNITY-BASED CARE

First Nations, Inuit, and Métis populations want to select from their own communities women to be trained to deliver midwifery services within those communities. If this is to succeed, health care providers must encourage the development of community-based midwifery programs. Ideally, such programs will allow community-chosen student midwives to be taught and mentored by a supervising midwife. Students would be involved in the care of all pregnant women at their local health centre or hospital. Students would also provide care, sexually transmitted infection screening, and health education to all girls and women of childbearing age.

Protocols for clinical care must be developed in conjunction with those providing midwifery care and with midwifery training programs. Perinatal review committees should meet regularly to plan for care. For example, every Thursday afternoon, staff in Puvirnituk, Inukjuak, and Salluit review the charts of women in each community who are over 34 weeks' gestation, risk is assessed, and a care plan is made for each woman. The plan may be for the woman to give birth in her own remote community, which has no transfusion capacity; to give birth at the Inuulitsivik Health Centre maternity, which has transfusion capacity; or to be sent to a tertiary care centre in Montreal.

Rather than the usual risk scoring methods, the Inuulitsivik maternity used a community-based model in which evaluating risk was the responsibility of a committee with equally weighted representation from midwives, medical staff and the community. The decision to evacuate was the sole responsibility of this committee, not the physicians alone.³

Recommendations

4. Midwifery care and midwifery training should be an integral part of changes in maternity care.
5. Protocols for clinical care should be developed in conjunction with midwifery programs.

6. Midwives working in rural and remote communities should be seen as primary caregivers for all pregnant women in the community.

CONCLUSION

Evidence suggests that expanding health centres and providing training for Aboriginal midwives within the communities will help to improve prenatal and birth experiences for Aboriginal women.

The models of care offered by the Inuulitsivik Health Centre maternity ward in Puvirnituk, the Inukjuaq maternity centre, and the Rankin Inlet birthing centre demonstrate that low-risk births can be safely managed in local or regional centres.

Standard means of assessing risk may need to be modified for women in remote and rural communities and to take into consideration the levels of care that can be provided by regional centres.

Aboriginal women in remote and rural communities should not have to choose between their culture and their safety.

ILLUSTRATIVE CASES

The authors visited three Inuit communities in Nunavik that are now able to support deliveries. Protocols and standards have been established to determine the practicality of keeping a pregnant woman in her community for the birth.¹⁴ The following composites are representative of cases dealt with at these centres. The characteristics of the patients described in these cases are similar to those of the patients in whose care the authors assisted during their stay.

Case One

An Inuit woman, Elizabeth, and her partner arrived at the Inuulitsivik Health Centre maternity in Puvirnituk on April 1, 2006. Elizabeth was expected to deliver her second child that evening. She and her partner had travelled from Inukjuak for the birth because Elizabeth had a hemoglobin level of < 100 g/L. Blood products are not available in Inukjuak, so during Elizabeth's prenatal care it was determined that she should deliver in the Puvirnituk maternity, which has transfusion capacity.

Elizabeth and her partner were together for the duration of her labour, and she was able to communicate with the midwives in Inuktitut.

A postnatal worker was assigned to stay with Elizabeth and her baby after the midwives went home. Postnatal workers are trained at the maternity centre in maternal and infant postnatal care and breastfeeding support, and they can take vital signs. Some postnatal workers go on to take community midwifery training.

The community was not her own, but the language and culture were. The birth was straightforward, with no complications, and the infant came into a world where his parents were together and where they felt comfortable and safe. Elizabeth had relatives living in Puvirnituk, and they were able to visit to welcome the infant and congratulate the proud parents.

Case Two

Sarah, a 16-year-old primiparous Inuit woman, arrived at the Inukjuaq maternity centre in early labour. A senior community midwife (not a registered midwife) was prepared to attend and manage the birth, and a registered midwife was asked to assist.

When Sarah was first assessed at approximately 4:00 a.m., the vertex was at station -2 to -3 and not well applied, her contractions were irregular and mild to moderate in strength, the membranes were intact and bulging, and the cervix was about 5 to 6 cm dilated.

Sarah's labour was slow to progress. Her contractions continued to be irregular and mild to moderate. By 11:00 a.m., there was no significant change, and the vertex was still too high to perform an artificial rupture of membranes. It was decided to augment the labour with herbal remedies long used by midwives as a gentle way to help stimulate contractions and sometimes even to induce labour. Although these herbs do not always work, they are used as a last resort if labour is not progressing, because it would not be safe to augment labour with oxytocin in such a remote setting.

Sarah was tired, but she was with her mother, her grandmother, her boyfriend, and the Inuit midwives she knew and trusted. She and the baby were still doing well: fetal heart rate was reassuring, and there were no signs of dehydration or fever. The herbs appeared to work, and Sarah's labour progressed.

At about 2:00 p.m., Sarah was checked by both the community midwife and the registered midwife. Although the dilatation had not increased much, there had been enough descent of the vertex for safe artificial rupture of the membranes, which resulted in better application of the vertex to the cervix. The labour also became more effective, with regular strong contractions.

By 5:00 p.m., Sarah had the urge to push. The urge quickly became very strong and the head was already visible. Sarah, tired of labour and pain, ignored the midwives' instructions (offered in both Inuktitut and English) to slow down and not push between contractions. The baby, born at 5:15 p.m., did not breathe spontaneously and needed a couple of puffs of positive pressure ventilation (PPV). He was watched closely, and he was given some free-flow oxygen over the next hour to make sure his breathing rate (which

had been high) came down to normal. A glucose check and a complete blood count were ordered. By one hour postpartum, the infant was breathing normally and was nursing.

Once both mother and baby were stable, special outdoor lights were turned on to signify to the community that a new baby had been born. Within a short period of time, many family members and friends had found their way to the maternity centre to meet the newest member of their community, bringing food and good wishes. Sarah and her son were surrounded by those who knew and loved them, by their language, and by their traditions and culture. The birth was celebrated into the evening, and the story of the new life was even told on the local radio so that those who could not come and meet the infant in person would be able to share in the story. Sarah's mother and grandmother expressed profound gratitude that Sarah had been able to give birth at the centre; both of them had been evacuated for their deliveries.

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