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Examining Midwifery-based Options to Improve Continuity of Maternity Care Services in Remote Nunavut Communities

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Key Implications for Decision Makers

- **Continuity of maternity care** for remote Nunavut communities is not simply about continuity of the provider-patient relationship. Continuity of maternity care is also about a range of services and their availability, relationships between providers, families, and communities, and continuity of place — where the care and childbirth take place.

- **The crisis in maternity care** for Nunavut communities is best described by the lack of sustainability brought about by the erosion of local capacity and participation through the gradual separation of family and community from childbirth. This separation is characterized by a lack of dialogue between communities and the institutions that govern them, as well as the divide between the widely held collective memory of an Inuit history of birthing in the North and the imposed southern approach to childbirth.

- Across Nunavut, ***maternity care is fragmented and inconsistent*** where the perinatal services (pre-natal nutrition and education programs, post-natal mother and baby support) that are available are often community-based with little integration or territorial/federal support apart from funding.

- Project participants describe a ***sustainable model of maternity*** for their communities as a comprehensive, collaborative, community-based continuum of care that builds on and develops local capacity.

    - As a comprehensive approach, it must reflect a broad continuum of integrated perinatal services and begin with the development of perinatal education and resources as defined by communities.
    - As a collaborative approach, policy makers, planners, and providers must foster collaboration by recognizing and supporting the range of providers involved in maternity care: traditional midwives, southern-trained midwives, nurses, perinatal educators and resource providers, maternity care workers, elders, and consulting physicians/obstetricians. This support will come through respective recognition of roles and expertise, collaborative training curricula, local training, and training that prepares providers for northern and remote practice, peer support, legislation and regulation, and remuneration processes that fit northern, remote practice.
    - As a community-based approach, it must recognize the importance of place and be informed by Inuit knowledge, experience, expertise, and *Inuit Qaujimajatuqangit*. It must include local training opportunities and community-based funding processes.

- Finally, to achieve this comprehensive, collaborative, community-based model of care we must attend to ***the roles of and relationships between*** communities, providers, researchers, non-governmental Inuit-representative organizations, as well as regional, provincial/territorial, and federal governments.

Executive Summary

Researchers and maternity care leaders across Canada have identified a crisis in maternity care, characterized by a shortage of skilled providers. For remote Inuit communities, this crisis is not only about a shortage of providers but also about a lack of local capacity and, as a result, program sustainability. Systemic dependence on evacuating women for childbirth has effectively removed childbirth from Nunavut families and communities. Efforts to return childbirth to communities have been challenged by a lack of mobilization of providers and communities, safety concerns, and relationships between communities, providers, decision makers, and various levels of government. Health planners struggle with how to shape new models of maternity care that reflect the importance the communities place on a long history of Inuit midwifery.

This research developed out of discussions between researchers, communities, Inuit-representative organizations, and the territorial government. Through these discussions the need to better understand how Nunavut communities were talking about current maternity care and their visions for change emerged. From November 2002 to December 2004, through a qualitative consultative methodology, we examined current maternity care and interruptions or problems in maternity care across 10 Nunavut communities and explored possible solutions to the problems as identified by project participants. We employed *three primary methods*: (1) semi-structured, in-depth interviews; (2) community consultation workshops; and (3) document analysis.

We found that maternity care talk — the ways that Nunavummiut talk about maternity care — is characterized by several phenomena. The first is the divide between the strong and widely held collective memory of an Inuit history of birthing in the North and the imposed southern approach to childbirth. The second is the lack of dialogue between communities and the institutions

that govern and provide for certain services and programs. The third phenomenon is the resulting marginalization of Inuit knowledge and practice and the rendering of the local as unfit for childbirth. The silos that characterize maternity care talk permeate its governance at several levels — system, planning, provision, and community.

Across study communities, Nunavummiut define maternity care as necessarily encompassing a broad, community-based, perinatal continuum including reproductive and sexual health, family health, family planning, prenatal education and support, childbirth, postnatal health, support for mother and baby, and participation of family and community. Moreover, they suggest that to be continuous, maternity care must involve continuity of place. Project participants describe ***a sustainable model of maternity care*** as a comprehensive, collaborative, community-based continuum of care that builds on and develops local capacity.

As a *comprehensive approach*, it must reflect a broad continuum of integrated perinatal services and begin with the development of perinatal education and resources as defined by communities. The centrality of nursing in current Nunavut healthcare and the salience of midwifery in the provision of maternity care for Inuit communities suggest that both need to be considered in addressing maternity care.

As a *collaborative approach*, policy makers, planners, and providers must foster collaboration by recognizing and supporting the range of providers involved in maternity care: traditional midwives, southern-trained midwives, nurses, perinatal educators and resource providers, maternity care workers, elders, and consulting family physicians and obstetricians.

As a *community-based approach*, it must be rooted in the communities it services. This will require recognition of the importance of place, as well as Inuit knowledge, experience, expertise, and *Inuit Qaujimajatuqangit*. Such an approach will build on local capacity to develop perinatal education and resources and, ultimately, bring birth back to families and communities.

To achieve this comprehensive, collaborative, community-based model of care we must attend to the roles of and relationships between communities, providers, researchers, non-governmental Inuit-representative organizations, as well as regional, provincial/territorial, and federal governments. These roles and relationships must ultimately contribute to local capacity to sustain programs that fit communities. Finally, local training will be crucial to the development and maintenance of local capacity.

While the Rankin Inlet Birthing Centre has not offered training for skilled attendants, this is slowly changing. In late 2003 it hired a second maternity care worker and the regional Department of Health and Social Services supports the development of maternity care worker training, and potentially midwifery training, to be offered at Nunavut Arctic College. With the possibility of territorial expansion and collaboration with Manitoba's Aboriginal Midwifery Education Program, Nunavut could eventually see local training for midwives. Moreover, efforts to develop regional birthing by building on the Rankin Inlet Birthing Centre model in the other two Nunavut regions may succeed in bringing childbirth closer to communities. However, to contribute to sustainable continuity of maternity care that fits with Nunavummiut visions, such efforts need to be part of a comprehensive, community-based, and collaborative approach.

I INTRODUCTION

Researchers and maternity care leaders in Canada have identified a crisis in maternity care. This crisis is characterized by a lack of continuity of care due to a shortage of skilled providers (obstetricians, family physicians, and midwives).[1-4] For remote Inuit communities, the maternity care crisis is not only about a lack of continuity but also about a lack of sustainability brought about by the erosion of local capacity and participation in governance. These communities face difficulties recruiting and retaining skilled providers, a lack of Aboriginal providers and access to training for Inuit, a lack of consistency in providers and services within and across Aboriginal communities in Canada, and systemic dependence on the evacuation of women in remote communities for childbirth.[5-15]

Systemic dependence on evacuation has effectively removed childbirth from Nunavut families and communities. This removal of birth began with the earliest introduction of the Canadian healthcare system, which brought nurse-midwives, nursing stations, and physician-attended births, and the eventual evacuation of women to hospitals in regional or southern centres.[16] Across Nunavut, efforts to return childbirth to communities have been challenged by a lack of mobilization of providers and communities, concerns about safety, and relationships between communities, providers, decision makers, and various levels of government.

From November 2002 to December 2004, through a qualitative consultative methodology, we examined current maternity care and interruptions or problems — discontinuities — in maternity care across 10 Nunavut communities and explored midwifery-based solutions to the problems identified by project participants. In this report we consider how these discontinuities inform strategies for sustainable continuity of midwifery-based maternity care across Nunavut communities. We find health policy and practice have worked to further colonize the local through the practice of evacuation, marginalizing community involvement in healthcare planning and provision while making the local unfit for childbirth. A return of childbirth to communities is, thus, not simply about hiring more providers and developing local training. This return will require a rethinking of relationships between communities, levels of government, and providers.

Study Context

The participation of Inuit midwives or traditional birth attendants (see Appendix A) in perinatal care and childbirth has disappeared from Nunavut communities. Currently, nurses are the primary and often only healthcare providers in Aboriginal communities across Canada. Over the past few decades nurse participation in local birthing, apart from pre- and post-natal

care, has almost disappeared as new policies (such as the evacuation policy) on birthing for remote communities have been established.

In the early 1990s, in response to Inuit lobbying for community birthing and the high cost of evacuation for childbirth, the government of the Northwest Territories supported the implementation of a midwifery-based birthing centre in Rankin Inlet as a pilot project. In 1995, this centre's status changed from a pilot project to a full program with a staff of three midwives, two Inuit maternity care workers, and a clerk interpreter. Currently, the birthing centre serves the Kivalliq region allowing many Kivalliq women to give birth closer to home. But women throughout this region *and* Nunavut still travel great distances for childbirth. This travel accounts for almost one-quarter of Nunavut's health spending. In addition, maternity services are burdened by poor staff recruitment and retention, high staff turnover, lack of local-level training programs, and lack of local-level midwifery services outside of Rankin Inlet. The birthing centre continues to operate outside any territorial legislation and has been plagued by recruitment and retention problems, often operating with only two midwives and one maternity worker.

This project comes at a time when health services planners and decision makers in the North are struggling to address continuity of maternity care and to develop and implement sustainable healthcare delivery strategies and models for remote, northern, and Aboriginal communities. In many parts of the world, expanding the role of nurses and midwives has improved access to services in rural and remote areas, and care by nurse-midwives has been shown to reduce maternal morbidity.[18] Moreover, many Aboriginal communities across Canada have a long history of traditional midwifery, and many are calling for a rebirth of this tradition.[5-6,19-21] In February, 2002, the government of Nunavut's minister of health and social services identified the expansion of community-based midwifery across the territory as a long-term priority. The Rankin Inlet Birthing Centre has since been expanded to a regional service, and the territorial government is now supporting the development of local training and the hiring of maternity care providers. Many providers and communities, however, are left wondering how these changes will comprise an integrated effort to bring sustainability or continuity, and why many of their demands for a return of childbirth have gone unanswered.

II RESEARCH APPROACH AND METHODOLOGY

This research developed out of discussions between researchers, communities, Inuit-representative organizations, and the territorial government. These discussions demonstrated the need to better understand how Nunavut communities were talking about current maternity care and potential for change. We began with these questions:

(1) What factors contribute to discontinuities of maternity care in remote Nunavut communities?
(2) What do these factors tell us about characteristics of sustainable midwifery-based maternity care for Nunavut communities that will provide for continuity of care?
(3) What strategies are needed to implement sustainable maternity care?

To answer these questions we approached health policy and programs as social phenomena that arise out of and within particular social, political, and institutional contexts.[22] We examine the assumptions that underlie the maternity care crisis in Nunavut and the implications of these for new models of care and their implementation. We treat health governance as a web of relationships between levels of government, communities, and providers where maternity care policy, planning, and delivery are expressions of those relationships and the political rationalities that shape them.[23-24]

Maternity care, maternal child health, maternal infant health, and perinatal health are terms that are variously defined and used across Canada. For the purposes of this research we began with the term "maternity care" and asked participants to explain their understandings of it. Throughout this report we treat maternity care as defined by project participants — a broad spectrum of care or services for women and their families with respect to pregnancy, childbirth, and maternal-infant health. We use the term perinatal care or continuum to refer to the services and experiences throughout pregnancy, childbirth, and post-natal phases.

Communities

This research took place largely in the Kivalliq region of Nunavut from November 2002 to December 2004. The presence of the Rankin Inlet birthing centre, the only birthing centre in Nunavut, provided for an exploration of how such a service could be built upon. The Kivalliq (known also as Keewatin) region has a population of 7,557 and encompasses the region north of Manitoba, east of the Northwest Territories, south of the Kitikmeot region, and west of the Hudson Bay. This region has seven communities which range in population from 400 to 2,400. We also visited two communities of the Kitikmeot (Cambridge Bay and Taloyoak) and

Qikitaani (Iqaluit and Pond Inlet) regions of Nunavut. The Kitikmeot borders the Kivalliq region as well as the Northwest Territories and it has the smallest population. The Qikiqtaani (or Baffin) region has the largest population (14,372) and is the most eastern. It encompasses Baffin Island as well as some of the islands to the northwest — approximately half of Nunavut's land mass (twice the size of the two other regions). This region is home to Iqaluit, the capital city of Nunavut, and the territory's only hospital.

Study Design

When planning for this study, decision-maker and community partners emphasized the need for research that would contribute to change. Our approach is thus rooted in the belief that to contribute to sustainable change research processes must involve the communities they will affect. To this end, this study is grounded in a qualitative, participatory methodology employing *three primary methods*: (1) semi-structured, in-depth interviews; (2) community consultation workshops; and (3) document analysis.

We began by identifying and consolidating the extensive range of research and policy documents on maternity in the North and remote Canadian communities. Following this review (some of which is captured in this report's reference list as well as Appendix F) we explored these through document analysis, paying particular attention to the ways in which researchers approached maternity care and the key issues of concern, as well as characteristics of models of community-based midwifery care across Canada.

This exploration complemented in-depth, semi-structured interviews and community consultative workshops with mothers, fathers, elders, healthcare providers, and program co-ordinators in the study communities as well as health planners and policy makers (see Appendix B). A first set of interviews and workshops was held in Rankin Inlet, Coral Harbour, Arviat, Repulse Bay, and Baker Lake, where participants discussed maternity care in the context of community-defined needs. The analysis that resulted from these visits contributed to a second stage to explore possibilities for change and how to implement change. This stage took place in eight communities (Rankin Inlet, Coral Harbour, Arviat, Baker Lake, Cambridge Bay, Taloyoak, Pond Inlet, and Iqaluit) through interviews, consultative workshops, and community discussions that provided for information sharing, discussion, and debate. In addition to interviews and workshops, we also met informally with elders, providers, program co-ordinators, and participants. In several communities, we also hosted radio shows where community members were invited to call in and share their perspectives on maternity care and needed changes.

The sampling strategy for interviews was purposive. Study communities were initially informed about our study intents through the Nunavut Research Institute's research licensing process (see Appendix E). Community partners then identified community representatives who assisted in identifying interview participants. In addition to mothers and fathers, we interviewed local providers, including nurses, perinatal educators, midwives, physicians from the Northern Medical Unit (which provides physician services to the Kivalliq region), and an obstetrician. We also conducted telephone interviews with nurses-in-charge as well as other providers and planners in Nunavut communities. Interviews highlighted community-specific variations in maternity care continuity and provided background for community consultative workshops. Workshops were open to all community members with some purposive sampling to ensure the participation of women of child-bearing age and women who have given birth. Study participants were invited to participate and were provided with a summary of the project and a consent form (in English and/or Inuktitut), as well as a copy of our Research License (see appendices C, D, and E). Participants who were not comfortable with written consent provided verbal consent. To provide confidentiality in any documents related to this study, we refer to participants only by the identifiers outlined in Appendix B as well as the community in which they work and live. Due to the small number of providers in communities we often omit their community to ensure confidentiality.

III RESULTS

Through the course of this study, maternity care and its governance emerged as very fragmented and discontinuous. In this section we briefly consider these two characteristics and what continuity of maternity care means for Nunavut communities.

A. Maternity Care Talk — A field of fragmented conversations

> *"My mother delivered when they were hunting on the land. When they were out caribou hunting she delivered a baby. That's how brave and capable they were."*
> (Inuit Midwife, Pond Inlet)

We approached this study with an interest in the ways in which maternity care is talked about and governed in Nunavut and what this talk tells us about possibilities for change. We find that maternity care talk is characterized by several phenomena. The first is the divide between the strong and widely held collective memory of an Inuit history of birthing in the North and the imposed southern approach to childbirth. The second is the lack of dialogue between communities and institutions that govern and provide certain services and programs. The third phenomenon is the resulting marginalization of Inuit knowledge and practice and the rendering of the local as

unfit for childbirth. Out of these conversations emerges a resistance to the marginalization and imposition of southern approaches and an effort to develop approaches that fit the remote, largely Inuit communities of Nunavut.

Inuit participants share a strong sense of their history of birthing as a people. Many participants tell stories about their parents' experiences, their own births, and the births of their children.

> *"When you are in labour for the first time, it is a little frightening. And it is your first time being with elder women — it's a little scary. I was supported by the women and delivered by Inuit women. The way they position you is very different. It is much more comfortable."* (Elder, Pond Inlet)

The presence of Inuit midwives at births and in nursing stations rapidly disappeared as evacuation for childbirth became increasingly widespread. Moreover, the introduction of southern approaches to birthing transformed and, in many ways, obliterated traditional Inuit experiences and knowledge around childbirth.[21]

The imposition of southern policy and practice has contributed to a great divide between Inuit and non-Inuit approaches. Participants do not speak about health centres as community-based but as being from or of the South and as non-Inuit or *Qallunaat*. When asked about current maternity care, many participants struggle to find the words to talk about it — often unaware of terms such as "maternity care" or "maternal-child health." Communities differ widely in their experiences of and access to maternal-child health services. There is little awareness of any shared perception of a current maternity care strategy or program.

Providers and planners vary in their understandings of available maternity care. Community health nurses are aware of other perinatal programs in their communities (such as Prenatal Nutrition Programs) and some are aware of Inuit midwives. Many providers, however, do not know where the local expertise lies and find it difficult to create the necessary bridge between their work and that local expertise. Providers also feel cut off from decision-making and planning processes that affect the kind of maternity care that is available or that they can provide.

> *"People come into positions and stay for a short time; they stay for a year or two and then leave. So everyone is starting from scratch. It's not like someone new comes up and runs the next leg; that leg never gets run because everyone's starting at the beginning."* (Northern Midwife)

Several providers echo this frustration about inconsistencies in leadership at the administrative and decision-making level and the resulting lack of attention to maternity care solutions. And decision makers and planners complain they do not have the "data" upon which to make decisions and are unclear about what communities want. Nunavummiut have little information about roles and responsibilities of levels (federal, provincial, territorial, and community) of government in maternity care policy-making and program planning. The perceived and real disconnects between the health system, providers, and communities leave Nunavummiut uncertain about their own participation and unsupported.

> *"When we have been told too many times that 'we can't do this and that,' it seems to be the dead end… When you are told that constantly it becomes a way of ignoring you. Therefore, we in the north have to start pushing harder for what we believe in."*
> (Elder, Coral Harbour)

B. Discontinuities in Maternity Care Planning and Provision

The silos that characterize maternity care talk permeate its governance at several levels. In this section we consider some of the problems, identified by participants, at planning, provision, and community levels.

In program planning

The discontinuities in perinatal program planning and provision highlight problems across the maternity care spectrum. At a territorial level, efforts to address maternity care have been very fragmented, and there has been little consistency in perinatal programming across communities. Community-based programming for pregnant women and new families has been largely dependent on local initiative. Baker Lake, for instance, has several community-based programs that support maternal-infant health in the community. Both the Pre-natal Nutrition Project and Healthy Moms Healthy Babies have been longstanding programs in the community due to the continuity of leadership for both programs. The continuity in leadership means experience in funding applications, which helps to ensure the continued existence of these programs.

While some communities have several resources for pregnant women and their families, others do not. Providers might be hired and funding might be granted, but there is often no funding for infrastructure and no support for workers and programs. Programs exist in relative isolation from one another, from community health centres, and from regional and territorial programs. Local programs survive from funding to funding and long-term sustainability is threatened by

staff turnover and lack of leadership and support. A nurse explains her effort to run a prenatal program in addition to, and outside of, her work as a nurse in the community:

> *"I tried to run the prenatal nutrition program here in [the community]. I got funding and I managed to make it through the year. I had about 10 women and it was a very popular course, everybody enjoyed it, they loved coming. It was exhausting for me because I would finish a day of work and then do another three hours between start and finish of this prenatal class. It was definitely beneficial to the ladies, but I just couldn't continue it. Plus I was also finding the funding, finding a place to hold the class that night. . . I would love to see more births in the community, I really would, but it is not going to happen until we start focusing on public health issues and increasing the community's wellness by providing information that these moms need."* (Nurse-in-Charge)

Several nurses-in-charge explain that the pregnant women in their communities are receiving regular prenatal clinical assessments, but they do not have time to address perinatal education. Moreover, nurses and community health representatives often do not have expertise in perinatal education. There is a resulting lack of effective and meaningful communication with pregnant women.

> *"When I was going to deliver my youngest one, they told me I was high risk. I didn't understand what high risk was. I thought the baby was high. They thought the cord was around the baby's neck."* (Inuit Mother, Baker Lake)

In providing maternity care

Through discussions about the provision of current maternity care, study participants point to issues of provider mix, recruitment and retention, and training. Nurses are often the only healthcare providers in the community so that "continuity of care is nurses," as one northern physician explains. While many nurses in Nunavut are nurse-midwives by training, many are not, and these nurses often come to the North with little or no perinatal training, remote area practice training, or exposure to midwives. As a result, many feel ill-equipped to deal with childbirth and pregnancy. Nevertheless, the burden of care and continuity of care is on the shoulders of nurses who are overworked and understaffed. One nurse-in-charge explains her work environment:

> *"We have supportive administrators in place now. This is especially important for [nurses-in-charge] and for all nurses. We need adequate staffing; we're riding on the*

cusp at the moment and we're burnt out too often. It's hard to continue. We need to have enough staff so that we're not going from crisis to crisis. . . It's a constant struggle to get staffing and permanent staff." (Nurse-in-Charge)

Many suggest that a midwifery-based approach to perinatal care would address provider shortages and would better fit communities because of the specific expertise of midwives and the long tradition of Inuit midwifery. There are, however, several structural barriers to practice in Nunavut that exacerbate recruitment and retention problems. Currently, midwives in Nunavut practice outside of any midwifery legislation. This has implications for their abilities to become insured as midwives. And it speaks to the lack of commitment and support for midwifery practice at a territorial level. The government of Nunavut has recently supported efforts to develop a Nunavut Association of Midwives. This territorial effort, though, is evolving within a broader national context where structural barriers are widespread for midwifery, including disparate legislation across the country and lack of recognition for midwifery as a fundable position on Aboriginal reserves.[6]

Finally, in discussing program planning and provision, participants point to two training issues. The first is the lack of northern, remote training that providers receive and the lack of collaborative training that is needed for remote practice. The second is the lack of local training for Inuit. Currently, apart from the nursing program at the Nunavut Arctic College in Iqaluit there is no local training for maternity care providers.

In 2004 the territorial government made a commitment to develop maternity care worker training across the territory and hire these workers for communities. To this end, the government of Nunavut has partnered with Manitoba's developing Aboriginal Midwifery Education Program and has appointed local people to develop its own maternity care worker training. This training, however, must link to further training possibilities as women throughout the territory are demanding a greater level of involvement and responsibility in the provision of maternity care and opportunities for advancement. Moreover, if this training initiative is not part of a broader, more comprehensive and long-term approach to maternity care, newly trained providers may find themselves working in isolation and without support.

At the community level

"Babies born in the community are considered special babies. . . Some women try to fool us, they lie about their last period so we have to try to get them out for an ultrasound." (Nurse-In-Charge)

> *"Why can't you have babies in places where you live? Even in small communities, like Bay Chimo, Bathurst, Gjoa Haven. Why should they have to fly them somewhere?"* (Inuit Father, Cambridge Bay)

In the above quotes, two participants point to the importance of place in Nunavummiut notions of birth and to the politics of place. Similarly, when talking about community birthing, many participants refer to the importance of community both as the *place* of birth and as a *resource* or *source of support* for birthing. Some point out that when women are able to have their babies in their communities with skilled attendants the positive outcomes are numerous, as one new mother in Rankin Inlet explains:

> *"I was able to have people around with me. My mom was there. There was no question I wanted my mom there. She's been through everything with me. I wanted the baby's father there. He wanted to be there. And the father's mother, because she wasn't there for her first grandchild. . . I had lots of support."* (Inuit Mother, Rankin Inlet)

This woman touches on several reasons why many participants feel that childbirth needs to be brought back to Nunavut communities and why communities need to be involved in childbirth. Discussions of community birthing, however, raise concerns about safety. One northern physician explains the difficult position he finds himself in when considering the possibility of local birth:

> *"I know it's very frustrating to women who have to leave perhaps even at 36 weeks to go down south. . . But having done about 1,200 deliveries, my concern is what happens if things go wrong. You can do the risk stratifications nicely for high risks and low risk but there are still low-risk people, one out of 30 times, suddenly the heart drops and right then you have half an hour to get to the plane, a two-hour flight. . . Obviously, they've been doing that in Rankin for a long time. We just have to accept that."* (Northern Physician)

The reliance on evacuation has made the local unfit for childbirth, marginalizing local community-based practice and expertise. In her exploration of birthing in Northern Manitoba, Shirley Hiebert found that the evacuation policy has contributed to a fear of birthing locally for some Aboriginal women.[5] Similarly, many participants feel their communities are no longer safe places for childbirth. One Inuit mother explains, "Even though it's not the 'Inuit way' to have a baby in a hospital, lots of women feel safer. (Inuit Mother, Rankin Inlet). Most Nunavummiut,

including many elders, have given birth with family physicians or obstetricians attending all or some of their births in a hospital in Iqaluit, Winnipeg, Churchill, or Yellowknife. This process of medicalizing birth has contributed to a fear of birthing locally and of non-physician care. While local confidence in community-based knowledge and expertise has been eroded, Nunavummiut still hold onto a strong sense of capability within and across their communities. At the same time, they feel that they have little say in program development and implementation.

Healthcare is administered from a regional level, and communities have few means of participating in planning and provision. Many communities have active health committees and some current capacity through already established community-based prenatal initiatives and early childhood and parenting resources. Arviat's community wellness committee, for example, has persisted in its decades-long effort to bring birthing back to Arviat and to ensure sustainability of perinatal care. Initiatives such as these, however, are often overlooked at regional planning levels and there is little integration of services. This lack of integration means that new services and programs are often not developed with existing ones in mind.

C. Planning for Maternity Care as a Community-based Continuum of Care

Through our exploration of maternity care in remote and Aboriginal communities across Canada, we identified six models (see Appendix F). We distinguish between these models based on community involvement in governance, their provider mix, perinatal education and resources, and provider training. While not officially recognized as formal maternity care *programs*, approaches to maternity care in most Nunavut communities fall under Model E, "Pre- and Post-Natal Care," where childbirth does not occur locally but in communities s uch as Iqaluit or Winnipeg.

The Rankin Inlet Birthing Centre is an example of Model A — an "Independent Midwifery Unit." The centre is staffed by up to three registered midwives, and the supervising midwife reports to the Kivalliq regional department of health and social services. In late 2003 the birthing centre became a regional service for Kivalliq communities. When staffing is sufficient to support it, midwives rotate through communities to provide pre-natal care, discuss birthing options, and provide referrals to other providers for medium- and high-risk pregnancies. Similarly, the *Tsi Non WI lonnakerastha* (the Place They will be Born) Maternal and Child Centre located at Six Nations on the Grand River, Ontario, is a community-based birthing centre that offers a range of perinatal services including childbirth and local training. Unlike the Rankin Inlet Birthing Centre, this centre is controlled by the Six Nations on the Grand River community and blends traditional Aboriginal and contemporary midwifery services and programs.

Model A is an approach to maternity care that has been recommended for the developing world, especially as a means of providing continuity of care and as a site for training skilled attendants.[25] Although the Rankin Inlet Birthing Centre provides services to women throughout the perinatal continuum, its existence is threatened by high staff turnover and lack of community involvement. While this birthing centre resulted from community demand, it is a regional government initiative with little community input. Moreover, it offers no local training and midwives work outside any territorial legislation.

The Innulitsivik Maternity located in Puvirnituq, Nunavik is an example of Model C — a "Community Maternity." This maternity began in 1986 as a community-based centre and is staffed by registered and community midwives as well as maternity care workers. Registered midwives from southern Canada and other countries provide support. The maternity offers the first formal Aboriginal midwifery training program in Canada and is recognized by the Inuulitsivik Hospital, the regional and provincial governments, and the Ordre des Sages Femmes du Quebec. Local Inuit women can train to be registered midwives — they begin as maternity workers, then become community midwives, and then, if desired, registered midwives. Most women in the community give birth at the maternity, and its success has been the development of two additional maternities — one in Inukjuak and one in Salluit.

Developing sustainable models for Nunavut communities

The success of the Six Nations and the Nunavik maternities suggests that the sustainability of a maternity care approach will depend partly upon the commitment and sense of ownership at the community level. It must, therefore, emerge out of local perceptions of or approaches to maternity care. In health services provision and research, the term "continuity of care" often refers to care from one provider or a small team of providers over a period of time. When speaking about continuity of maternity care, Nunavummiut *also* talk about services and their availability as well as continuity of place. They define maternity care as necessarily encompassing a broad, community-based, perinatal continuum including reproductive and sexual health, family health, family planning, prenatal education and support, childbirth, postnatal health, support for mother and baby, and participation of family and community.

Project participants describe a *sustainable model of maternity care* for their communities as a comprehensive, collaborative, community-based continuum of care that builds on and develops local capacity. *As a comprehensive approach*, it must reflect a broad continuum of integrated perinatal services and begin with the development of perinatal education and resources as defined by communities. Based on a long history of traditional midwifery and some experience

with the midwives at the Rankin Inlet Birthing Centre, many participants see a model based on midwifery practice as an appropriate approach to providing this continuum of care. The centrality of nursing in current Aboriginal healthcare and the salience of midwifery in the provision of maternity care for Aboriginal communities suggest that we need to consider both in any strategies to address the current maternity care crisis. Moreover, the broad reach of Nunavummiut perceptions of maternity care suggests the need for a generalist approach where providers such as midwives bring their specialist skills but have wider responsibilities for maternal, infant, adolescent, and women's health.

As a *collaborative approach*, policy makers, planners, and providers must foster collaboration by recognizing and supporting the range of providers involved in maternity care: traditional midwives, southern-trained midwives, nurses, perinatal educators and resource providers, maternity care workers, elders, family physicians, and consulting obstetricians. This support will come through the recognition of roles and expertise, collaborative training curricula, training that prepares providers for northern and remote practice, peer support, legislation and regulation, and remuneration processes that fit northern, remote practice.

As a *community-based approach*, it must recognize the importance of place and be informed by Inuit knowledge, experience, expertise, and *Inuit Qaujimajatuqangit*. Such an approach will build on local capacity to develop perinatal education and resources and, ultimately, bring birth back to families and communities. Aboriginal communities have long been struggling to birth closer to home,[5-6, 19-21] and evidence supports *community-based* maternity care for rural and remote communities rather than the centralization of maternity care.[26-30, 14] Moreover, evidence suggests that maintaining *community-based maternity* services for rural and remote communities improves obstetric and neonatal outcomes.[31, 28, 14] Developing a community-based approach will require attention to governance structures and relationships as well as addressing care provision and safety needs specific to northern and remote practice. Moreover, such an approach must include local training opportunities and community-based funding processes.

Community-based models of maternity care such as those in Nunavik and at Six Nations bring childbirth back to communities and provide for continuity of place in maternity care. Inuit across Nunavut emphasize the centrality of place in their perceptions of appropriate maternity care. Most suggest that a birthing centre in each community would ultimately resolve the problems brought about by evacuation. And many see this birthing centre as something separate from the health centre, because they associate the health centre with illness. One

community health representative and Inuk mother states, "My vision is of a separate *wellness* centre." An Inuk father explains the benefits of a local birthing centre:

> *"A birthing centre here in the community would save the government money. If there were 60 to 80 births imagine the cost of airfare. And the stress, especially for us men, trying to raise our families. And being men we don't know how to raise our families. . . If fathers were given a chance to bond earlier with the baby that would make the father feel more like participating."* (Inuit Father, Arviat)

> A nurse explains, *"My vision would definitely include a birthing centre and training for Inuit midwives. For it to be sustainable, that needs to be in place."* (Community Health Nurse, Baker Lake)

While study participants point to the need for local birthing centres there is widespread understanding that everything cannot be done locally, and there is desire to couple Inuit expertise with non-Inuit expertise. There is also demand for integration of services and programs and linkages with provider resources such as those available to Kivalliq family physicians through the Northern Medical Unit. While regions operate rather separately when it comes to healthcare and draw on different resources from the South and the North, maternities should be part of an overall territorial program. A territorial midwifery association, legislation, regulation, and education program would contribute to this. Moreover, the governance of hospitals and health centres which the midwives work within, or in relation to, need to include midwives and especially local midwives as part of the decision-making process; otherwise they can be marginalized and the service can struggle to survive or grow. Governance structures should be inter-professional and model and foster trust and respect.

Finally, when discussing program planning and provision, participants suggest that any comprehensive approach to maternity care has to include training that incorporates local knowledge and expertise. In the six models described in Appendix F, midwifery training is either done on-site in an apprenticeship model or midwives are hired after having been trained at a southern university. In Canada the university-based bachelor's programs (Ontario Midwifery Education Program at Laurentian, McMaster, and Ryerson Polytechnic universities; UBC Midwifery Program; and Université du Québec à Trois-Rivières) have campus-based education programs. While more than half of the programs are done as practica off-site, as close a possible to student's home communities, there may not be placements available. These programs lead to a bachelor's degree recognized across the country, in jurisdictions where midwifery has been

recognized. This type of training is largely inaccessible to Nunavummiut because of the costs, the educational requirements for entry, and the time required to be away from family. Local training programs such as those offered by the Nunavik and Six Nations maternities enable students to remain closer to home. Moreover, these programs are apprenticeship models which Inuit participants are calling for:

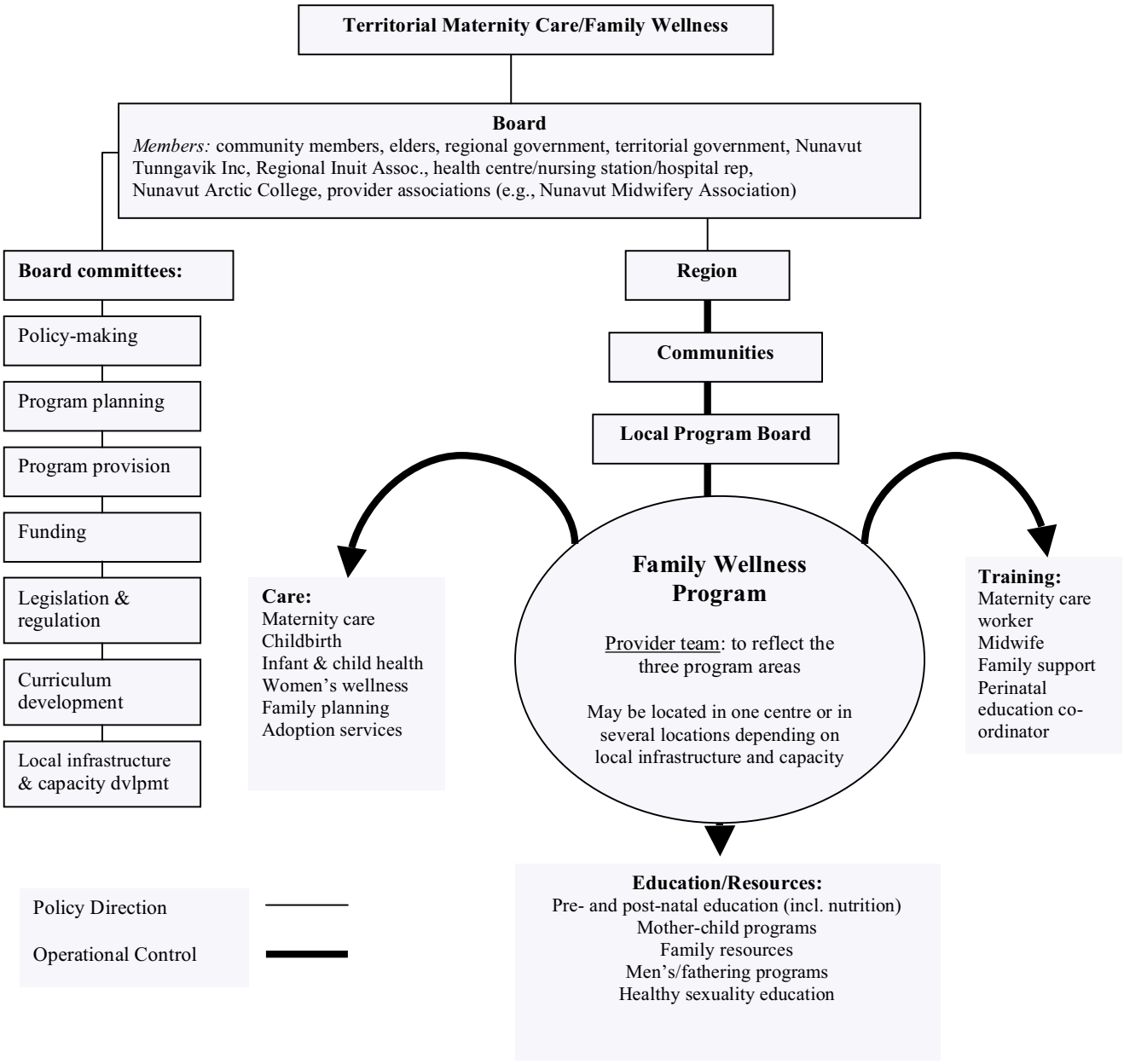
> *"As Inuit, we learn from practicing, seeing, etc., not from sitting in the classroom, not from the black board. We learn fast by helping, practice, experience, and to me that is practical and best way to learn."* (Inuit Midwife, Pond Inlet)

The risk in local apprenticeship models is that, once trained, midwives are not able to work outside of certain communities. While Ontario's midwifery legislation's Aboriginal midwifery exemption clause enables the Six Nations program to exist, it restricts midwives who are trained through this program to practice in specific contexts. Quebec midwifery legislation also restricts Inuit midwives who have trained in the Nunavik maternities, but Nunavik midwives are working to challenge this legislation. In developing midwifery education in Nunavut, communities need to be involved in program development to ensure that the implications of those programs fit community expectations.

Visualizing a model of maternity care for Nunavut communities

So what would this comprehensive, community-based, collaborative model of maternity care for Nunavut communities look like? Figure 1 incorporates these three characteristics and provides an approach not simply to care provision but to policy-making, program planning, and training. As outlined in Figure 1, a local board would oversee program development and provision for the community. This model allows for flexibility across communities and regions, with each involved in governance and able to craft region- and community-specific models. This flexibility is important to avoid imposing one single approach that may not work across communities. At the same time, while providing for differences in provision and planning across regions and communities, this model connects regional and local programs into a territorial approach. Representatives from regions and communities would participate not only in local decision-making but also in territorial decision-making through a territorial board and its committees.

FIGURE 1: A MODEL OF MATERNITY CARE FOR NUNAVUT COMMUNITIES



IV STRATEGIES FOR CHANGE

The results of this study support other research and evaluative processes that recommend comprehensiveness as well as collaboration among providers, sustainability, cultural relevance, interdisciplinarity, and community-based services and training as important elements of new maternity care models for remote and aboriginal communities.[33-34, 2, 18, 30] In our community consultations and document analysis we went further to explore how to develop and implement comprehensive, collaborative, and community-based approaches to maternity care that ensure sustainability and continuity. We conclude this report by touching on strategies to bring about change in maternity care that address the fragmentation in maternity care talk, program planning and provision, and community involvement.

Study participants suggest that **a shift in the ways in which maternity care is addressed or talked about** is required to bring about a strong sense of ownership. To this end the following recommendations emerge:

- Begin with local knowledge and experience:
  - incorporate *Inuit Qaujimajatuqangit* into all levels of governance.
- Broaden the conversation across regions, the territory, and the North.
- Clearly define roles (federal, territorial/provincial, regional, community) in a comprehensive approach to maternity care.
- Increase the evidence base to provide services and care that fit remote, Inuit communities while rooting research processes a community-based approach.

Beginning with Nunavummiut requires that maternity care talk be informed by *Inuit Qaujumajatuqanjut. Inuit Qaujumajatuqanjut* is most simply defined as Inuit traditional knowledge, expertise, and experience; however, this definition fails to capture the breadth of the term as well as the evolving, fluid quality of this knowledge, expertise, and experience. Inuit Qaujumajatuqanjut is too often reduced to the ways in which things were done long ago. This treatment risks the oversimplification of its incorporation into maternity care governance through the gathering of stories about birthing on the land — the tools and knowledge that were used. While Inuit Qaujumajatuqanjut certainly includes these ways, its is an ever-evolving, all-encompassing approach to life that is based in Inuit history and experiences of living on the land, colonialism, and resulting settlement of communities and the imposition of Western European religions and Southern Canadian healthcare. One elder suggests that to appreciate the evolving nature of *Inuit Qaujumajatuqanjut* we should think of it as Inuit experiences rather than traditional knowledge.

> *"Whenever someone says* Inuit Qaujimajatuqangit*, I ask myself what are Inuit qaujimajatuqangit? I personally think the name should change. It should change to* Inuit Atursimajangit *(Inuit experiences). It would be much better to identify exactly what the Inuit traditions are."* (Elder)

Participants suggest that policy-making must approach maternity care as a broad, community-based continuum of care, incorporating local knowledge and experience, and recognizing the historic roles of women and men in childbirth and the potential role of elders and communities in all aspects of the planning and provision process. Thinking and talking about maternity care this way will have implications for infrastructure and where maternity care services are provided, the complement of providers, relationships between providers and programs within and across communities, funding processes, and training programs.

To address the fractured nature of maternity care talk, the conversation has to be broadened to include communities and the people of those communities. To do so, we must address barriers between providers, researchers, communities, and decision makers. Moreover, any successful approach to maternity care has to be rooted in a commitment at all levels of government to address legislation, regulation, and infrastructure that make *community-based program* planning possible and provide the necessary environment for continuity of providers.

To address discontinuities in program planning and provision:

- plan for programs and services as part of a holistic, comprehensive, community-based approach to maternity care;
- develop policies and programs that build on local capacity and foster local capacity development;
- consider human resource issues and infrastructure for *northern, remote communities:*
  - address peer support, remuneration and recruitment, local training, and local capacity as part of program planning;
- develop provincial/territorial and federal support for midwifery and expanded nursing practice that would facilitate the kind of maternity care northern communities have identified as necessary:
  - support midwifery legislation and regulation;
  - ensure that employment, regulatory, and legislative processes do not marginalize certain providers such as traditional midwives that are central to community-based care; and
  - provide for funding processes that foster local development;

- recognize maternity care as provided by various kinds of providers including traditional and southern-trained midwives, nurses, maternity care workers, perinatal educators, resource providers, elders, and family physicians and obstetricians;
- consider the implications of a holistic and comprehensive approach:
  - consider a generalist approach to maternity care provision rather than a specialist approach; and
  - collaborate with existing providers in developing new programs and services;
- provide for peer support (for example, support efforts such as the regular teleconferencing between Nunavik, Nunavut, and Northwest Territories midwives);
- consider remuneration alternatives that are appropriate for northern, remote practice; and
- develop local training programs that are informed by local experience and expertise.

To further ensure that maternity care governance is community-based, we make the following recommendations:

- recognize that importance of community-ownership in sustainability;
- develop policy and plan for programs that are flexible and fit the differences as well as the similarities across communities;
- develop policy and programs that build on and foster local capacity (training, infrastructure, experience and expertise, and mobilization to make change);
- enhance and emphasize the advocacy role of Inuit-representative organizations for local communities and local capacity development; and
- build relationships between municipal, regional, territorial, and federal levels of government as well as non-governmental organizations that contribute to community involvement.

To achieve the comprehensive, collaborative, community-based model of care proposed by participants we must attend to the roles of and relationships between communities, providers, researchers, and non-governmental Inuit-representative organizations, as well as regional, provincial/territorial, and federal governments. These roles and relationships must ultimately contribute to local capacity to sustain programs that fit communities. Crucial to the development and maintenance of local capacity and is local training.

New territorial efforts are slowly making local training and births closer to home possible. In late 2003 the Rankin Inlet Birthing Centre hired a second maternity care worker and the regional Department of Health and Social Services is now supporting the development of maternity care worker training, and potentially midwifery training, to be offered at Nunavut Arctic College. With the possibility of territorial expansion and collaboration with Manitoba's

Aboriginal Midwifery Education Program, Nunavut could eventually see local training for midwives. Moreover, efforts to develop a territorial program may succeed in bringing childbirth closer to communities. It is not clear, however, how efforts across regions are connected or how communities are involved in developing program direction and implementation. To contribute to sustainable continuity of maternity care that fits with Nunavummiut visions, such efforts need to be part of a comprehensive, community-based, and collaborative approach.

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