

Access to Maternal Health Care for Native Canadians on Reserves in Northern Canada

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Résumé :

(traduction)

L'historique de violence et d'isolement des populations autochtones du Canada a créé un écart dans les soins de santé maternelle, entraînant des taux de mortalité infantile (TMI) de 12 décès pour 1000 naissances pour les populations des réserves par rapport à 5,8 décès pour 1000 naissances pour la population canadienne en général. Cet écart est considéré comme un sérieux enjeu de santé des populations puisque les Autochtones, qui représentent environ 3% de la population canadienne, ont des taux de mortalité infantile similaires à des pays du « tiers monde ». Actuellement, il existe de multiples organisations gouvernementales et non-gouvernementales en charge de la prestation des soins de santé maternelle auprès des populations des réserves. L'absence d'un système de communication unifié reliant ces organisations entre elles provoque des lacunes importantes dans la prestation de services de soins et compromet les soins prénataux chez les Canadiens autochtones. La méthode actuelle de prise en charge des grossesses à haut risque dans les réserves du Nord canadien consiste à transporter par voie aérienne les mères depuis leur communauté d'origine jusqu'à un hôpital qui se trouve être à la fois loin de leur famille et complètement étranger pour elles. Cette pratique contraste avec les normes culturelles de la population autochtone du Canada où les femmes reçoivent normalement des soins prénataux dispensés par des femmes plus âgées au sein de leur communauté. De nouveaux modèles de soins, dans lesquels les sages-femmes sont les principales dispensatrices de soins prénataux au sein d'une communauté donnée, ont récemment été mis en œuvre dans le nord du Québec et dans d'autres régions isolées du Canada. Les sages-femmes travaillent avec les aînées de la communauté pour fournir un système complet de soins de santé maternelle. Ces nouveaux modèles sont très prometteurs quant à l'amélioration de notre système actuel de soins de santé maternelle pour les Canadiens autochtones en fournissant des soins prénataux potentiellement plus efficaces et plus accessibles tout en intégrant les normes culturelles des communautés.

Mots-clés :

Santé maternelle, Autochtones canadiens, réserves Autochtones, programmes prénataux, santé Autochtone

Abstract:

The history of abuse and isolation of Native Canadian populations has created a gap in maternal health care, resulting in infant mortality rates (IMRs) of 12 per 1000 births for on-reserve populations compared to 5.8 per 1000 births for the general Canadian population. This discrepancy is deemed a population health issue, as Native Canadian people constitute roughly 3% of the Canadian population, but have infant mortality rates similar to other third world countries.

Currently, there are multiple government and non-government organizations in charge of providing maternal health care for on-reserve populations. A lack of a unified communication system linking these organizations creates a gap in the delivery of services and compromises the prenatal care in Native Canadians. The current method of caring for high risk pregnancies on Northern Canadian reserves is to fly the mothers out of their home community to a hospital that is both far away from their families and completely foreign to them. This practice contrasts with the cultural norms of the Native Canadian population, where expecting women receive antenatal care from elder women within their community. New models of care, in which midwives are the primary providers of antenatal care within a given community, have recently been implemented in Northern Quebec and other isolated areas of Canada. The midwives work with women elders of the community to provide a full system of maternal care. These new models show great promise in improving our current system of maternal health care for Native Canadians by providing more efficient and accessible antenatal care while also incorporating cultural norms of the communities.

Keywords:

Maternal health, Native Canadians, Aboriginal reserves, prenatal programs, Aboriginal health

Introduction

The current practice in maternal health care for on-reserve Native Canadian populations (ORNCs) is rooted in the history of the community and the key decision makers involved in health care structuring. Historically, in native communities, the Canadian government has provided universal health care since the late 1960s; however, due to inefficiencies in its delivery and internal colonization of Native Canadian populations, there has been an ever-widening gap between the health care services provided on-reserve and off-reserve (Adelson, 2005).

The internal colonization of Native Canadian populations, defined as the encroachment and subjugation of Aboriginal people since the arrival of Europeans has isolated these populations from political focus, which has resulted in less access to health care funding and services offered to the general population (Adelson, 2005). These political and economic disadvantages are part of the long-standing history of European settlement in Canada. The movement of Native Canadians to onto reserves, the abuse of students in residential schools, and the neglect of the federal government to provide adequate and effective health care have further amplified the health disparities for Native Canadian populations (Adelson, 2005).

According to Smith (2003), current Canadian maternal health practice says that a native Canadian woman nearing the end of gestation must be transferred to Southern Canada to ensure a medically safe birth. This means that pregnant women are absent from their family and community to give birth in unfamiliar environments with no social support network (Smith, 2003). Up to 40% of women on-reserve in Northern communities travel more than 100 km to give birth, and 77% of these women were also away from their community overnight for the first time (Butler-Jones, 2009).

According to Smith (2003), remote Northern Canadian communities are strained by a shortage of resources, especially qualified human resources or health care professionals. In many isolated communities, the medical staff turnover rate is over 40% during an 18-month period, and over 50% of positions are persistently vacant. Due to the strain put on the existing staff, emergency care is the priority among health care providers. With the resources to only provide emergency care, other areas of medicine such as health promotion and prevention are neglected and com-

prehensive maternal care may not be provided (Smith, 2003).

Population Health Issues

Statistics Canada data show that roughly one million people (3% of the population) in Canada identify themselves as Native Canadian, including First Nations, Métis and Inuit peoples (Statistics Canada, 2008). This number is thought to be an underestimate since many individuals, especially in more remote areas of the country, do not report their ethnic status to Statistics Canada. This visible minority group constitutes a significant portion of the Canadian population and their poor health status produces a substantial problem for the nation's health care system (Adelson, 2005).

In maternal health, infant mortality rate (IMR) is a universally accurate and reliable indicator of the country's current maternal health status. The on-reserve IMR is 12 per 1000 as compared to 5.8 per 1000 in the general populations (Smith, 2003). This twofold difference between on-reserve and general population IMR has been consistent over two decades, with no reduction in the IMR between the populations. As the IMR is a widely used indicator for the health status of a population, the great difference in rates between the general Canadian population and on-reserve populations point to a lack of access for maternal care on-reserve (Smylie, Fell, & Ohlsson, 2010).

The isolation of Northern reserves, limited access to maternal care, and great distances travelled to give birth all contribute to an IMR that is more than double that of the rest of Canada. Barriers to easily accessible maternal care is thus a significant population health concern and should be addressed by the federal government, a key organization charged with providing care to on-reserve Native Canadian women.

Key Drivers of the Issue

The First Nations and Inuit Health Branch (FNIHB) of Health Canada is the main organization responsible for providing health care to on-reserve populations. The Native Canadian populations have requested an autonomous, locally accountable system of health care delivery body that would be separate from the federal government. This re-

quest has been denied based on the Indian Act of 1876, which was amended in 1939. The Indian Act is a treaty that was signed by both parties to define the governance of Native Canadians. This act placed Native Canadians under the control of the federal government of Canada and did not leave room for self-governance. As a result, the current health care system for Native Canadians is fragmented between many different governing bodies (Adelson, 2005).

There are multiple government agencies that directly or indirectly target maternal health for on-reserve women in Canada: Human Resources Development Canada, Indian and Northern Affairs Canada, local Native Canadian governments, and the FNIHB of Health Canada. As a result of these independent governing bodies, there is a lack of unified communication between maternal health programs. This disconnect of communication between organizations creates inconsistencies in program governance and duplication or neglect of certain health care coverage may occur. The lack of a coherent, integrated health network slows down and ultimately prevents the process of improvement for maternal health coverage on-reserves (Smith & Davis, 2006).

Potential Solutions and Barriers

According to O'Driscoll et al. (2011), Native Canadian women who give birth and raise a family are viewed as community leaders and are expected to pass down their knowledge of birthing and mothering to the younger generation of women. Most girls living on reserves learn how to care for themselves and their future families from elder women and extended family in their communities. However, the current maternal health system isolates some women from their families during birth, depriving them of the social support and maternal education that their elders can provide.

Programs on the Northern Quebec Inuit reserve of Povungnituk have combined traditional birthing methods with safe modern practices of birthing to improve the overall maternal health of women in their community. The programs aim to put the responsibility of women's health care services into the hands of fellow Inuit women. Female elders are recruited from the community and trained to work in collaboration with midwives trained in modern birthing techniques. This model of providing culturally sensitive and safe care in the community reduces the need to

transport pregnant women out of the community to a hospital (Smith, 2003).

According to Miller et al. (2012), evidence shows that maternal outcomes are better when women do not have to travel away from their community but are provided care through an integrated antenatal care system. Training programs that are offered in the community and combine modern birthing techniques with traditional Native Canadian healing techniques are ideal models of integrated antenatal care. The combination of the two health care approaches encourages cultural sensitivity and can greatly improve access to maternal health care on isolated reserves. In 2008, the Nunavut Arctic College was one of the first programs in the Northern Territories to graduate midwives who were trained under a curriculum partially designed by local Elders and containing a traditional component. This program regularly includes traditional midwives in seminars and develops a connection with the communities to incorporate a cultural component to their training in midwifery (Stout & Harp, 2009).

The collaboration of traditional and modern practices addresses many of the issues associated with current birthing practices on reserves. This collaborative approach allows the women to give birth in their community where their family and support network can assist alongside health care professionals. Their social and emotional needs can be met within the social network of their community. This collaborative model creates less of a need for relocation to southern Canada to give birth in an unfamiliar environment and that community support has been shown to improve maternal outcomes (Miller et al., 2012).

The collaborative model is an ideal system for providing high quality maternal care to Native Canadian women in isolated regions of Canada. The various agencies and organizations that are in charge of providing maternal health services to women on-reserve should address the various barriers of improved access to these services. The FNIHB of Health Canada should take the lead to implement a unified system of communication between the different federal government departments that directly or indirectly influence provision of maternal care so that more efficient programs are provided. With on-reserve, culturally sensitive maternal health care the discrepancy in maternal mortality rates between on-reserve and off-reserve populations can be bridged which leads to improved maternal health outcomes. On a population health level, improved care for on-reserve Native Canadians reduces the health inequities that

are perpetuated by the remoteness of many Northern Canadian communities.

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