Midwifery 29 (2013) 981–987

Contents lists available at SciVerse ScienceDirect

Midwifery

journal homepage: www.elsevier.com/midw

Returning birth: The politics of midwifery implementation on First Nations reserves in Canada

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ARTICLE INFO

Article history:
Received 30 January 2012
Received in revised form
31 October 2012
Accepted 17 December 2012

Keywords:
Indigenous midwifery
Remote birth
Maternal health policy

ABSTRACT

Objective: to explore the role of midwives in the implementation of an elective birthing programme in one remote First Nation community in Canada, and to identify current barriers and challenges to the practice of midwifery in these settings
Design: the study is a multisited ethnography based on 15 months of fieldwork in Manitoba, Canada. Thirty-nine individual qualitative, semi-structured interviews were completed. The data from the interviews were coded into themes and presented in the paper.
Setting: the study focuses on one First Nation community and their process of implementation of midwifery services. This case study is used to address broader themes of midwifery and policy at a national level.
Participants: participants included Aboriginal midwives from across Canada, policy makers from provincial and federal jurisdictions, medical professionals involved in Aboriginal health care, Aboriginal political leadership, and Aboriginal women and their families.
Findings: national policy and issues of jurisdiction among levels of government were shown to be a barrier to midwifery implementation.
Key conclusions: the current policy of evacuation in most Aboriginal communities does not effectively address the Millennium Development Goal of having a skilled birth attendant at every birth. The role of midwifery is central to the process of returning birth to Aboriginal communities, and steps must be taken at both the policy and clinical level to ensure that midwifery implementation and education can become an option for all Aboriginal communities in Canada.
Implications for practice: when considering midwifery implementation in communities, midwives must engage in both political and clinical negotiations to ensure their ability to practice effectively. Understanding the complexity of the policy discourse, along with the place of midwifery within the existing clinical guidelines is integral to the success of this process.

Introduction

In Canada, place of birth is central to the discussion of improving Aboriginal maternal health care. Internationally, Canada is often cited as being leaders in the repatriation of birth to remote communities based on the success of the Inuit midwives in northern Arctic regions (Van Wagner et al., 2007). However, the majority of Aboriginal communities in Canada are still required to leave their communities for childbirth late in pregnancy and deliver in urban centre tertiary care facilities. In Canada, the Aboriginal population is divided into three groups: Inuit, First Nations (formerly known as Indians), and Metis peoples. This paper focuses on First Nations, and in particular, First Nations who live on federal reserves. This is because there is a difference in how health care is delivered in these settings that directly impact the ability to provide midwifery care in this setting. In First Nations communities, accessing health care is complex. The provision of providing health care comes from the provincial governments, whilst health-care provision for First Nations on reserve is the responsibility of a federal branch of Health Canada called First Nations and Inuit Health. This arrangement is due to the fact that Canada as a constitutional responsibility to First Nations and Inuit peoples (Government of Canada, 2011). This jurisdictional complication is a major factor in many issues of adequate health-care delivery for First Nations people, and has major implications for bringing birthing back to communities.

This paper explores the role of midwifery, and in particular, Aboriginal midwifery in the implementation of low-risk, elective birth programmes in northern Manitoba, Canada. In this setting,

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http://dx.doi.org/10.1016/j.midw.2012.12.005

there has been an explicit attempt to implement midwifery through the kanaciotinawawasowin Baccalaureate Programme (KOBP) in the First Nation community of Norway House Cree Nation. Within this discussion, the authors feel there is a need to re-affirm the central role that midwifery plays in repatriating birth, and address the challenges that this re-positioning of midwifery creates. For the purposes of this paper, the results pertaining to the challenges of midwifery implementation will be discussed in the context of shifting current birthing practices to midwifery-led care in First Nation communities in Canada. Focusing on the Millennium Development Goal (5.2) of having a skilled birth attendant at each delivery, this paper explores this notion from the perspective of the location of the health provider in relation to the pregnant mother, rather than the current model of evacuation which focuses on the location of women in relation to hospitals and 'safe places' to give birth. In the current model, the primacy of the tertiary hospital setting as the safest place to give birth overrides any previous concerns about the risks associated with leaving other children, family, or a supportive environment. The questions currently being asked in Canada are, 'Is it safe to have a midwife attend deliveries in remote areas? Are midwives as safe as physicians in these remote regions?' (Simonet et al., 2009) Instead of this, we pose the question, 'Is it safe *not* to have midwives in rural and remote regions where pregnant women live?' The question of place of birth then becomes of the place of skilled health personnel, and at the moment, the current health system does not support skilled birth attendants to be located in rural and remote First Nation communities.

Population

In 2006, 1,172,790 people identified themselves as being Aboriginal (North American Indian, Metis, or Inuit). Of these, 698,025 identified as North American Indians. The First Nations population is growing at a rate nearly four times faster than the non-Aboriginal population. The fastest increase in the past ten years occurred in Manitoba. It is noted that Aboriginal people in Canada are increasingly urban. Approximately 40% live on reserve. Of the other 60% off reserve population, three of four lived in an urban centre. Winnipeg, the capital of Manitoba, has the largest urban Aboriginal population at 63,380. The Aboriginal population is also younger than the non-Aboriginal population, with almost half (48%) under the age of 24 compared with 31% of the non-Aboriginal population. The median age of First Nations in Manitoba is 21 years old. The population of Aboriginal peoples is also growing, and from 1996 to 2001 the population grew by 22%, in contrast to the national population growth of 3%. This is attributed to a higher fertility rate and also the increasing self-identification of Aboriginal peoples within the survey data (Statistics Canada, 2008). Despite the fertility rate lowering since the 1960s, it still remains higher at 2.2% compared to 1.0% in the non-Aboriginal population. In the period of 2005/2006, the odds of bearing a child if you were First Nations woman was 1.49 compared to the non-Aboriginal rate of 1.00. Living on reserve and being a Registered Indian were also positively associated with this data (Malenfant and Morency, 2011: p. 21).

According to Statistics Canada (2008), Aboriginal peoples do not share the same 'quality of life' as the rest of the population. The two biggest concerns have been identified as 'access to adequate housing and their overall health' (p. 1). The percentage of Aboriginal peoples living in overcrowded housing is five to six times higher than the national population. In terms of disease and illness, rates of tuberculosis, diabetes, HIV/AIDS are also extremely high, compared to that of the national population (Statistics Canada, 2007: p. 2). The mobility of Aboriginal peoples is also cited as being much higher than the national population, and it is recorded that one in five Aboriginal peoples moved in the past year.

Birth outcomes for Aboriginal peoples in Canada are significantly worse across all birth outcomes than the non-Aboriginal population (Smylie et al., 2010). In the Royal Commission of Aboriginal Peoples (1996), it was stated that 'stillbirth and perinatal death rates among Indians are about double the Canadian average; among Inuit living in the Northwest Territories, they are about two and a half times the Canadian average'. The Canadian Institute of Child Health (2000) compared the difference in Aboriginal post- neonatal mortality from 1979 to 1981 and 1991 to 1993, and found that the rates were three times higher than the national population. More recent data analysis show that this disparity continues. For example, in the infant mortality rate of First Nations in Manitoba, between 1991 and 2000 is 10.2 per 1000 live births as compared to a rate of 5.4 for the 'non-First Nations' population in the province (Smylie et al., 2010).

Maternal evacuation

During the period from the mid-19th century until the middle of the 20th century, major changes took place in the field of childbirth, and midwives, both Aboriginal and European were marginalised and eventually prohibited from attending to childbearing women. There was a push to medicalise and modernise childbearing practices across Canada. Childbirth in a hospital setting, under the authority of clinicians grew steadily and by the 1940s, midwifery was 'no longer an option for the vast majority of Canadian women' (MacDonald, 2006). The intervention of the federal government into childbearing practices, and more specifically, into changing these practices, occurred relatively late, especially in the northern and more remote regions of Canada. Kaufert and O'Neil (1990) regard the building of nursing stations by the federal government in the 1960s as the point in which 'full-scale medicalisation of birth' occurred (p. 431). The push to begin taking control of birthing practices was the 'extremely high infant mortality' among Aboriginal peoples, and this was seen as a 'tremendous concern' for the Canadian state. Despite the fact that midwives were being quite literally outlawed from practicing in southern Canada, 'non-native midwives were recruited to work in nursing stations' and these midwives became a part of the effort of the state to ' bring birth into nursing stations at least, and ideally, into hospitals' (Plummer, 2000: p. 172). During the 1970s, the Medical Services Branch (which later became renamed the First Nations and Inuit Health Branch) set the criteria to determine if women should be flown out of the community to deliver in a tertiary hospital. During this time, non-native women in these communities were often flown out to deliver their babies in urban centres, and it is interpreted by some that the policy of evacuation for all women was, in some ways, allowing Aboriginal women to receive the same care as the non-Native women in their communities (Birch, personal communication, June 3, 2008). By the 1980s, this policy has expanded to include all pregnant women.

Since the implementation of the practice of in the early 1980s, there have been many vocal opponents to maternal evacuation. Academics and policy makers have written about the practise of evacuating pregnant women from rural, northern communities to give birth in urban centres in Manitoba (Guse, 1982; Kaufert and O'Neil, 1990; Hiebert, 2003; Eni, 2005). This literature consistently shows that medical relocation for birth has negative effects. This includes 'increased maternal newborn complications, increased postpartum depression and decreased breast-feeding rates' (O'Neil et al., 1990; Smith, 2002, Klein et al., 2002a). Yet