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REVIEW ARTICLE

Role of the nurse in returning birth to the North

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ABSTRACT

With the colonization of the Americas came the eventual stigmatization of Aboriginal women and their traditional birthing methods. Gradual introduction of Western ideology and medicine led to government pressure to medicalize birth. Women were eventually flown to southern hospitals with immediate medical and surgical services available to ensure 'safer' deliveries and thereby improve serious maternal and infant morbidity and mortality statistics that were becoming too obvious to ignore. This process led to devastating consequences for women and families, which are still being felt today. The history of colonization of birth for Aboriginal families is discussed, with current strategies to alleviate this suffering in the north. Proposals for change from the Society of Obstetricians and Gynecologists of Canada (SOGC) are discussed. The role of the nurse is described, including being culturally competent, fostering an environment of respect, dispelling myths and stereotypes, ensuring research involving Aboriginal peoples is done ethically, and promoting pursuing a career in health care.

Key words: Aboriginal, birth, colonization, evacuation, infants, mothers, northern Canada, role of the nurse.

Context

The Canadian Arctic represents approximately 40% of the country's landmass, and is home to approximately 100 000 people[1]. More than 80% of these individuals are Aboriginal, and nearly 50% of this population is Inuit[2]. Aboriginal peoples in Canada include Indian, Inuit and Métis peoples, according to the Canadian Constitutional Act[3].

There are glaring health disparities between Aboriginal and non-Aboriginal Canadians, particularly for those who live in remote areas of northern Canada. Health statistics of infant mortality and morbidity are even worse. Although colonization of the Americas began in the late 1800s, the

colonization of birthing practices for Aboriginal women in Canada continued until the late 20th century[4]. Based on a western bio-medical assumption of risk, that physical harm is of paramount concern, and that the immediate availability of medical and surgical services is essential, women were required to evacuate to tertiary care centers to await delivery sometimes a month in advance[4]. Recent literature has shown the devastating consequences of this continuing colonization for women, children, families and communities, including loss of cultural identity, Aboriginal midwifery, and the stress of separation from family.

As a neonatal nurse practitioner, the author is sensitive to the importance of improved health for mothers and infants, but cautious to assume that Western medicalization is the answer. This paper will highlight the current health trends of Aboriginal mothers and infants in northern Canada. It will then describe the process of colonization and eventual medicalization of birth in these areas. The consequences of this medicalization will be described, and actions currently underway to return birth to the north will be outlined. Changes in birthing practices in areas of northern Canada that are addressing these health issues without medicalizing birth will be discussed, as these populations have fought to gain back control of local birthing, and have succeeded. Their communities have thrived with the regaining of this power, and birth outcomes are reassuring. Further proposals for change will be made with the role of the nurse in mind.

Current statistics

Current literature supports poorer health status and outcomes for Aboriginal than for non-Aboriginal Canadians. Aboriginal Canadians suffer from higher rates of diabetes, high blood pressure, certain types of cancer, accidental injury, suicide and drug and alcohol abuse[5]. Aboriginal mothers and their newborns also experience poorer health than non-Aboriginal mothers and newborns. Aboriginal mothers tend to be younger, under the age of 18, have shorter life expectancies, and have higher rates of HIV, substance abuse and incarceration, and Aboriginal newborns have higher rates of mortality[4]. The prevalence of preterm birth, stillbirth and neonatal death were found to be much higher in the Inuit population than in other populations residing in northern Canada, and in Canada as a whole[6]. Due to these statistics, government officials, policy-makers and healthcare professionals could no longer ignore the obvious need for health intervention in the north to improve maternal and birth outcomes. This process of further colonization led to devastating consequences for families in the north.

Issues

The colonization of North America has drastically changed life for the Aboriginal peoples of Canada. Specifically, birthing practices have been heavily influenced. Through a review of the literature, one can begin to understand the implications of colonization on the Aboriginal peoples of Canada, and more specifically, its impact on birthing practices in northern Canada.

Colonization of Aboriginal birth

The colonization of Aboriginal birth practices began shortly after Europeans began to settle in North America. The following briefly describes Aboriginal birth practices prior to colonization, and colonization in North America, its impact on women and birthing practices, and its subsequent impact on the family.

History of birth practices prior to colonization: Prior to colonization, Aboriginal births were commonly attended by a traditional Aboriginal midwife, or women gave birth with the aid of their spouse or on their own during periods of travel[4]. Women were taught how to birth infants by their mothers and grandmothers, who were taught by their mothers and grandmothers[4,7]. In addition to knowledge of different birthing positions, they had knowledge of various herbal remedies, including those for pain relief, prevention of hemorrhage, and others[4]. With the arrival of Europeans, Aboriginal midwives were commonly called upon to aid in the delivery of European births until European, or Western, health care began to arrive in colonies with the development

of the fur trade[8]. With the arrival of Western health care came the creation of rumours and legends related to Aboriginal women and their birthing practices. These rumours further enforced Aboriginal women as *others*, and reinforced their savagery.

Description of colonization: Colonization has been described by Moffitt[9] as involving three components: Eurocentrism, universality and strategy of difference. First, Eurocentrism refers to the Europeans asserting dominance over all other culture groups in an effort to create a state of superiority[9]. Second, universality refers to the assumption that European values were held by everyone[9]. Other beliefs, including Aboriginal beliefs, therefore, were judged against the mainstream values deemed universal, and were therefore different, wrong, and immoral. Third, a strategy of difference refers to the development of racism as the dominant culture group, the Europeans, judged others for their differences, and valued people different from them as lesser[9].

Creating myths about Aboriginal women: Despite Aboriginal midwives being involved in European births early post-contact, European settlers began to create rumours and myths about Aboriginal women as being wild and savages[10,11]. They said that they gave birth without pain, and that this lack of pain during childbirth was due to their infants' small head sizes, which was directly linked to lower intelligence levels[10,11]. Aboriginal mothers were said to pause in their travels for a short time to give birth to their infants, then strap them to their back, and toss a breast over their shoulder to feed them while they continued travelling[10].

These myths started to create the feeling among Europeans that Aboriginal people were inferior and different. These myths helped to further segregate the Aboriginal people as *other,* or different from non-Aboriginal people, and helped to promote colonization among the growing population of Aboriginal and non-Aboriginal people alike. With the availability of Western health care coming to the Americas, Aboriginal healers and midwives were no longer required, and myths and rumours led to the beliefs that Aboriginal healers were evil and immoral, and that midwives could not assist birthing safely[10]. This eventually brought about the medicalization of Aboriginal birthing.

History of Western medicalization of birth for Aboriginal women: In the 1960s, the government started to insist on local nursing stations in Aboriginal communities, staffed by nurses and at least one midwife[7]. Community members were pressured to birth at these stations, even though some of the healthcare staff were in disagreement with its necessity[7]. By the 1970s, criteria for evacuating mothers with high-risk pregnancies were established, and women began to birth in tertiary care centers within their region[7]. Further government pressure into the 1980s led to almost all deliveries occurring in tertiary care centers, many of which were not in local regions, but were teaching hospitals in southern cities[7]. At this time, it was believed that the hospitals with advanced equipment and services available were the safest in which to birth infants. This process occurred fairly quickly over a 20 year span, with some mothers having birthed their first infants at home at nursing stations with the care of an Aboriginal midwife, and flying to a major urban center outside their region for their fourth delivery[7].

Definition of risk: The medicalization of birth was due to a Western biomedical assumption that having the most advanced medical and surgical care available for birthing was the safest option. This biomedical assumption of risk is not in line with Aboriginal beliefs of health, or of risk[10]. In addition to its conflict with Aboriginal values, evacuation in itself is not without risk. Transferring from northern rural areas can be dangerous due to precarious weather conditions[12]. Some mothers have co-morbidities, and are not prime candidates for flying[12]. Some evacuations occur during premature labour, with the birth of infants occurring in-flight, which is the worst situation for safe birthing and newborn care[7].

Aboriginal people view health and wellbeing in a holistic way, as noted by the medicine wheel. The medicine wheel depicts health as including mental, emotional, spiritual and physical aspects, and one cannot be truly healthy without a balance

between all elements[13,14]. Aboriginal beliefs, therefore, conflict with the Western biomedical belief that physical health is the most important, and that a holistic balance is not necessary to achieve health. This is echoed in a quote used in an article by Kildea[15] which stated:

> *Safety is not an absolute concept. It is a part of a greater picture encompassing all aspects of health and wellbeing. We believe that safety, encompassing as it does the emotional and physical wellbeing of the mother and baby, must remain the foundation of good maternity care*. (p. 389)

Within the Inuit culture, the loss of infants during pregnancy or birth is seen as a normal part of life[12]. Inuits do not demand perfect outcomes as those in the Western medical mindset do. They believe that the loss of infants is an acceptable risk for living in rural and remote areas. Their loss of community during evacuation is believed to be more of a risk than less than perfect birth outcomes[12]. Although difficult for those of a Western belief system to understand, it is important for decision-makers to take the beliefs and wishes of the community into consideration when making such drastic health policies such as evacuation for all births.

Implications of evacuating Aboriginal mothers: With the initiation of evacuating all pregnant women to tertiary care centers, in either their region or southern cities, came devastating consequences for Aboriginal mothers, families and communities. Being separated from her family and community has led to an increased rate of postpartum depression[16]. Women describe feeling very lonely, isolated and bored and very stressed about their children and families left without them at home[16,17]. For some women this led to emotional over-eating, and for others it meant under-eating, both of which were unhealthy choices, particularly for their unborn children[18]. Children of mothers who were evacuated from their communities for delivery suffered from a lack of child care and being separated from their mothers, and developed a sense of jealousy towards the unborn child who had taken their mother away[18]. Partners were left to care for the children, which sometimes meant they could not hunt to provide food for family[17,18]. This led to expensive meals purchased at grocery stores, and an increased financial burden. Partners were left without the support of their spouses, were not able to attend the birth of their infant, and suffered from late bonding with their newborn when it finally arrived home[17]. Community members commonly try to help with child care and offer support to the partner, and some communities are able to provide financial means to pay for additional expenses not covered by the government, such as phone cards and meals[16]. Not all communities have the financial means to assist families though, and the family is placed under financial stress.

Lessons learned

Several lessons can be taken from this review of the literature. These include recommendations from the Society of Obstetricians and Gynecologists of Canada (SOGC), lessons learned from Aboriginal populations who have successfully returned birth to their northern communities, and a further look at expert opinion on the role of the nurse in returning birth to northern Canada.

Moving birth back home

History has now come full circle, and due to decreasing numbers of obstetricians and gynecologists in Canada, particularly in the north, there is now a push for increasing the numbers of midwives available in remote areas. The SOGC has created a multidisciplinary model to ensure safe delivery of maternal and newborn care in remote areas, which includes a new process to ensure informed consent of mothers, and ability for quick referral to tertiary care centers for complications[19]. The model also insists on promoting culturally sensitive care in referral centers where mothers find themselves delivering[19].

The Inuit population in northern Canada lobbied the government for the return of birthing to their northern communities, and won. Aboriginal midwives now assist in deliveries in a number of northern communities. These birthing centers have available on-call physician support, and

have created a multidisciplinary, community approach to decisions regarding the need for evacuation of high-risk mothers. A comparison study was conducted of two different communities: the first is in Hudson's Bay, where birthing occurs assisted by midwives, with physician backup; the second is in Ungava Bay where all births are assisted by physicians[20]. No significant differences were found in regards to maternal or infant mortality or morbidity, although the study was underpowered to find many of these outcomes. Rankin Inlet, in Nunavik, also has a midwife-led community birthing center, which has demonstrated a reduction in birthing complications and interventions, and similar outcomes to those on obstetric wards[21]. Kildea[15] reports the positive impacts of bringing birth back to northern communities, including a sense of dignity, improved self-esteem, and trust in their own community. Van Wagner et al[12]. describe the Aboriginal-focused education for midwives in Nunavik, including utilizing elders and Aboriginal teachers, traditional Inuit approaches to labor, birth and care of the newborn, as well as advanced skills such as intubation, use of vacuum, and umbilical vein catheterization necessary for emergency situations. These studies and papers give reassurance for the safety of midwife-led local delivery options for Aboriginal women in remote areas of Canada, and the positive impact of returning birth to local communities.

Proposals for change and the role of the nurse

Nurses can take a leadership role in promoting the continuation of returning health services to the power and control of local Aboriginal communities. Varcoe et al[16]. suggest a number of roles for the nurse including promoting training for all healthcare professionals on Aboriginal culture and traditions. This will promote the provision of culturally safe care. This is particularly important for hospitals that care for mothers who are evacuated out of their communities for birth, and are particularly vulnerable as they are in an unfamiliar environment and often alone. Second, nurses should promote an environment of respect within their healthcare settings[16]. It is important for nurses to dispel myths about Aboriginal people, and educate colleagues on the social determinants of health and how they relate uniquely to Aboriginal people. Third, healthcare professionals should encourage Aboriginal people to enter the healthcare field[16]. With a greater number of Aboriginal people in the healthcare field, healthcare professionals will gain a better understanding of their beliefs and culture, as well as an improved ability to provide culturally safe care with the assistance of Aboriginal colleagues. Fourth, any research that is conducted involving Aboriginal people should be done in collaboration with the Aboriginal community[16]. Canadian ethical standards for research involving human participants encourages the use of participatory action research to promote the inclusion of Aboriginal people throughout the research process[22]. This will ensure that research is done appropriately, and that it benefits the Aboriginal community. It will also assist in dissemination of findings when the community is involved in the project from the beginning. Finally, nurses need to promote self-governance for Aboriginal people over their own health care[16]. It has been demonstrated in the studies mentioned in this paper that returning birth to the power and control of Aboriginal communities has not led to poor health outcomes, but has improved the community's sense of worth and restored dignity[15].

Conclusions

With the arrival of the Europeans in the Americas came the eventual realization of the poor health of northern Aboriginal people, particularly in regards to maternal and newborn outcomes. Western biomedical assumptions led to the evacuation of all pregnant women to southern tertiary care centers where emergency equipment and surgical means was believed to be the safest option for improved outcomes. These assumptions were in direct conflict with Aboriginal beliefs of holistic health and the importance of community, and led to distressing consequences for mothers, families, and the communities left behind. Some Inuit communities were able to lobby the government and win the return of birthing services to their northern communities. Evidence has shown that the return of birth to the north has not led to poorer health outcomes, but has instead improved the community's sense of wellbeing and trust in its own abilities[15]. Further

research and larger studies are needed to validate these outcomes.

The nurse has a significant role to play in promoting a sense of respect for Aboriginal people in Canada, and improving the provision of culturally safe care[16]. Nurses can also promote Aboriginal people to pursue careers in health care, and promote appropriate research strategies for researchers involved with Aboriginal people[16]. It would seem that birthing in the north is progressing in the right direction, with return of birthing services to northern communities. Nurses can continue to advocate for Aboriginal people to gain self-governance for all of their healthcare services.

References

1. Government of Canada. *The Canadian Arctic* (Online). 2013. Available: http://www.canadainternational.gc.ca/united_kingdom-royaume_uni/bilateral_relations_bilaterales/arctic-arctique.aspx?lang=eng (Accessed 18 February 2014).

2. Simeone T. *The Arctic: Northern Aboriginal peoples*. Library of Parliament, Info Series (Online). October 2008. Available: http://www.parl.gc.ca/content/lop/researchpublications/prb0810-e.pdf (Accessed 18 February 2014).

3. *Canadian Charter of Rights and Freedoms. Constitution Act, 1982* (Online). 2004. Available: http://www.solon.org/Constitutions/Canada/English/ca_1982.html (Accessed 18 February 2014).

4. Lalonde AB, Butt C, Bucio A. Maternal health in Canadian Aboriginal communities: challenges and opportunities. *Journal of Obstetrics and Gynaecol Canada* **31(10):** 956-962. (Online) October 2009. Available: http://www.ncbi.nlm.nih.gov/pubmed/19941725 (Accessed 18 February 2014).

5. Reading C, Wien F. *Health inequalities and social determinants of Aboriginal peoples' health*. Prince George, BC: National Collaborating Centre for Aboriginal Health (NCCAH). (Online) 2009. Available: http://www.nccah-ccnsa.ca/docs/nccah reports/LoppieWien-2.pdf (Accessed 18 February 2014).

6. Luo Z-C, Senécal S, Simonet F, Guimond E, Penney C, Wilkins R. Birth outcomes in the Inuit-inhabited areas of Canada. *Canadian Medical Association Journal* **182(3):** 235-242. (Online) 23 February 2010. Available: http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2826464&tool=pmcentrez&rendertype=abstract (Accessed 6 January 2014).

7. Kaufert P, O'Neil J. Cooptation and control: the reconstruction of Inuit birth. *Medical Anthropology Quarterly* 1990; **4(4):** 427-442.

8. Healey GK, Meadows LM. Inuit women's health in Nunavut, Canada: a review of the literature. *International Journal of Circumpolar Health* **66(3):** 199-214. (Online) 18 July 2007. Available: http://www.circumpolarhealthjournal.net/index.php/ijch/article/view/18256 (Accessed 6 January 2014).

9. Moffitt PM. Colonialization: a health determinant for pregnant Dogrib women. *Journal of Transcultural Nursing* **15(4):** 323-330. (Online) October 2004. Available: http://www.ncbi.nlm.nih.gov/pubmed/15359066 (Accessed 19 January 2014).

10. Jasen P. Race, culture, and the colonization of childbirth in northern Canada. *Journal of the Society for the Social History of Medicine* **10(3):** 383-400. (Online) December 1997. Available: http://www.ncbi.nlm.nih.gov/pubmed/11619824 (Accessed 19 January 2014).

11. Schiebinger L. *Nature's body: gender in the making of modern science*. 2nd ed. New Jersey: Rutgers University Press; 2004.

12. Van Wagner V, Epoo B, Nastapoka J, Harney E. Reclaiming birth, health, and community: midwifery in the Inuit villages of Nunavik, Canada. *Journal of Midwifery and Women's Health* **52(4):** 384-391. (Online) 2007. Available: http://www.ncbi.nlm.nih.gov/pubmed/17603961 (Accessed 18 February 2014).

13. Shroff FM. Power politics and the takeover of holistic health in North America: an exploratory historical analysis. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health* 2011; **9(1):** 129-152.

14. Hunter LM, Logan J, Goulet J-G, Barton S. Aboriginal healing: regaining balance and culture. *Journal of Transcultural Nursing* **17(1):** 13-22. (Online) January 2006. Available: http://www.ncbi.nlm.nih.gov/pubmed/16410432 (Accessed 7 February 2014).

15. Kildea S. Risky business: Contested knowledge over safe birthing services for Aboriginal women. *Health Sociology Review* 2006; **15(4):** 387.

16. Varcoe C, Brown H, Calam B, Harvey T, Tallio M. Help bring back the celebration of life: a community-based participatory study of rural Aboriginal women's maternity experiences and outcomes. *BMC Pregnancy Childbirth* **13(1):** 26. (Online) 2013. Available: http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3577503&tool=pmcentrez&rendertype=abstract (Accessed 7 February 2014).

17. Chamberlain M, Barclay K. Psychosocial costs of transferring indigenous women from their community for birth. *Midwifery* **16(2):** 116-122. (Online) 2000. Available: http://www.ncbi.nlm.nih.gov/pubmed/11151547 (Accessed 12 February 2014).

18. Kornelsen J, Grzybowski S. The costs of separation: the birth experiences of women in isolated and remote communities in British Columbia. *Canadian Woman Studies* 2000; **24(1):** 75-80.

19. The Society of Obstetricians and Gynecologists of Canada (SOGC). Returning birth to Aboriginal, rural, and remote communities. *SOGC Policy Statement* **251:** 1186-1188. (Online) 2010. Available: http://sogc.org/wp-content/uploads/2013/01/gui251PS1012E2.pdf (Accessed 12 February 2014).

20. Simonet F, Wilkins R, Labranche E, Smylie J, Heaman M, Martens P et al. Primary birthing attendants and birth outcomes in remote Inuit communities: a natural 'experiment' in Nunavik, Canada. *Journal of Epidemiology and Community Health* 2009; **63(7):** 546-551.

21. Douglas VK. Childbirth among the Canadian Inuit: a review of the clinical and cultural literature. *International Journal of Circumpolar Health* **65(2):** 117-132. (Online) 2006. Available: http://www.ncbi.nlm.nih.gov/pubmed/16711464 (Accessed 12 February 2014).

22. Government of Canada. Research involving the First Nations, Inuit and Metis people of Canada. In: *Tri-Council Policy Statement 2* (Online) 2013. Available: http://www.pre.ethics.gc.ca/eng/policy-politique/initiatives/tcps2-eptc2/chapter9-chapitre9 (Accessed 6 January 2014).