First Nations, Inuit, and Métis Maternal Health

Many First Nations, Inuit, and Métis experience poor access to quality and culturally safe maternal health care, and are at an increased risk of poor maternal health outcomes, including higher rates of low and high birth weight babies, preterm birth, gestational diabetes, Caesarean sections, and poor access to specialist care due to geographic location, among other outcomes.[1]

Maternal health outcomes are a result of genetic and environmental factors. Genetic factors, conventionally seen as non-modifiable, are increasingly evaluated using epigenetics, which will be discussed later. Environmental factors are conventionally seen as modifiable factors, such as behaviours that can impact on obesity and weight gain: diet and exercise, substance abuse, stress and depression, social support, and violence. Each of these environmental factors can be assessed during the prenatal encounter.

THE COLONIALIZATION OF BIRTH

Historically, women were often considered the centre of the Nation or the backbone of the community. They gave birth, raised the children, provided teachings to their younger relatives about the motherhood process, understood the medicines that would help them have less painful birth, stop postpartum bleeding, and promote breast milk, and were involved in ceremonies that saw children through the stages of their childhood.

In the 20th century, the birthing process was colonialized, and women were no longer the prime caregivers during the birthing process. Presently, in rural and remote communities, pregnant women are transferred midway through their third trimester to distant medical centres to give birth. There, for several weeks, they are often alone, without the help of their families. The birth is not a community event, as traditionally intended.

The absence of birth in a community disrupts the transference of experiential, traditional knowledge. Traditionally, young girls would be present for the labour and the delivery, and learn about the process. They would learn that they were part of a community responsible for the upbringing of this new being. Most importantly, they would see their family and other women as active participants throughout this intense experience. It easily follows that this experience would impact their future pre-conceptual and perinatal expectations, behaviours, and overall health, including the cultural knowledge and values surrounding birth. Bringing birth back into the lands of the community would have profound, unmeasured implications for both mothers and the women around them. Currently there are efforts to bring back birth in remote and rural communities for women who have low risk pregnancies. The ultimate goal is to provide the best pre-conceptual and perinatal care possible to ensure that the most pregnancies possible are rendered low risk and the expectant mothers can therefore deliver at home in their communities.

CLINICAL TIP

It is important to many First Nations, Inuit, and Métis women to have family members present when seeing a health professional. The presence of family members at a birth is an important way many First Nations, Inuit, and Métis communities are "reclaiming birth" for their healing. Ensure that there is adequate space and chairs so that everyone can be seated at the same level, including the health professional.

Some traditional practices for birth are still in use today, such as the First Nations and Métis practice of burying the placenta in the lands the child lives on, to ground the child and offer it a sense of belonging and connectedness for the rest of its life. Others believe that the placenta provides nutrients for the mother and may process it for consumption after the birth. Tissue obtained from miscarriages or surgical removal via dilatation and curettage for a missed, incomplete, or therapeutic abortion should be handled in a culturally safe manner. Burial of fetal and/or placental tissue after a miscarriage may be a symbolic event offering much solace to the mother and family.

Certain postmortem evaluations of bodies or organs may be culturally inappropriate. For some peoples, in order for someone to remain spiritually whole, the physical body must be buried with all organs and tissues intact. These beliefs have clinical implications for autopsy in the cases of a stillborn, maternal death, or postoperative death, as well as for cord blood banking and bone marrow donation. It is important to ask your patient about her beliefs and values.

Recommendation

18. Health care providers should ask about, respect, and advocate for institutional protocols and policies supporting the wishes of individuals and families regarding disposal or preservation of tissues involved in conception, pregnancy, miscarriages, terminations, hysterectomy, and other procedures. (III-A)

PRENATAL CARE

The first prenatal visit is the most important clinical encounter, because if done well, it identifies the modifiable risk factors that can be focused on to provide the most effective care, result in a low-risk third trimester pregnancy, and achieve a better health outcome. In the first prenatal visit with a First Nations, Inuit, or Métis patient, using the intake sheet as a template, health professionals should be particularly sensitive to issues such as geographic location, personal history of sexually transmitted disease, mental health, home environment, social support network, trauma/abuse, recent viral exposure, the use of alcohol, drugs, and cigarettes, and access to quality foods.

Adequate prenatal care has been defined as consisting of at least 6 visits with a health care practitioner, and a Manitoba study found that Aboriginal women were 5 times more likely than non-Aboriginal women not to have accessed adequate prenatal care.[2] Risk factors for inadequate prenatal care include low family income, higher unemployment, low education, single-parent families, immigrant status, smoking during pregnancy, and Aboriginal status.[3] Therefore, consideration should be given to whether the barriers to adequate prenatal care for an individual are financial, cultural, social, attitudinal, geographical, or related to accessibility of care. Another important consideration is to evaluate what Aboriginal women expect from their prenatal care provider. Prenatal vitamins and other medications needed during the prenatal course are covered by NIHB for Status First Nations and Inuit.

Geographic location can be a significant barrier to a woman getting to her prenatal, blood work, ultrasound, or specialist appointments on time. Transportation barriers include lacking such things as a car or driver, a babysitter to take care of older children, and the money to pay for gas and parking. Non-Insured Health Benefits have not kept up with the cost of living and do not provide adequate funding to travel to a larger centre for appointments.

CLINICAL TIPS

Instruct staff to inquire about best appointment times rather than assigning them. Be aware of a patient's travel context in terms of distance, financial constraints, child care challenges, etc. If you are receiving patients from the North, be aware of flight schedules and travel time and schedule your appointments accordingly.

Use your prenatal sheet: the checklist on your prenatal sheet can help you identify barriers and challenges to a healthy pregnancy and inquire about the patient's socioeconomic situation in a sensitive manner. Go through the sheet one question at a time, ask follow-up questions sensitively, and allow time for your patient to respond.

The standard of care is a timely gynaecological examination early in the prenatal period. If there is a history of sexual abuse, however, a timely gynaecological examination may be very difficult for a patient to accept, and may also be a reason for her presenting to the clinic for prenatal care later on in her pregnancy. It may be culturally safer to offer a gynaecological examination after the establishment of a safe physician–patient relationship if the pregnant woman is a low risk for gynaecological infection.

Depression is more common among Aboriginal women, and women with depression use more tobacco, alcohol, and drugs than those without depression. Women who quit smoking or drinking in pregnancy may need to be monitored more closely for depression than those who stop becoming pregnant. The high prevalence of smoking during pregnancy, particularly among Aboriginal women, necessitates coordinated efforts aimed at smoking prevention and cessation. Self-advocating during pregnancy for a healthier environment is difficult if women do not own the home they reside in.

CLINICAL TIP

Ask your patient about her support networks and if there are other agencies involved in her care, such as mental health or social services.

Weight gain and obesity during pregnancy are common physical health issues for Aboriginal women. As discussed in the Social Determinants of Health chapter, food insecurity is a significant issue for many First Nations, Inuit, and Métis women. Transitions away from a traditional diet and lack of access to healthy foods may contribute to weight gain and obesity. The Canadian Nutrition Guide does not consider the cultural and nutritional value of country foods, but there are more culturally relevant resources such as Pauktuutit's prenatal guide, "Born on the Land with Helping Hands."[4]

A recent paradigm shift in the field of developmental biology, termed epigenetics, suggests that environmental factors such as nutrition, environmental compounds, and stress during the prenatal period are associated with early alterations in the normal development of cells and tissues. There is particular interest in the relation between the

prenatal environment of the fetus and the development of adiposity and insulin resistance later in life.[5] Evidence has been found showing Aboriginal people as part of a biological food chain consuming deleterious amounts of harmful organic compounds that affect their personal health, but also the health of future generations via fetal absorption, breast milk contamination, consumption by newborns, and other exposures that cause disease.[6]

CLINICAL TIP

For many First Nations communities, tobacco has a sacred role in healing and ceremonies. Being culturally safe includes respecting this sacred role and clearly distinguishing between smoking and ceremonial tobacco use.

Recommendation

19. Health professionals should recognize that mental illnesses such as mood disorders, anxiety, and addictions are a major public health issue for many First Nations, Inuit, and Métis. (II-3B) Use of mood-altering substances that lead to addiction is often a mechanism for coping with the pain of their intergenerational trauma. Health professionals should familiarize themselves with culturally safe harm reduction strategies that can be used to support First Nations, Inuit and Métis women and their families struggling with substance dependence. (II-2A)

THE POSTNATAL PERIOD

The postnatal period includes the initiation of breastfeeding and nutrition, healthy environments and early childhood education. Breastfeeding among Aboriginal women in Saskatchewan was found to be related to the sociocultural and environmental context and attitudes, knowledge, beliefs, information, previous infant feeding experiences, and psychological factors.[7] Women who experience food insecurity and are more socioeconomically disadvantaged are less likely to breastfeed.[8] Estimates of the prevalence of breastfeeding in First Nations, Inuit, and Métis women are variable, but parallel to the general Canadian population, there is a trend towards increased breastfeeding.[8] Among Inuit breastfeeding rates are notably high, and ongoing promotion is a key priority of Inuit women's organizations such as Pauktuutit Inuit Women of Canada.

MISCARRIAGE

Spontaneous abortion or miscarriage likely occurs as frequently in Aboriginal populations as in others. However, because of the widespread understanding of Mother Nature and her often indiscriminate decisions, the event may be felt to be part of the cycle of life. There is very little reference to this stressful life event among First Nations, Inuit, and Métis women.

SEXUAL ABUSE AND BIRTH: RE-TRAUMATIZATION

It is crucial for health care providers to be aware of the high rates of sexual abuse among First Nations, Inuit, and Métis women, and to shape their care in a way that will not re-traumatize a victim of sexual abuse or assault. There are a number of challenges that a sexual abuse/assault survivor may face during the birthing process.[9] In 2004, Simkin and Klaus published the document, "*When Survivors Give Birth: Understanding and Healing the Effects of Early Sexual Abuse on Childbearing Women*," which includes important recommendations excerpted in Appendix 3.

TURNING IT AROUND

Though many of the childbearing women today did not attend the residential schools, they have heard of and indirectly experienced the trauma inflicted on their families. They have intergenerational trauma. Furthermore, many current Aboriginal childbearing women are also products of the Sixties Scoop, and were raised by non-Aboriginal families. In each case, there is a feeling of immeasurable cultural loss, and for many people, a desire to consciously reverse the effects of this troubled past. Many women see pregnancy and child rearing as an opportunity to turn their lifestyles and behaviours around for the well-being of their children. They are turning towards their families, communities, and other support systems to relearn some of the cultural values and teachings and they are making changes in their lives. In a study on the intergenerational impacts of residential schools, participants described their efforts to develop the knowledge, skills, confidence, and networks of support required to work towards their vision for a strong and healthy family and community.

CLINICAL TIPS

Communication and collaboration is important. Engage with others in your community of practice to ensure continuity of culturally safe care, including within intervention chains, should they be needed.

Know your local social service resources, personnel, and their contact information, and establish a collaborative rapport with them. Encourage your local social services to connect with you on an ongoing basis so that you can strengthen efforts made to achieve positive outcomes.

Be aware of and educate staff about patterns of automatic referral and understand that flags are flexible. When appropriate, work collaboratively with medical and social services to implement preventative care and support your patient and her family in improving outcomes.

CHALLENGES AND SOLUTIONS: MATERNITY CARE IN CANADA

As Canada enters an era that is facing an extreme shortage of maternity care providers, and as the global economic recession increasingly affects existing resources and funding, it is necessary to re-examine current practice and find a balance that will blend sustainability, safety, and cultural sensitivity in future interventions that aim to reduce maternal mortality and morbidity. Canada has already taken steps towards achieving this goal. For example, there are a growing number of Aboriginal midwives. Some of the barriers to the growth and establishment of Aboriginal midwifery include misunderstanding of the scope and role of midwives; pay structures; lack of culturally appropriate education programs and community based education opportunities; and lack of understanding of midwives by other health professionals. Inter-professional collaboration between obstetricians, physicians, and midwives is not only key to bringing birth closer to home in rural and remote areas, but also to the ability to address the overarching shortage of maternity care providers experienced across the country.

Training both Traditional and direct-entry midwives is a strategic approach to improving maternal health, which integrates community involvement and cultural sensitivity. It is also key to providing services in rural and remote areas that lack proper health facilities. The return of midwifery care to Aboriginal communities could reduce the number of obstacles inhibiting the success of maternal health care delivery while allowing for a more holistic and patient-centred approach to providing health services in general. Successful examples include the Hudson Bay communities' midwife-led maternity care program and the Midwifery Program in Fort Smith.

Recommendation

20. Health professionals should support and promote the return of birth to rural and remote communities for women at low risk of complications. The necessary involvement of community in decision-making around the distribution and allocation of resources for maternity care should be acknowledged and facilitated. (III-A)

Providing timely, accessible, and flexible prenatal care, with knowledge of the social determinants of health and the cultural values of the population that is being served, would be an initial step towards providing culturally and socially competent care. Many young pregnant women are maximizing their new role as mothers to make changes in their lives and follow a healthier path. The barriers towards following this healthier path are innumerable and unpredictable. By recognizing these barriers health care practitioners can support these women to meet the challenges and provide a healthier future for themselves, their children, families, and communities. After all, being in control of one's future is one of the strongest correlates of health.

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