MIDWIFERY IN THE NORTH

A Research Paper Submitted To

THE ROYAL COMMISSION ON ABORIGINAL PEOPLES

by

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1.0 EXECUTIVE SUMMARY

This report examines the issue of midwifery in the north, and in particular, its relevance to aboriginal women. Numerous aspects of the contemporary situation are addressed, in light of both traditional and historical experiences of childbirth and maternal health care, from Labrador to the Yukon.

The traditional practice of midwifery among northern aboriginal peoples was integral to a way of life in which birth was experienced close to the land, within the sphere of the family and the community. Traditional midwifery practice was not only essential to the physical survival of successive generations, but also served to foster significant social relationships among those who participated in the transformative life cycle event of birth. The legacy of traditional midwifery knowledge, passed from one generation to another, continues to be regarded as an important conveyor of cultural knowledge and identity, and as a source of esteem among aboriginal women.

The colonization of Canada's north ultimately led to the medicalization of childbirth. While traditional midwifery practice has been almost wholly displaced, the technology and ideology of southern-style obstetrics has entirely transformed the experience of childbirth for most aboriginal women today. Government health agencies continue to implement a policy of evacuation of all pregnant women to secondary and tertiary centres for delivery, although the policy remains unsupported by epidemiological studies of mortality and morbidity. In recent years, aboriginal women have begun to articulate a wide range of concerns about the disruption, stress, and alienation experienced by families when women must leave their communities to give birth. A call for the return to community birthing and the revitalization of midwifery has been heard repeatedly.

Few examples of contemporary midwifery practice can be found in the north today. In Labrador and in isolated instances in the N.W.T., "nurse-midwifery" models of care are incorporated into government administered health care services. A very few "lay-midwives" are practising in northern communities, entirely outside of the health care system. One truly outstanding example of midwifery practice, however, can be cited in Povungnituk, Quebec, where aboriginal and non-aboriginal midwives work together, in collaboration with other health professionals, to provide a full range of maternal health services to women in their region. Outcomes to date in Povungnituk indicate that midwifery practice in the north can be effective and beneficial to the health of mothers and babies.

Current debate about the future of midwifery in the north raises questions about appropriate legislation, mechanisms of registration and licensure, educational requirements, and models of training, as well as questions about safety, acceptable levels of risk, and financial costs. Many of the questions remain unanswered in a vacuum of hypothesis, while little effort is being put into the development of concrete midwifery care options.

Aboriginal women are absent or under-represented in the power structures that retain control over maternal health services in the north. The revitalization of midwifery can only be accomplished with the full participation of aboriginal women, within a context of increased self-reliance and local control in health care.

RECOMMENDATIONS

The following recommendations are put forward with a view to increasing the opportunities for aboriginal women to make decisions about midwifery care which are appropriate for themselves, their families, and their communities:

1) Give full support to the efforts of aboriginal women, throughout the north, to preserve and enhance their indigenous midwifery traditions, including the training of aboriginal midwives.

2) Create access to the resources needed by aboriginal women in order to research and explore the potential of midwifery as it relates to their needs and aspirations at the local and regional levels.

3) Support and facilitate communication amongst aboriginal women, and other interested women, throughout the north so that information and ideas concerning midwifery may be freely exchanged. If deemed appropriate by women themselves, support the work of an inter-disciplinary task force mandated to address questions related to the recognition and implementation of midwifery in the north.

4) Ensure the direct involvement of aboriginal women, at local and regional levels, in decision-making with respect to the kind of maternal/infant health care that is appropriate for their communities. Support the developmental efforts of communities and regions which favour the inclusion of midwifery in their health care service.

5) Ensure the direct input of aboriginal women in the development of any legislation, regulatory policies, or standards of practice relating to midwifery in northern jurisdictions.

6) Ensure the direct involvement of aboriginal women in the development and implementation of training programs for midwives in the north.

2.0 METHODOLOGY

Purpose and scope of the research

The stated intent of this paper was to provide the Royal Commission with a thorough and concise discussion of the issues pertaining to midwifery in the north, with particular reference to their significance for aboriginal women.

The scope of the paper encompassed an examination of traditional aboriginal midwifery, the changing experience of childbirth in the north, and the current status and future of midwifery in the north. The geographic scope of the research, in accordance with the requirements of the Commission, included the Yukon, the Northwest Territories, northern Quebec, and Labrador.

In retrospect, the scope of the research was indeed overly ambitious. Given the constraints of time and funds available to complete the work, combined with the militating factors of vast geography, expensive travel and telecommunication in the north, the coincidence of the research period with the summer vacation season, and the fact that the author was working with a nursing baby in one arm, the achievement of the research objectives was difficult, and not wholly successful.

Data collection

A search of the literature was undertaken with assistance from the Otto Schaeffer Health Library in Yellowknife. Medline and ASTIS were searched for references to midwifery and maternal/infant health in the Canadian north and the international circumpolar region. The

bibliographies of several recent reports on midwifery in the north were also reviewed. Publications identified through this search provided much of the data related to traditional midwifery and the changing experience of childbirth in the north.

In addition to published works, a number of unpublished reports and internal documents were acquired from personal contacts within government departments, non-government organizations, healthcare facilities, and research institutions. These documents proved to be valuable sources of data for the discussion of the current and future status of midwifery in the north.

Interviews were conducted with twenty-one individuals, identified by the author as key informants in the discussion of midwifery in the north. These individuals were identified on the basis of their known involvement in either the current provision of maternal health care in the north, or in the discussion and/or promotion of midwifery options in northern communities. The persons interviewed included health care professionals (physicians, nurses, and midwives, and health care administrators), consumer advocates, researchers, employees and elected representatives of women's (and specifically aboriginal women's) groups, and managers and policy makers within government and first nations' organization.

An interview format was developed (see Appendix A) which incorporated several questions related to traditional midwifery, as well as to current issues in midwifery. Seven interviews were conducted in person, in Yellowknife, while the remainder were conducted by telephone. Each interview lasted, on average, fifty minutes. Interviews were not recorded by means of audiotape, but rather notes were made during the interview by the author.

Data Analysis

Data from the interviews was organized thematically, and integrated, along with data from the literature review, into the appropriate areas of discussion. Because of the open-ended nature of the questions, and the diverse backgrounds of the informants which gave rise to differing emphases in their responses, it was not possible to summarize the data quantitatively. Rather, the value of the interview data was recognized in the qualitative contribution which the informants made to an understanding of the complexity of the issues under study.

Terminology

Throughout this report, and in the interview questions, the term "traditional midwife" is employed in favour of "traditional birth attendant", a term commonly used in the literature to describe indigenous women who have no formal midwifery training, but who serve as birth attendants to women in their own social and cultural group. It is the author's experience that aboriginal women in the north themselves employ the term "midwife" when describing, in English, the aboriginal woman who was traditionally recognized as being knowledgeable and skilled in matters related to birth.

3.0 TRADITIONAL EXPERIENCES OF BIRTH AND MIDWIFERY IN THE NORTH

The relatively recent practice of traditional midwifery among the aboriginal peoples of the north is a singular feature which distinguishes the discussion of midwifery in the north from the discussion of midwifery in other parts of Canada. In northern regions, where aboriginal people still constitute the majority of the population and where traditional lifestyles have only recently given over to contemporary or transitional lifestyles, the importance of the traditional midwife to

the survival of the people is still recognized and remembered by many today. Traditional wisdom about the care of pregnant women and the skills of birthing babies is still regarded as a distinct and important body of knowledge which continues to live in the memories of the elders. Thus, the discussion of midwifery in the north, while encompassing all the issues which have received attention in other parts of the country such as the safety, training, regulation, and cost of midwives, also brings into focus important questions regarding cultural renewal and the self-determination of aboriginal women, families, and communities.

3.1 Recollections of Traditional Birthing and Midwifery

Several northern Aboriginal groups are currently researching and documenting traditional experiences of birth and midwifery. Their work will make an invaluable contribution to a full and meaningful understanding of the subject. In the meantime, some general comments may be made about traditional practices, based on research conducted to date by Pauktuutit, the Native Women's Association of the N.W.T., aboriginal groups in the Yukon and Labrador, and several other authored sources.

Among the Inuit, Dene, and other first nations of the north, a rich body of knowledge about the normal process of pregnancy and birth was widely appreciated by a whole community of women (and men) who shared in the experience of childbirth as a family-centred event. The education of young people in this regard often began at the time of puberty, which in some regions was marked by special ceremonies or periods of intense instruction.[1] Young women were taught what to expect during pregnancy, childbirth, and child-rearing, and young men were instructed about the responsibilities of husbands, fathers and providers. While there are, naturally, differences in

the specific beliefs and instructions that were passed on in different regions of the north and among different cultural groups, there are also many remarkable similarities and common themes.

When a young woman became pregnant, she was counselled by her mother and/or other female relatives about the right way to look after herself and her baby during pregnancy. She was expected to take good care of herself, and at the same time, other members of the family accepted some measure of responsibility for ensuring her well-being. The expectant mother was encouraged to eat well, but not to overeat.[2] There were certain foods which were considered especially important to the pregnant woman's diet, and others which she was forbidden to eat, although these varied from region to region and from one cultural group to another.[3]

The pregnant woman was instructed to rise early in the morning, and stay active throughout the day, maintaining her daily routine and doing moderate physical work.[4] To lay around and be lazy was to invite a longer, harder labour. She was also cautioned to observe certain guidelines of behaviour, so as to avoid problems in labour and to ensure a healthy baby. For example, she was not to loiter in doorways or to back up through the entrance of a tent or igloo, lest she have a longer birth or predispose herself to a breech birth.[5]

Pregnancy was often considered a time of heightened sensitivity for the mother, on an emotional and spiritual level, because of the presence of the new spirit/baby growing within her. Respect for the spirituality of the child was of utmost importance. The woman was reminded to think positive thoughts and to try to create for herself a pleasant, harmonious environment. "The baby is a separate spirit, so what you think, what you feel, what you do and what you eat will effect

this new spirit." [6]

The traditional approach to childbirth itself seems to have been characterized by an underlying confidence in the natural process and a sense of personal competence. Birth was not considered a disease process, but rather a normal function of life, and as such, something with which most family members were intimately acquainted.[7] By the time a young woman was ready to give birth to her first baby, she often times had already attended the births of others, and so had learned by observation and by explanation from older, experienced women.[8]

Prior to the mid-1960's, birth among the Inuit usually took place in tents or igloos in the isolated camps of small, nomadic family groups. The Dene and other aboriginal peoples of the north also traditionally experienced childbirth in the context of extended-family life. Before the establishment of settlements, in the days when people spent most of the year on the land travelling in small family groups, birth occurred in camp or on the trail. News of a woman in labour spread quickly, and women who were available to help simply showed up. The birth assistant might be an elder woman with considerable birth experience, a sister or other female relative, or even the husband or another male relative, if necessary. Even in the presence of female helpers, husbands very often took an active role in supporting their wives in labour.[9] It was not uncommon for a woman to birth her baby by herself, either by personal preference or as circumstances in camp or on the trail might dictate.[10]

When people lived in small family groups, the knowledge and skills associated with birthing babies were necessarily shared among many people, and any given individual might have call to

attend only a few births in a lifetime. The practice of "midwifery" as a distinct vocation became more developed in situations where more births were occurring and where there were more experienced women to draw on, such as in larger family camps, and in later years when people began to cluster in and around the small settlements. Traditional midwives were women who were drawn to birth or particularly gifted, and whose experience and capability were recognized and sought out by other women. Often they had learned their skills from older midwives, and would in turn pass on what they knew to a younger apprentice.[11]

No one model of traditional birthing can be described, in the sense of a strictly prescribed set of protocols defining where birth should be, who should be present, or how it should be managed. Traditions and rituals concerning the "correct" way of doing things varied from region to region, or as a function of the unique circumstances of the birth. However, certain common themes emerge. For example, women were generally encouraged to be up and active during their labour, and to seek the positions which felt most comfortable and effective. Most oftn women birthed in an upright position, either standing, kneeling or squatting over a bed of moss or animal skins. They may have hung on to a rope or a stick hanging from the ceiling of their dwelling for support, or they may have been supported from behind by their husband or by female attendants.[12]

In the recollection of the elders, women tended to be in better shape in the old days, and labours were shorter and more efficient than they seem to be today. Usually labour and delivery were normal, and minor complications were handled as they arose by the midwife and attending relatives. Teas prepared from roots or bark might be employed to aid the birth process. Few other interventions were called for in the course of a normal birth. More experienced birth attendants

possessed a repertoire of skills for dealing with more serious deviations from normal. Traditional midwives have reported turning breech babies in utero, manually removing retained placentas, and even performing emergency Cesarean sections.[13] Occasionally, the assistance of a medicine man or shaman might be enlisted to help with a particularly difficult birth.[14] There were, of course, occasions on which a baby or even a mother would die in childbirth, in spite of everyone's best efforts. In the recollection of the elders, and consistent with the traditional world view of the people, these events were accepted as being the way things were meant to be, perhaps reflecting the will of a higher power.[15]

3.2 The Significance of Midwifery in the Traditional Culture of Aboriginal Peoples

At one time, birth was one of several important life cycle events shared intimately by family and community members. Indeed, birth was a strong bonding experience that served to strengthen the ties between generations, and to ensure strong caring relationships between community members that were essential to the survival of the people. Among the Inuit, one form in which these relationships found symbolic expression was in the custom of giving periodic gifts to one's midwife. A boy would give the first of every animal or fish that he killed to the midwife who assisted at his birth, while a girl would give the first of every article she had made. Kinship terms were also employed that signalled the relations between the midwife and the children she had delivered, and between children born with the same midwife.[16]

Participation in the rites of childbirth, regardless of the role which a person played, was a significant, transformative experience that conferred on the participant personal and social rewards. As O'Neil reports, "Managing birth by oneself, or helping other women birth, emerged

as a source of pride for women, a public sign of virtue."[17] One elder from Fort Franklin, N.W.T. expressed the personal rewards of her work, and also the sadness of feeling displaced, this way:

> "Delivering babies, you're doing the work of God, just like looking after the sick or the elderly. It helps you to stay good. But nowadays, they take young pregnant girls off to the hospital, just like the sick elders, and it seems they have no use for us any more."[18]

Elders have suggested that in the days when families gave birth together in the traditional way, the bonds between family members were stronger than they are today. In particular, men seem to have had a different kind of appreciation for their wives, and a closer relationship to their children. Questions have been raised about the relationship between the isolation and alienation which characterize the experience of birth for so many aboriginal families today, and the increase in family violence and dysfunction.

Elders in the Yukon have also identified the importance of returning to traditional values and teachings about pregnancy, birthing, and motherhood as a strategy for addressing the current problems of fetal alcohol syndrome, fetal alcohol effects, child abuse, and child neglect. At a time when the future generations of aboriginal peoples are in serious jeopardy because of these ills, the elders speak with urgency about the need to minimize risk and restore traditional care for the unborn, the newborn, and the young child through a revitalization of traditional knowledge.[19]

Some elders in the Sahtu region of the N.W.T. have expressed grave concern over the contemporary practice of disposing of the placenta or afterbirth in the hospital incinerator, rather

than carefully disposing of it on the land in a ritual manner, as was the custom. The traditional practice, wherein the father carries the placenta out to a chosen spot in the bush and then places it high in a tree, is considered important to the spiritual well-being of the child, and a means by which the child becomes connected in a meaningful way with his or her homeland and guardian spirit. In the opinion of these elders, the abandonment of this practice is a contributing factor in the rising rate of suicide among young people who are essentially lost and without a deep-rooted sense of belonging anywhere.[20]

The body of traditional knowledge about pregnancy, childbirth, midwifery, and parenting, which still resides in the memories of the elders, is seen to be critical to the very survival of the people, both in the physical and cultural sense.

"Loss of wellness comes from loss of identity; when we find out who we are and where we come from, we will know where our children are going."[21] The practice of traditional midwifery represents one tangible expression of the accumulated wisdom and competence of peoples who at one time were self-reliant, being capable of looking after one another in life and death situations in order to ensure their collective survival. In this light, the call for the return of traditional midwives in the communities of the north may be understood as a call for the fundamental re-empowerment of aboriginal women, families, and communities.

4.0 THE CHANGING EXPERIENCE OF CHILDBIRTH IN THE NORTH

In the span of only two or three generations, the experience of childbirth for northern aboriginal women has changed radically. Childbirth has been removed from the life of the smaller communities and from the sphere of the family, and now occurs within a medicalized system of

health care, funded and largely controlled by governments. This change can perhaps be best understood in the context of the overwhelming changes that have aboriginal people have experienced in all areas of their lives since the late 19th and early 20th centuries.

4.1 Transitions from Traditional Life to Life in the Settlements

Early contact between northern aboriginal peoples and outsiders brought with it some changes which were easily integrated into the traditional cultures. Metals, textiles, and tools of European manufacture, along with some of the new staples such as tea, flour, and sugar, were readily incorporated into a lifestyle which remained tied to the seasons and the resources of the land. People maintained their traditional cycles of travel and activity, altered only slightly to include occasional trips to the trading posts at different times of the year.

The very earliest contact, however, also brought with it devastation and a series of changes, the full impact of which could never have been foreseen at the outset. Epidemics of smallpox, influenza, tuberculosis, and other infectious diseases ravaged the aboriginal populations, from the late 18th century up until the 1960's. The flourishing presence of the fur trade, the mining and petroleum industries, and the military at various times in the recent history of the north resulted in aboriginal people being drawn into economic and social relationships which were, to an increasing degree, being shaped by forces outside their control.

By the end of the 1950's, the Canadian government was adopting a position in favour of economic development in the north which would eventually supplant traditional livelihoods with a wage-labour economy for all northerners. The Federal government,and later it's colonial arm,

the Government of the Northwest Territories, undertook the development of permanent settlements, encouraging people to live there year round so that they might avail themselves of universal education and a proliferation of other services such as housing and healthcare. The shift to settlement life altered aboriginal peoples' lifestyles in fundamental ways, requiring them to forge a whole new set of economic and social relationships which were foreign in origin, and which served to subtly undermine many of the traditional values and principles which were the very foundation of aboriginal societies. The self-reliance of the individual and the group gave way in many instances to overwhelming dependence on the government. Where the responsibility for survival had once been shared by all family and community members, caring for each other in an interdependent way, much of that responsibility had now been assumed by the government.

These great economic, social, and cultural changes have required of aboriginal people a tremendous uprooting and readaptation, and have had serious consequences for the physical, mental and emotional health of the people. In settlements characterized by poverty, poor nutrition, inadequate housing and infrastructure, and social and cultural upheaval, people have succumbed to infectious disease, accidental and violent death (often alcohol-related), and suicide at rates much greater than the average Canadian population. Infant mortality rates, especially in the post-neonatal period, have been as high as three and four times the national average.

4.2 Early Health Care to Northern Settlements: from the Missions to the Medical Services Branch

The Anglican and Roman Catholic churches were active during the second half of the 19th century and the early part of the 20th century, establishing missions in the eastern, central, and

western Arctic and sub-Arctic. In the absence of any government aid or services in the north at the time, the missions took it on themselves to provide health care and relief aid to the aboriginal peoples. They were responsible for the construction of some of the earliest hospitals, such as the Catholic hospital in Fort Providence, and the Anglican and Catholic hospitals in Aklavik.

In the 1930's , the Canadian government began funding the missions to provide hospitals, such as the ones in Pangnirtung and Chesterfield Inlet, and to staff them with doctors and nurses. It was not until the mid-1940's that the government itself became involved in the direct provision of health care to the Inuit and other northern aboriginal peoples. The newly formed Indian Health Branch of the Department of Health and Welfare (later the Medical Services Branch) sent medical survey teams north to tackle the problem of tuberculosis among the aboriginal population. At the same time, a plan was developed to create a network of nursing stations across the north, to be staffed by nurses who would undertake public health activities especially directed to maternal-child health and communicable diseases, and provide early treatment of acute conditions. The first of these stations were built in the late 1940's, and numerous others were constructed in the 50's and early 60's.

In the early years of the nursing stations, birth was still taking place in bushcamps or in women's homes in the settlements, attended by traditional midwives. Nurses attended these births by invitation only, as the people felt the need.[22] However, in time, pressure was effectively brought to bear to move birth out of the home and into the nursing station. Nurses had begun to persuade local women to come to the nursing station for their pre-natal care, which included no-cost vitamins and food supplements to needy mothers. Consistent with the public health perspective adopted by the nurses, the cleaner and less crowded environment of the nursing

station was then held out to be the more desirable place of birth. The percentage of births in the Northwest Territories occurring in hospital or nursing station rose sharply, from 38.9 per cent in 1953 to 90.6 per cent in 1968.[23]

In the early years, traditional midwives were often present at births in the nursing stations, and in a setting where little capability for medical intervention existed, birth practices may not have been so very different from those traditional to the aboriginal birth culture.[24] Relative to the current situation in which most expectant mothers are evacuated from their community to birth in a hospital far from their home, the experience of birthing in the nursing station with midwives is a fond recollection for some northern aboriginal (and non-aboriginal) women.[25]

While infant mortality rates have declined appreciably from the mid-1950's on, is it not at all clear that they have declined as a result of the changes in the place of birth or type of birth attendant present. It is more likely that improvements in mortality rates throughout the 1960's and early 70's were due to improved living conditions and nutrition. As O'Neil points out, the 1950's was a period of particular hardship for the Inuit of the Keewatin, moving from nomadic camps to permanent settlements. Poor housing, deteriorating nutrition, and high levels of infectious disease, especially tuberculosis, compounded the problem of periodic famines. These circumstances were unique to this era, and "pre-contact" traditional mortality rates may have been much lower.[26] Dr. Otto Schaeffer, a well-known physician who began his service in the north in 1952, was not entirely convinced of the need to promote nursing station and hospital deliveries because in his experience the number of complications which arose in hunting camp deliveries, handled by traditional midwives, seemed to be no higher than in the births handled by

the nurses.[27]

Nevertheless, for a period of approximately fifteen years, nurse-midwives were the backbone of the government's health service to childbearing women in the north. Their skill and experience has been credited with the maintenance of "acceptable" perinatal mortality rates in a high-risk population under conditions of isolation.[28]

4.3 The Shift to Hospital Birth: the Policy of Obstetric Evacuation

When nursing station births were still considered the norm, the decision to send selected women out to birth in a hospital was based on a relatively informal assessment of the likelihood that complications might develop. It was established policy that women having their first baby or their fifth or subsequent baby had to leave the community to birth in a hospital. Women experiencing complications in their pregnancies, or who were anticipated to have complications at birth, were also sent out.

While the criteria for evacuation were not officially changed throughout the 1970's, a gradual and steady decline in the number of nursing station births occurred during this period.[29] It is clear that the shift towards evacuating all pregnant women to hospital was not based on epidemiological evidence, as only limited efforts had been made to analyse perinatal mortality and morbidity before the introduction of this policy.[30] Rather, the shift in policy appears to have been based on the belief of government policy makers in the inherent superior safety of hospital births.[31] In a country where midwifery received virtually no official support at the time, the system of nurse-midwifery created in the north was tolerated only as long as the obstacles of

isolation, poor communications, and difficult transportation persisted. But as improved transporation and communication technology eventually overcame at least some of these obstacles, and as developments in obstetric technology increased the apparent gap between the nursing station and the hospital ward[32], pressure from the medical profession mounted and government policy makers were quick to conform. As O'Neil and Kaufert suggest,

> "Seen in it's historical context, the demise of the Northern midwife is part of a much older competition for control over childbirth between the medical profession, on the one hand, and women and midwives, on the other hand."[33]

Additional factors have been cited in the decline in community births. Changes in Canadian immigration laws made it more difficult to hire foreign trained nurse midwives during the 1970's. The Canadian nurses hired to replace the foreign nurses usually did not have any midwifery training. Consequently, the nurses being sent in to staff the stations, many of whom were very young and inexperienced, were ill-prepared to handle births. An Irish midwife, formerly working in Labrador, recalls that as the policy of evacuation became more pronounced, even the experienced nurses became more nervous about doing low-risk deliveries, even when their results were excellent. An atmosphere of crisis began to develop around birth. As Mason observes, the reduction in births at the nursing stations also resulted in a real decline in the competence of the nurse, since they now had very few opportunities to deliver babies. In this sense, then, the policy of regarding birth as too dangerous to be handled by midwives outside hospital became a self-fulfilling prophecy. [34]

Mason further notes that Canadian nurses were also less willing than the foreign midwives had been to be on call twenty-four hours a day and to work the extra hours required of them when

there was a maternity patient at the station.[35] Strike action by northern nurses in 1978 resulted in overtime pay beyond a normal eight hour shift. The result was an increase in the costs of nursing services, especially in the face of growing demands for treatment services and health promotion activities. Recruiting problems and a general shortage of nurses made it was difficult to hire more nurses, in an attempt to reduce overtime costs and to alleviate the stress placed on nurses who were expected to work all day and be on call all night. Even if enough nurses could be recruited to meet demands, many nursing stations were not large enough to accommodate these additional staff, and some health centres were not able to accommodate inpatients (including maternity patients) without restricting space to carry out treatment services.[36]

4.4 Obstetric Evacuation and its Impact on Aboriginal women, Families, and Communities

While it is not possible to pinpoint an exact date when obstetric evacuation became the policy of choice, by the early 1980's birth in the nursing station had become the exception rather than the rule. Similarly, while reference is often made to the "official policy" in the Northwest Territories of evacuating all pregnant women at 37 or 38 weeks gestation to a hospital for delivery, the territorial Department of Health is quick to clarify that there is no such strict policy per se. Rather, the Nursing Services Division has developed a policy, adopted with few modifications by most of the regional health boards, which establishes guidelines for elective low-risk births in the community health centres.[37] The guidelines are such that few occasions could ever arise when the circumstances would be favourable for an elective birth in the community. The first problem is in the requirement that a certified nurse-midwife be on site. As discussed above, few nursing stations in the N.W.T. are any longer staffed by certified nurse-midwives. Even in the presence of

a certified nurse-midwife, the experience and comfort level of the practitioner is a major consideration. Secondly, the practice is not supported in one-nurse stations or in any under-staffed stations. The combined effect of these first few guidelines is that birthing is ruled out in almost all nursing stations in the north. Even when staffing guidelines are met, other policy considerations, such as the distance of the community from the nearest hospital, the accessibility to medical evacuation transportation, and weather conditions, in most cases work against the decision to plan a delivery in the community. Thus, in practice, almost all women are electively evacuated at 37 - 38 weeks gestation to hospitals in Yellowknife, Inuvik, Churchill and Iqualuit, or tertiary care centres in Edmonton, Winnipeg, and Montreal.

A similar practice is in effect in the Yukon, where women are referred in the final weeks of their pregnancy to give birth in the hospital in either Whitehorse or Watson Lake. In Labrador, the present policy of the Grenfell Regional Health Services is that all pregnant women are sent out to Happy Valley/Goose Bay or St. Anthony for delivery at 37 -38 weeks, or earlier if there are complications.[38] In the Ungava Bay and Hudson Bay regions of northern Quebec, women are similarly referred from the villages, at 36-37 weeks gestation, to deliver in the hospitals in Kuujjuaq and Povungnituk.

The Keewatin region is notable as an area where extensive, systematic research into the experience of childbirth and the impact of obstetric evacuation has been carried out over a period of several years. Personnel from the Northern Health Research Unit at the University of Manitoba have collaborated with the Keewatin Regional Health Board in carrying out a major research project funded by the Health and Welfare Canada (NHRDP).[39] Women and men in Rankin Inlet, a Keewatin community, have also been surveyed by the GNWT Department of

Health as part of an effort to determine the feasibility of establishing a birthing centre in the community. Many of the comments of these mothers and fathers, reflecting on the disruptive impact of childbirth on their lives today, are particulary poignant.[40]

While it cannot be assumed that the experience of women in the Keewatin, as described in the findings of these studies, represent the experience of aboriginal women in all areas of the north, much of what is reported in the Keewatin has been echoed at one time or another by women from Labrador clear across to the Yukon. Key informants interviewed in the preparation of this report, when asked whether or not they thought women were satisfied with the services they are currently receiving, were able to identify the practice of obstetric evacuation as a major cause of dissatisfaction for aboriginal women. It is an issue which has been discussed repeatedly at regional and territorial meetings of aboriginal people, and has been raised on several occasions in the Legislative Assembly of the Northwest Territories. It has also received widespread media attention, both in the north and in southern Canada. Finally, it is a theme which surfaces repeatedly in the literature about childbirth and obstetrics in the north.

The combination of elective evacuation at 37 - 38 weeks, the fact that estimated due dates are not always accurate and that babies can easily be born a week or more 'late' anyway, the post-partum stay, and transportation time, all add up to a stay away from home that averages three weeks or more, and can in some instances be as long as two months. The normal stresses of childbirth are compounded by the stresses associated with being way from home and family. The impact is felt by the woman herself, her family, and indeed the entire community.

Separation from home and family for an extended period of time creates feelings of loneliness,

isolation, and anxiety in women who must go out to have their babies. Forced to live the final weeks of their pregnancy in medical boarding homes or hotel rooms, women are separated from their immediate and extended family members at a time when they most need their support. They may have little opportunity, if any, to converse with anyone in their mother tongue. Their nutrition may suffer in the important final weeks of gestation because of changes in diet, which sometimes include a sudden departure from country foods, and changes in appetite associated with stress. Some women may be tempted by the availability of alcohol and other harmful substances, especially in association with feelings of loneliness and anxiety.[41]

Most husbands cannot afford to make the trip themselves, let alone to bring the entire family with them. Not only do mothers miss their families, which often include other small children, they also worry about how the family is managing in their absence. More stress is placed on fathers, many of whom are not accustomed to the role of being primary caretaker of the children, especially in communities where men's and women's roles are traditionally quite distinct. The husband's traditional activity of hunting to provide for his family may be necessarily curtailed, or his job security threatened, because of problems in finding suitable childcare. The extended family may come to the aid of the husband in his wife's absence, but care of the children in the extended family can be more formal, less intimate, and less attentive.[42]

Members of the family left behind may develop health and social problems, such as illness and behavioural problems among children, or drinking and other forms of inappropriate behaviour on the part of fathers or teenagers. Stresses and strains on relationships between family members, created during the mother's absence, are often exacerbated when she returns home with a new baby. The alienation of other family members, especially fathers, from the experience of the birth

itself is seen as contributing to significant and lasting rifts within families, and to the increase in family violence.[43]

Economic hardships are also experienced by women and their families in the period surrounding the birth. Long distance telephone calls to and from the evacuated mother, and the cost of hiring babysitters so that the husband can continue to work or pursue traditional activities on the land figure prominently in the additional expenses which accumulate in the mother's absence. Other expenses which have been noted include those of buying more easily prepared foods not normally purchased when the mother is at home, along with money spent by the mother on entertainment during a long, boring wait at the referral centre.[44] Enormous costs are incurred, should the family try to reunite in the referral centre at the time of the birth.

Community concerns about the policy obstetric evacuation have frequently been expressed in relation to the loss of traditional cultural knowledge and skills about childbirth. Associated with this is the loss of a particular set of relationships, developed during the birthing process, which traditionally bound together people of different generations in a meaningful and lasting way. Also seen to be at stake is the very self-esteem and identity of aboriginal women themselves, as the medicalization of birth erodes one of women's very significant roles.

> "It's demeaning to a woman to take her rights away, in a sense of killing one of the reasons for living, for her purpose was to help with birthing, and birthing was a part of woman's responsibility and when you take responsibility away from a person, she becomes a worthless person."[45]

Furthermore, the practice of obstetric evacuation to southern centres touches on questions of identity and birthright. In that many Inuit babies are born outside of the Northwest Territories,

fears have surfaced that children with Manitoba birth certificates might not be entitled to the full benefits of a land claims settlement. More deep-rooted than this, however, is a concern that children born away from their ancestral homeland lose their true identity as Inuit, because the place of birth is so significant in the peoples' cultural definition of who they are.

> "I was born in the Northwest Territories from my mother, there were no doctors. I was born...here in Rankin Inlet, born ten miles that way, in that little island...People ask me where I was born, my home town, Northwest Territories. Now for my own big boys, some people ask where were you born? Manitoba, Ontario. You know, outside. Oh, you are white man, you was born in Manitoba, you not Inuit, that's what they say now...
>
> Like most of all the children from 1959 till now, none of them was born in Rankin Inlet. They all white people now, they were born in Manitoba, they were born in Ontario. There's no more Inuit from 1959 till now."[46]

From a health care perspective, some critics have suggested that the policy of obstetric evacuation has resulted in the fragmentation of maternal health services, and a serious lack of continuity of care in the childbearing cycle, which leads to negative impacts on maternal and infant health.[47]

A different, but somewhat related concern centres around the fact that while very few, if any, nursing stations are the site of regular elective deliveries, nevertheless a small percentage of women (approximately 7 - 10 %) continue to give birth in their communities. These may be women who have gone into premature labour (and intra-partum evacuation is not possible), or they may be women who have deliberately fudged the date of their last menstrual period, concealed their pregnancy, or gone into hiding when the plane came to take them out.[48] These women simply present themselves at the nursing station in labour. Women who deliberately refuse to go out for delivery are made to sign a waiver, relieving the health board and health workers of responsibility. The waiver basically states that the mother is refusing medical

treatment. In fact, she is not refusing medical care, she is merely choosing where she wishes to receive that care. By signing a refusal of medical treatment, the mother is in essence classified as a non-compliant and awkward patient. At the same time, the health worker who is required to ask the mother to sign a waiver may be perceived as unwilling to look after the woman in labour. Thus, the unfortunate potential is created for undercurrents of mistrust and antagonism at the time when the woman shows up in labour.[49]

In any case, the births which now occur from time to time in the nursing stations tend to be characterized by a greater element of risk (e.g. premature labour, women who have received little or no prenatal care) than the planned, low-risk deliveries which used to occur regularly in the communities. The nurses must attend to these births as best they can, given their typical lack of training and experience with even normal birth. The common practice of elective evacuation means that the recruitment of nurses with midwifery training, while still regarded favourably, is not a priority anymore. Consequently, all pregnant women in the community stand a much lesser chance of benefiting from these skilled personnel during the pre -natal and post-natal period, and the small percentage that will deliver in the nursing stations anyway are at increased risk. Thus, as Stevenson has suggested, the policy of elective evacuation, which ostensibly supports safer birthing for aboriginal women living in isolated communities, may in fact put these women at greater risk.[50]

4.5 Aboriginal Women's Experience of Birth Today

Very little systematic research has been done to determine how aboriginal women right across the north feel about their birthing experiences and their preferences in birth. Having said that,

some general comments may be made, based on the bits and pieces of data that have emerged in different regions from time to time.

It seems quite clear that the experience of childbirth, which at one time united different generations of aboriginal women in a cyclical ceremony of life renewal, has now become one more stark example of the gulf across which the older and younger generations struggle to communicate. Due to the medicalization of childbirth and the overwhelming emphasis on hospital deliveries, most young women today are largely ignorant of the traditional knowledge which their grandmothers have about female health and childbearing, and can hardly imagine what it must have been like to give birth at home, in a squatting position, surrounded and supported by their husbands and female relatives. Similarly, the elders are baffled and disturbed when they contemplate their granddaughters giving birth alone in hospital, lying on their backs with their feet in stirrups, deprived of the support of their husbands and other family members.[51] Indeed, the experience of childbirth in the hospital today is so different from the traditional experience of birth at home that elders are ill-equipped to provide counsel and support to young women, as they have little idea themselves what goes on behind hospital doors.

The elders' fears that drugs have taken the place of personalized attention as a means for helping women cope with the intense sensations of labour are confirmed by the data. Two-thirds of Indian and Inuit women receive analgesia at least once during their labour and delivery.[52] Research elsewhere has confirmed a positive relationship between the presence of supportive persons, during labour and delivery, and a diminished experience of pain and use of medication by labouring women.[53] The comments of women from the Keewatin who have experienced

birth far from their homes and supportive family members are revealing:

> "I was alone with the nurse in the room and I found it kind of scary and difficult. Like the pains - I didn't have anyone to hold onto to make me feel a little better."[54]

> "You're hooked up to all these machines, you're scared, especially when it's a first time baby. It's a traumatic experience... I personally would rather be where I have a few of my family, close friends to hold my hand and feel sympathy for me to just being hooked up to a machine.
>
> After you have babies in the home and you suddenly have to go out to the hospital you notice a lot of differences mentally and physically."[55]

The traditional approach of allowing labour to occur at its own time and at its' own pace stands in contrast to medical management that often seeks to artificially hasten or delay birth. Bouchard reports on the experience of Inuit women birthing at a hospital in the Ungava Bay region during a four year period. Twelve per cent received an oxytocin for induction and stimulation of labour, forty per cent had their membranes ruptured artificially, and eighty-five per cent of first time mothers had an episiotomy.[56]

O'Neil and Kaufert report the feelings among Inuit women that hospitalization has taken from them a sense of their own competence to deal with the experience of childbirth. Davis-Putt goes further to suggest that forced evacuation to unknown surroundings with unfamiliar practitioners wielding unknown, invasive instruments may give rise to a feeling of violation and subsequent denial of the experience.[57] "Numbed" is the word which one consumer advocate uses to describe her sense of aboriginal women's feelings about their birth experiences today.[58]

Dissatisfaction with the practice of evacuating all women to hospital for delivery has provided a

focal point for discussion of aboriginal women's birth preferences, and possible alternatives to the current state of affairs. Native representatives from Labrador to the Yukon have called for a return to birthing in the communities, and a return to midwifery as integral component in any strategy to provide full maternity care once again in their regions.

Inuit women in the Keewatin Region of the N.W.T. have been particularly vocal in stating their preferences. They have also been the subject of more systematic research on this question than any other group of northern aboriginal women. In a study of their childbirth experiences and preferences, eighty-two per cent of Keewatin women, interviewed shortly after delivering their babies, indicated a preference for childbirth in a Keewatin community. Some of these women expressed interest in the option of a birthing centre in Rankin Inlet, while others still preferred to give birth in their own home settlement. A minority of women overall in the region favoured going south to Churchill or Winnipeg to deliver.[59]

Of the nineteen recently delivered women interviewed in Rankin Inlet as part of a study of the feasibility of establishing a birthing centre in that community, fourteen indicated their preference for having the next baby in Rankin Inlet. The other five preferred to go out to Yellowknife or Winnipeg, even though three of them were classified as "low risk". Smith notes that some of the mothers were more willing to accept the medical model than others. "Indeed some perceived pregnancy and childbirth with a very medicalized view and felt that they needed to go out for specialized medical care, just in case something went wrong. Some of the mothers had been encouraged to view their pregnancies as potentially problematic, despite the fact that they had not experienced problems previously and that they were medically classified as "low risk".[60]

Thus, it is apparent that aboriginal women's preferences with respect to the place of birth, while tending overall to favour birthing closer to home, also reflect important regional, community, and individual differences which must not be overlooked or minimized. Preferences with respect to caregivers and birth attendants have not been the subject of systematic population-based research, although frequent mention of an interest in the revitalization of midwifery has been made in public forums and in individual interviews.

Key informants interviewed for this report, including health care practitioners and representatives of government health agencies, acknowledged that little effort has been made to invite aboriginal women to evaluate or even comment on their experience as consumers of maternal health services in the communities and in hospitals. Apart from the widespread concern about the impact of obstetric evacuation on women and their families, few specific complaints have been received by health care providers.[61] The fact that women in the communities make good use of the prenatal services offered is taken as a sign that women are, on the whole, quite satisfied with this aspect of maternity care.[62] Yet, as one respondent commented, the way in which feedback is invited (or in many cases not invited) may combine with cultural edicts about not complaining or confronting persons in authority, to result in a situation where aboriginal women feel less than comfortable making known their feelings and preferences about birth.[63]

Clearly, this is an area which requires a great deal more attention, and invites further research by aboriginal women themselves, if maternal health services in the north are ever to truly reflect the needs and aspirations of the women who use them.

5.0 CURRENT ISSUES AND FUTURE DIRECTIONS FOR MIDWIFERY IN THE NORTH

Midwifery in the north is a subject which has commanded considerable media attention in recent years, even in major southern Canadian newspapers. In actuality, there are very few places in the north today where midwifery is being practised with any regularity. But it is, perhaps, the great cultural significance which still attaches to midwifery for many aboriginal people, coupled with the persistent dissatisfaction experienced by many women who must leave their homes and families in order to give birth in distant hospitals, which causes the issue of midwifery to resurface periodically on the agendas of aboriginal women's groups and politicians alike.

5.1 Traditional Aboriginal Midwifery in the North Today

In the early days of the government nursing stations, traditional midwives were still attending births in women's homes, and then later were invited to assist in deliveries at the nursing stations by nurses who welcomed the experience and expertise of the aboriginal women. But as several Inuit midwives recall, even this role was eventually abrogated:

> "Even when we settled in Pangnirtung from the land, I assisted in deliveries. It's only now that the women go out of their settlement to have their babies because of changes in the government and doctors and we have lost the opportunity to act as midwives....
>
> I have always known that Inuit women have been delivering babies for years and they have the knowledge and experience in delivering. I have also asked medical people why they are sending women to have their babies outside and the responses I got were that the Inuit midwives are not recognized as midwives, and we do not have certificates or diplomas to prove it.....
>
> Back in 1963, we were not included anymore in the delivery of babies and have not been involved in assisting deliveries. This is not good for the people who have been involved before and have had their experience taken away."[64]

In a health care system where only doctors and nurses are recognized as legitimate caregivers, aboriginal midwives have been almost entirely displaced, to the point where there are scarcely any traditional midwives practising at all today in the north. A notable exception has been reported in the Baffin community of Pond Inlet where traditional Inuit midwives are attending births in women's homes from time to time. Little, if any, information about these midwives (their experience, training, number of births attended, outcomes) is on the record. The constraints of time, distance, and language combined to make it very difficult for the researcher to gather more than superficial data about their practice. Even the researcher for Pauktuutit, who had conducted interviews with traditional Inuit midwives across the north, had not had direct contact with these women.[65] According to the MLA for the area, there are five women serving as birth attendants, whose ages and experiences with birth are apparently quite varied. All are unilingual and are unlikely to have received any formal training in midwifery. Rather, their knowledge and skills have been acquired in the traditional manner from elders and midwives before them.[66]

Four of the respondents in this study were aware that traditional midwives were active in Pond Inlet, although none of them had very many details about their practice.[67] Two of the respondents mentioned some concern that these midwives were operating entirely apart from the nursing station, and that the only time there had been contact was when problems had arisen, such as post-partum hemorrhage requiring medical attention. Interestingly, the nurse in charge at the community health centre in Pond Inlet was not aware that any such major problems had arisen, either before or during her term of employment. While she acknowledged that on no occasion had the traditional midwives and the nurses ever really sat down together to talk about

birthing in the community, she mentioned that the midwives do notify the nurse when a woman was in labour, and the nursing station in turn provides some basic supplies for the birth.[68] She said that she could envision a role for these traditional midwives in assisting women who do, from time to time, deliver in the nursing station, but that current policies do not provide for any such involvement. And as long as obstetric evacuation remains the general practice, there will be few births in the nursing station anyway.

While most of the remaining traditional midwives in the north are no longer practising, their collective experience and expertise continue to command respect and consideration, particularly among aboriginal people. Most of the key informants interviewed in the preparation of this report expressed the view that traditional midwives and other knowledgeable elders should be encouraged to participate in a collaborative way in the provision of maternal health services in their communities. Their activity might include counselling young women in the prenatal period, providing labour support at the time of birth, and providing education and support in the post-partum period. They might also play a vital role in ensuring that traditional knowledge and skills are incorporated into the training of younger aboriginal midwives.

At the Innulitsivik Maternity in Povungnituk, Quebec, efforts have been made to restore legitimacy to the role of elders who still have traditional knowledge about pregnancy and birth. Traditional midwives and other elders in the community provide consultation and input into a unique program of comprehensive perinatal care delivered by a team of trained aboriginal and non-aboriginal midwives. A similar consultative role for traditional midwives is envisaged in the design of the community birthing pilot project which began operating in Rankin Inlet in 1993. These examples, however, stand out in stark contrast to the rest of the maternal health care

services in the north which have yet to acknowledge a role for traditional midwives.

In the meantime, aboriginal women have taken the lead in initiating research designed to document traditional knowledge about birthing and midwifery. Many of the well-remembered traditional midwives have already died over the years, and with them has been lost a great deal of knowledge and skill. As the remaining midwives become increasingly advanced in age, the need to document what they know while they are still able to share it has taken on a new urgency. To varying degrees Pauktuutit (the Inuit Women's Association), the Native Women's Association of the N.W.T, and aboriginal groups in the Yukon have all reponded to that need.

Pauktuutit, has been vocal for a number of years about the importance of traditional midwifery. At its second Annual General Meeting in 1986, the need to teach midwifery skills to the younger generation was identified by delegates. The following year, delegates to the AGM again expressed concern that the knowledge of Inuit women with respect to delivering babies is not being passed on to younger women and "this is yet another aspect of Inuit culture that could die with the elders".[69]

Pauktuutit has since undertaken two projects that are seen to be important steps in a process to revitalize traditional midwifery and to develop viable alternatives in birthing for contemporary Inuit women. The first, a video production entitled Ikajurti (the Helper) discusses traditional Inuit birth practices, the current experience of Inuit women who must leave their home communities to birth in hospital, and the aspirations and experience of Inuit women currently engaged in creating community-based alternatives in childbirth. The video has been widely viewed and well received in the north, both on public broadcast media, and in the context of

numerous public education and discussion groups.

The second initiative, a major research project undertaken with a grant from the National Health Research and Development Program of Health and Welfare Canada, documents traditional Inuit practices related to pregnancy and childbirth as recalled by the elders. Interviews have been conducted with Inuit midwives and elders in ten communities throughout the various regions of the N.W.T. and northern Quebec. Currently undergoing translation into English, the interviews will soon be published by Pauktuutit in the form of a book, in both Inuktitut and English.[70]

The Native Women's Association of the N.W.T., in 1987, initiated a research project designed to document both the traditional and contemporary childbearing experience of the Dene of the western N.W.T.. In the first phase, interviews were conducted with a number of elders, among them several traditional midwives, in two Dene communities in the Mackenzie Valley. The findings of this research have been reported and published.[71] Funding was sought from the NHRDP (Health and Welfare Canada) to carry out the second phase of project, designed to document more fully the traditional midwifery knowledge of the Dene and to encourage dialogue about the experience of childbirth among women of different generations. But competing priorities, coupled with management problems within the organization in subsequent years resulted in the project being put aside, and to date no further work has been done.

In the Yukon, aboriginal people have recently voiced their interest in documenting and revitalizing the traditions of their people with respect to childbirth and parenting. In April 1993, the Skookum Jim Friendship Centre in Whitehorse hosted a series of workshops on the Rediscovery of Traditional Motherhood. Elders from the Teslin Tlingit and Southern Tutchone

nations provided teachings and guidance related to puberty training, pregnancy, spirituality of the mother and baby, preparation for labour and birth, and care of the mother and young child. An evaluation of the process led to recommendations that traditional teachings on motherhood should continue and should target teens, expectant mothers, couples, and men. It was stressed that these traditional teachings should be documented, by first nations people themselves, in the form of booklets, cassettes, videos, and pamphlets. It was further recommended that the idea of traditional midwifery be revisited :

> "People from the communities have to come to Whitehorse to have their babies, that's no good. They are away from their families and their husbands. We should go back to having babies at home: our grandmothers did this."72

The Council of Yukon Indians (CYI), in response to a request from the Yukon Indian Women's Association, also included the topic of traditional birthing in discussions which took place at an elder's gathering in Klukshu in July 1993. Part of a traditional knowledge documentation project, the elders' gathering was videotaped and audiotaped, and the information generated will become part of the curriculum development project of the CYI . In discussions about childbirth, the elders called for a return to birthing in the communities, and a revitalization of traditional midwifery. They also spoke of the importance of reviving the customs and teachings that traditionally accompanied young people's transition through puberty.[73]

Aboriginal women in Labrador have also expressed interest in preserving their midwifery traditions. In 1990, several Innu and Inuit traditional midwives took part in a three day workshop devoted to childbirth issues in Labrador. Their input prompted delegates to call for further documentation of traditional knowledge, and the enhancement of traditional skills. To date, however, no further work has been done on this in Labrador.[74]

5.2 Future Directions for Aboriginal Midwifery

Aboriginal women in the north are working on many difficult issues such as employment, education and training, childcare, addictions, family violence, and sexual abuse. It is not surprising, then, that the issue of midwifery is not always found at the top of the list of competing priorities. However, when aboriginal women do speak of childbirth, they do not speak of something reduced to a mere physical and medical event. They speak of a powerful transformative event in their personal lives, and in the lives of their families and communities. When they talk about midwifery, they speak passionately about something that touches on the very essence of who they are. As aboriginal women struggle to emerge from the historic domination of colonial powers, and the institutions allied to them, the goal of revitalizing indigenous midwifery traditions encompasses such themes as the empowerment of women, the healing of families and communities, the preservation of culture and identity, and the restoration of greater self-reliance. The determination of aboriginal women to reclaim their birthrights represents an ideological shift away from seeing the health of mothers and babies as a commodity over which outside powers claim control, and a return to the view that the health of mothers and babies flows directly from the strength and health of the people themselves.

The following comments of aboriginal women themselves speak most eloquently to these issues:

> "We are encouraging pregnant women to be able to decide. Every woman has the right to deliver where they wish and too many women don't know that they have that right. We are too easily persuaded to go to another place for delivery. We are starting to understand this more. We are in total support for women sticking to their rights."[75]

> "We're going to continue to push in order to have midwives deliver babies in their communities, because they had practised it and done it before the doctors started coming

into the North, and they had done it with pride and they've done it successfully in the past, and they'll continue to fight for what they think should be given to them. [76]

5.3 Non-traditional Models of Midwifery Practice in the North

Up until 1994, Fort Simpson was one of the few communities in the Northwest Territories where low-risk births still took place quite frequently with the aid of a nurse-midwife. The Fort Simpson Hospital, a 14 bed unit with a sizeable staff of nurses and other providers of direct patient care, had been able to offer women this birthing option over the years because it had managed to retain an experienced certified nurse-midwife who was comfortable attending deliveries in the community; because it had the staffing levels and the facilities to accommodate labouring and post-partum women; and because it was within reasonable distance of a referral centre (Yellowknife). Thus, the guidelines for elective deliveries in the communities, developed by the Nursing Services Division of the Department of Health, and adopted by the Mackenzie Regional Health Board, were satisfied.

The nurse-midwife at the Fort Simpson hospital had been practising there since 1977, a time when the active presence of nurse-midwives in the communities was the norm rather than the exception. Over the years, she had demonstrated her competence and her comfort level in attending births, and consequently many women in the community preferred to stay in Fort Simpson, rather than go to Stanton Yellowknife Hospital to deliver. From 1989 to 1991, only 47% of the births to Fort Simpson area women occurred in the Yellowknife Hospital. This number included most, though not all, first-time mothers as well as any pregnancy assessed to be at high risk for complications.[77]

When the midwife in question retired in 1994, another nurse-midwife was hired in Fort Simpson. She, however, did not feel comfortable conducting deliveries in the community, and consequently almost all Fort Simpson area women now travel to Yellowknife to deliver. Acccording to the Nursing Services Director for the region, there has been no evidence that the people of Fort Simpson see community birthing as a priority issue.[78]

In the case of the Grenfell Regional Health Services in Labrador, nurse-midwives (mostly British-trained) are still actively recruited to staff the maternity units in the two hospitals in Saint Anthony and Goose Bay. In a system that resembles a European hospital-based midwifery service, the midwives provide most of the primary care to birthing women. The services of physicians, including a consultant obstetrician, are available in the event that obstetrical complications should arise.

Most of the nursing stations in Labrador are also staffed by foreign trained nurse/midwives. However, the current policy of elective evacuation of all pregnant women in the final weeks of their pregnancy results in few, if any, elective low-risk deliveries in the communities. The presence of midwives in Labrador, while perhaps affording aboriginal women certain benefits associated with midwifery care as opposed to highly medicalized physician care, does nothing to address the concerns of women who must leave their families and communities to give birth far from home. It has been suggested that the skills of the midwives in the communities are not being optimally utilized at present and that a return to a policy of selective evacuation, or at least a more flexible policy of evacuation, might be preferable, provided there is community support for the move and women are aware of and accept the associated risks.[79] Aboriginal women in

Labrador have also voiced their interest in having regional birthing centres, staffed by nurse-midwives and Inuit midwives, as an alternative to hospital deliveries.[80]

Any discussion of northern birthing centers invariably leads to references to the Innulitisivik Maternity in Povungnituk, Quebec and the Birthing Centre Pilot Project in Rankin Inlet, N.W.T., the only two such establishments in northern Canada. Comparisons between the two reveal more differences, in fact, than similarities.

The Rankin Inlet Birthing Centre is a pilot project whose mandate is strictly experimental. Conceived in response to years of vocal support in the Keewatin region for a return to a community birthing, and a great deal of lobbying on the part of the Keewatin Inuit Association and the MLA for Rankin Inlet, the project was announced by the N.W.T. Minister of Health in 1990. Under the direction of a steering group/ perinatal committee made up of representatives from the Department of Health and the Keewatin Regional Health Board, the project was originally slated to operate for two years, starting in September 1992. However, a series of delays at the outset resulted in the project starting only in the fall of 1993. Wholly dependent on special funds from the Department of Health, the pilot project has been granted an extension until March 31, 1996. Serving only the women of Rankin Inlet proper rather than the region, it is an add-on service to the routine practice of obstetric evacuation to Churchill and Winnipeg; during the pilot project period, women whose pregnancies are assessed as low-risk will have the option to stay in Rankin Inlet to give birth, or to go south as before.

The Innulitsivik Maternity was created when the health board in Povungnituk, in response to a proposal from the local Native Women's Assocation and a supportive physician, decided to

utilize its regular operating budget differently in order to provide more appropriate services to the population. From the outset in 1986, the Maternity was conceived as a fundamentally new maternity service, not only for Povungnituk but for the whole of the Hudson Bay region, designed to replace the old system of obstetric evacuation to Moose Factory and Montreal. Decision-making with regard to the development and operation of the Maternity has always rested with the local health board, rather than with provincial health agencies. Consequently, the locus of control in the case of the Maternity resides much closer to the childbearing women of the community than it does in the case of the Rankin Inlet pilot project.

The Maternity in Povungnituk is a four bed unit, annexed to the twenty-one bed Innulitsivik Hospital. The hospital has a blood bank and a laboratory, but no surgery, general anaesthesia, or ultrasound. Although housed in the same building as the hospital, the Maternity is considered a separate place for healthy people.

The Maternity is staffed by three midwives, three midwives in training, and four maternity workers who work together to provide a full spectrum of prenatal, intra-partum and post-partum care.

All basic care is provided by Inuit women under the supervision of the midwives, and the working language of the maternity is Inuktitut. The training of aboriginal midwives has been an integral component of the program since its inception. Initially, the three senior midwives were all Qalunaak, that is non-aboriginal. However, one or two of the Inuit midwives who began their training in 1986 are now fully competent midwives. Traditional midwives and other elders in the community provide consultation to the midwives in training, as well as participate in prenatal counselling and education of expectant mothers. They also provide labour support at the time of

birth, especially to women having their first baby.

In Povungnituk, a conscious decision was made to employ competent midwives, without regard to their status as nurses. At the outset, in the absence of midwifery legislation in the province of Quebec, this meant that the midwives practiced solely under the authority and regulation of the local hospital board, the governing professional body of the hospital, and the Makivik Regional Government.The hospital assumed liability for the actions of its' professional staff. Since the recent introduction of Midwifery Pilot Project legislation in Quebec, the service at Povungnituk has been accorded "Pilot Project" status under the law. This designation is ironic, as the people of Povungnituk took the initiative in creating the Maternity several years before the province was prepared to introduce any legislation, and have never regarded their program as a pilot project at all.

The situation in Rankin Inlet is quite different. The Pilot Project Co-ordinator, herself a nurse-midwife, supervises two other nurse-midwives who provide primary care to women during their pregnancy, labour and delivery, and post-partum period. The Department of Health has made it very clear that the nurse-midwives will be practising under the Nursing Professions Act, and "will be performing advanced nursing skills, as outlined in the Department's Nursing Practise Guidelines".[81] An aboriginal woman is also employed as a Maternity Worker, and her role has evolved thus far to include considerable counselling activities with women who are dealing with personal and social issues.[82] According to staff in the Nursing Services Division, traditional midwives in the community have expressed their interest in and support for the project, but apparently prefer to serve in an advisory role to the perinatal committee and to the maternity worker, rather than being involved in the direct provision of care.[83] It is anticipated

that the documentation of local traditional knowledge about pregnancy and birth will result from their involvement in the project. One thing is certain, however, that the training of aboriginal midwives is not one of the objectives of the pilot project.[84] Thus, in Rankin Inlet the perception may be reinforced that knowledge and skills about birthing remain the prerogative of health professionals from the outside, whereas in Povungnituk the sharing of knowledge and skills, and the enhancement of local competencies, is fundamental to the process.

An evaluation of the Rankin Inlet pilot project experience is deemed to be an important aspect of the endeavour, and according to the Minister of Health, will provide the basis for future action with respect to the government's recognition of midwifery in the N.W.T..[85] The criteria on which the evaluation will be based have at last been finalized, and an external evaluator has been identified. Funding for the evaluation is expected to be approved early in 1995, and the target date for the commencement of the evaluation is April 1, 1995.

A formal evaluation of the Innulitisivik Maternity has been completed and published by Projet Nord, the Quebec regional health authority.[86] In general, satisfaction with the Maternity has been expressed by both the population and the professionals involved.
Some women from the villages along the Hudson Bay coast who must come into Povungnituk in the final weeks of their pregnancies don't like the fact that they still have to travel away from home to have their babies. But at least they are coming into an environment that is consistent with their language and culture, and where they may have kinship ties.[87] (The local airline company, which is Inuit owned and operated, also offers discount fares to fathers wishing to accompany their wives so that they may be present at the delivery of their children.)

Within the first two years of its' operation, the Maternity was able to achieve perinatal mortality rates comparable to or lower than the rates for the entire province of Quebec, while managing 84% of all the births in the Hudson bay region.[88] These excellent results are attributed to thorough prenatal care and teaching, combined with effective risk screening conducted by the Perinatal Committee. The Perinatal Committee is a team mechanism responsible for all major care decisions concerning pregnant women on the coast. Chaired by a midwife and composed of doctors, midwives, midwives in training, and a member of the local Native Women's Association, the Committee meets regularly to review all pregnancies as they enter the third trimester. At this time, a general care plan is developed for the final weeks of each woman's pregnancy, and the place of birth is determined.

When risk status is reviewed, not only medical risk factors but also social risk factors are taken into consideration. It is this holistic approach which has made it possible for the team to reduce the number of women who are sent south, and to find ways to provide more effective and supportive care in the community instead. For example, through education and nutritional support, the number of women at risk because of anaemia has been reduced. Likewise, through specific efforts targeted at very young mothers, the number of pregnant teenagers who are sent south has been reduced.

According to Stonier, much trust has been generated among professionals and community alike as the competence of the maternity and the positive effect of having birth within the community becomes evident.

"Our practice has taught us that the cultural aspect of birth is not a mere 'nicety" that can

be appended to the care once all the other acute obstetrical techniques are in place. It is essential to perinatal health.

In fact, even though obstetrical intervention is obviously part of team care, on its own, especially where no real medical condition exists, it can only place bandaids where prevention and promotional health policies have failed. It is from within the culture and the community that real positive changes in the health of a people begins."[89]

5.4 Legalization of Midwifery in the North

At present, the legal status of midwifery in most parts of the north is debatable. Only in Labrador, because of Newfoundland's Midwifery Act of 1936, is midwifery clearly legal. Provisions are still in place under the Act for midwives to be licensed by the Midwives Board. However few midwives are currently licensed.[90]

In northern Quebec, the midwifery practice at Povungnituk was already well established when, in 1990, the Quebec National Assembly passed Bill 4, An Act Respecting the Practice of Midwifery Within the Framework of Pilot Projects. The subsequent designation of the Innulitsivik Maternity as a "pilot project", within the meaning of the Act, has had little, if any, effect on the actual practice. [91]

In the Yukon and the Northwest Territories, the respective Medical Professions Ordinances delineate the exclusive right of physicians to practise medicine. However, no specific mention is made of "midwifery" in the ordinances. Therefore, in the absence of specific legislation regulating the practice of midwifery, the practice is neither clearly legal nor clearly illegal. In the Yukon, where the transfer of health services from the federal government to the territorial government is currently in process, very little work has been done on the midwifery issue to date.

In the N.W.T., where the responsibility for the delivery of health services was transferred from the federal to the territorial government in 1983, the legalization of midwifery has often been raised as a topic for discussion, but has seen little practical advancement.

One of the few concrete proposals for the legalization of midwifery in the N.W.T. can be found in an internal report prepared for the Nursing Services Division of the Department of Health in 1989. In it, the author notes that midwives have always practised in the N.W.T., and the midwifery issue is not going to disappear, so it is better to recognize the practice formally than to ignore it. The author proposes specifically that a Midwives Act be introduced that is flexible enough to accommodate the unique circumstances of midwifery practice in remote, northern communities. She recommends the creation of a licensing system and a regulatory board which would recognize equally the competence of nurse-midwives and direct entry midwives, through means of a common midwifery examination, offered in a variety of forms. The author suggests that a Midwives Board in the north should consist of a majority of midwives, with possible additional representation from the medical and nursing professions, and from northern aboriginal women's groups.[92]

These proposals are echoed in another internal document prepared within the Nursing Services Division in 1990. In a discussion paper on Community Birthing Practices, Issues, and Strategies, several references are made to a hypothetical Midwives Act which would govern the practice of both nurse-midwives and "traditional lay midwives". Numerous specific suggestions are offered regarding the scope of practice of midwives, the settings in which they might work and the manner in which they might be integrated into the health care system. Reference is also made to the changes which would be required in other pieces of territorial legislation in order to

accommodate the profession of midwifery.[85]

In spite of this evidence that some civil servants have given considerable thought to the issues surrounding the legalization of midwifery in the N.W.T., the Government has made it clear that it is not prepared at this time to deal with the question of legalization directly. Instead, the official position of the Department of Health remains that no further decisions regarding the development of midwifery legislation will be made until the Rankin Inlet pilot project is completed and evaluated.[94]

Recent developments in midwifery legislation in several provinces, however, are an indication that the legalization of midwifery in Canada is well underway, In 1993 in Ontario, the proclamation of Bill 56, An Act respecting the regulation of the Profession of Midwifery, signalled the recognition of midwives as members of an autonomous, self-governing profession, distinct from both medicine and nursing. Today, Ontario midwives are practising in hospitals, birth centres, and women's homes, and are paid for their services by the provincial health insurance system. In Alberta, the Professional Statutes Amendment Act, passed in July 1992, gives legal recognition to the autonomous profession of midwifery. The Regulations to the Act, scheduled to come into effect August 1,1995, will provide for the registration of midwives and the integration of midwifery services into the provincial health plan. The scope of practice, as well as the settings where midwives may work, will be similar to those delineated in Ontario.[95] British Columbia is the latest province to announce its decision to legalize the practice of midwifery. An announcement by the Minister of Health in May 1993 confirmed the government's intent to recognize midwifery as a legitimate, self-governing profession. Midwives in B.C. will provide a full spectrum of care to women with normal, low-risk pregnancies, and will attend

deliveries in hospitals, birthing centres, and, eventually, at home.[96]

Informants interviewed for this report provided an interesting range of responses when asked whether or not they favoured an approach to midwifery legislation for the north similar to that taken in Ontario, Alberta, and B.C.. While some respondents with a nursing background questioned the feasibility of creating a new classification of practitioner within the health care system, especially in a climate of severe fiscal restraint, most respondents indicated that they really didn't care if midwifery was recognized as a distinct profession or as a speciality of nursing, so long as established core competencies and standards were met.[97] Several respondents pointed out that some sort of omnibus legislation, such as a Health Disciplines Act, might be the most efficient and expedient way to proceed with legalization of midwives, as there are several other classes of health practitioners also awaiting legal designation in the N.W.T., (e.g. certified nursing assistants, community health representatives, and psychiatric nurses), and a serious backlog of bills in the Legislative Assembly.[98]

Comments were made that the eventual legalization of midwifery in the north must be tailored to meet the unique circumstances and conditions in which midwives would practise, for instance the geographic isolation and the relatively low numbers of deliveries in sparsely populated areas. As well, legislation must somehow take into account the traditional practice of midwifery among aboriginal populations.[99]

The designation of an autonomous midwifery profession in Ontario, Alberta, and eventually B.C., eliminates the distinction between nurse-midwives and direct entry midwives and creates, instead, a single body of professional midwives whose competence can be judged by means of a

common assessment process. This model, based on the World Health Organization (WHO)'s international definition of a midwife,[100] recognizes midwives who have completed a prescribed program of midwifery education (or its equivalent) and have acquired the requisite qualifications to be registered or legally licensed to practise in the country or jurisdiction in question. This international definition is useful in that it recognizes a distinct and unified health profession, built on a common foundation of core competencies, without regard to the diverse routes by which its' members may have come to acquire those competencies. Unfortunately, problems arise when attempts are made to apply it in settings where a traditional, non-literate birth culture persists. Many of the women throughout the world, who are regarded as midwives within their own indigenous population, have never completed a "prescribed course of studies", nor have they acquired "requisite qualifications" established by a formal government. They remain, nevertheless, the guardians of normal birth within their own social and cultural milieu, and attempts to discredit their claim to be midwives, or their designation as such by women of their own communities, run the risk of crumbling under the weight of their own ethnocentrism.

The Canadian north is obviously one such setting where the definition of a midwife and, hence, the legalization of midwifery are not simple matters. If legislation were introduced to regulate the activities of professional midwives, where would traditional aboriginal midwives fit into this scheme? First of all, is it appropriate, either culturally or politically, to try to subsume traditional aboriginal midwifery practice under territorial or provinAs well, legislation must somehow take into account the traditional practice of midwifery among aboriginal populations.[99]

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integrated into a modern health care system that is highly regulated and specialized? Will aboriginal midwifery ever be practised again in the truly traditional way, or will longstanding midwifery traditions be adapted and incorporated into the training and practice of contemporary aboriginal midwives? In the Yukon, the N.W.T., and Labrador, these and other related questions remain largely unanswered.

These issues have already been raised in Ontario, where the intervention of aboriginal organizations resulted in the exemption of aboriginal midwives from the midwifery legislation.[101] The Ontario Ministry of Health is now working in collaboration with aboriginal groups to explore such issues as the role and scope of practice of traditional midwives, training, and accreditation (if there is to be any, and by whom).[102] There is concern both for the protection of aboriginal midwifery, and also for the assurance of public safety and accountability where aboriginal midwives practice.

Equay-Wuk, one of the Ontario aboriginal women's groups studying these issues, has cited the training program at the Maternity in Povungnituk as an excellent example of the appropriate integration of traditional and contemporary midwifery skills.[103] A somewhat related approach to upgrading the knowledge and skills of traditional midwives has been outlined in the N.W.T. Department of Health's discussion paper on community birthing.[104]

The opinion has been expressed by some that these non-conventional approaches to training will yield aboriginal birth attendants who cannot meet standard qualifications, but rather are qualified only to practise in a specific setting or jurisdiction, under the ongoing supervision of professional

midwives.[105] While this could be the case in some instances, the experience of the Inuit midwives in Povungnituk attests to the fact that aboriginal birth attendants, trained in a non-conventional manner, are indeed able to achieve a level of competence which prepares them to practise as primary caregivers, on an equal footing with "professional" midwives trained elsewhere. The greater challenge may lie, not in the training of aboriginal midwives, but in the development of appropriate methodologies for assessing the competence of midwives whose first language is not English, and whose mode of learning has not been the conventional, literate one with which the mainstream health professions are most familiar and comfortable.

Several key informants suggested that, ideally, an accredited midwifery training program, uniquely tailored to the needs of northern women, should be offered through a northern educational institution such as Arctic College. Such a program would necessarily take into consideration such issues as educational levels, aboriginal and English language proficiency, and options for part-time study and distance education. Until such a program is available, other options for aboriginal women include attendance at an educational program in one of the provinces where midwifery is recognized, or the development of situation specific training programs, such as the one in Povungnituk, associated with a clinical setting.

5.5 Questions of Safety and Acceptable Risk

Traditionally, aboriginal people in the north accepted birth as a normal function of life, carrying with it no more and no less risk than many other aspects of living a life in which there could never be absolute guarantees. The recognized risks were reduced as much as possible through preventive measures, such as exercise and good nutrition when available. Threats to the life of

the mother or baby were handled as best they could be, given the tools and knowledge of the birth culture, and the loss of life, when it occurred, was accepted as part of life as it was meant to be.

> "We had children survive without the medical profession. We really helped each other to keep as many Inuit babies alive as possible."[106]

The colonization of the Canadian north, however, was eventually accompanied by the medicalization of life, including the life cycle events of birth and death. While the conditions which ultimately supported (or failed to support) health among northern aboriginal people were in fact shaped largely by a variety of political, economic, and social determinants, new expectations were imported from the south about the supposed capability of medical institutions and personnel to manage and control health outcomes. In the realm of childbirth, this translated into the expectation that every pregnancy should result in the birth of a live baby, regardless of the conditions or life circumstances that might militate against such an outcome. As access was improved to hospitals in large centres with c-section capability and neonatal intensive care units, these expectations became more powerful and gave rise to a new definition of "acceptable risk". In the view of health care professionals and policy makers, it was no longer acceptable for aboriginal people to "risk" giving birth in isolated settlements or hunting camps, as they had done for generations, when the option had become available to evacuate all birthing women to hospitals where birth could be managed and controlled with the aid of the latest technologies known to western medicine.

> "I think in the medical world, any risk to newborns is now pretty much unacceptable. We have the ability, through intervention and agressive measures, to intervene with babes who are so small that ten years ago it wouldn't have even been considered."[107]

While the medicalization of birth and the wholesale removal of birth from the context of family

and community life represents the antithesis of the traditional approach to birth, the attitudes and expectations which gave rise to the policy of obstetric evacuation have been internalized to some extent by many aboriginal women themselves, especially those of the current childbearing generation. Smith notes that some women interviewed in Rankin Inlet believe that hospital births are the safest births, and that they should go out for specialised care, just in case something goes wrong.[108] Other women, it has been noted, simply accept the policy of referral out to hospital without question because the practice has become the norm, and because the overriding dependency of many women on the health care system does nothing to foster a questioning stance.[109]

Where traditional birth culture remains strong, the distinction between normal healthy pregnancy and potentially complicated pregnancy and birth is still recognized and respected by women themselves. But as Davis-Putt points out, the policy of sending everyone out has elsewhere created the dangerous situation in which the distinction between low-risk and high-risk birth is lost altogether, and in the backlash against the policy of universal evacuation, some women who are truly at greater risk may be among those resistant to leaving their community to give birth.[110]

Health care professionals and policy makers have often cited trends in perinatal mortality rates as justification for the continued policy of obstetric evacuation. Conversely, proposals to return birthing to the communities are often met with anxious concern that such a move might cause perinatal mortality to rise again.

However, as Kaufert and O'Neil have pointed out, in two articles based on their researcch in the Keewatin region of the N.W.T., the use of perinatal mortality rates as "proof" of the benefits

of bringing birth into the hospital is highly questionable.

First of all, the collection and conversion of data presents problems. In the early days of government data collection, the recording of births and infant deaths in the small communities and outlying camps of the north was often inaccurate, with the result that different sources for the same year claimed widely divergent statistics, calling into question the reliability of all of them. Given the small numbers to begin with, the omission of even one or two births or deaths could seriously skew the data. The numerical conversion of very small numbers of births, and even smaller numbers of stillbirths, neonatal deaths, and maternal deaths, into rates per thousand live births, yields statistics which are crude and misleading: it is statistically impossible to tell whether a difference in the rate from one year to another reflects some real change or is simply due to chance. The kinds of numbers which would be required in order to constitute a statistically significant sample are simply not found in the north.[111]

Secondly, the interpretation of these statistics has been subject to faulty logic based on the common error of mistaking trends and correlations for causal relationships. Perinatal mortality may, in fact, have declined somewhat in the period during which the practice of obstetric evacuation became widespread. However, in the absence of a controlled study designed to assess the effect of obstetric evacuation on birth outcomes, it is not possible to tell whether this change in mortality is due to the location of birth and the type of birth attendant, or to other unrelated variables, such as improved prenatal nutrition or a decline in maternal infectious disease. Kaufert et al discuss the example of perinatal mortality in nursing stations births and hospital births in the Keewatin region in the early 1970's. While the higher rate of mortality in the nursing station births could be used to argue the dangers of birthing in the communities and

the relative safety of birthing in the hospital, a closer analysis of the data reveals that prematurity and congenital anomalies incompatible with life were significant factors in the baby deaths. Thus, the data sheds very little light on the relative safety of nursing stations as a place of birth, or of midwives as birth attendants, especially in the case of healthy term pregnancies. Indeed, the few formal published reviews of perinatal mortality in the Keewatin acknowledge that shifting births from nursing stations to hospitals would have minimal impact on rates.[112]

Kaufert and O'Neil conclude that a meaningful epidemiological comparison of hospital and nursing station births would require random assignment of women to one place of birth or another (which raises grave ethical concerns), and a minimum sample size, the magnitude of which could never be achieved in today's north. Thus, while government health agencies remain preoccupied with mortality rates and the potential impact that a return to midwifery and/or community birthing might have on those rates, the debate remains statistically meaningless as neither side can conclusively prove its point with numbers.[113]

The northern aboriginal maternal and infant population is still characterized as being high risk, and the infant mortality and morbidity rates remain higher than the national averages. However, it is clear that lifestyle factors remain the major contributors to this situation, and that the provision of medical services per se does little to change the risk profile. Low birth weight, anaemia, and infectious disease are just three examples of health problems, the solutions to which lie in education, better nutrition, and socially supportive health promotion strategies.[114] Given that women in the north are continuing to express their dissatisfaction with the policy of obstetric evacuation, and that the government and medical community are hard pressed to prove that birth is truly safer for all women in hospitals, it seems likely that the call for a return to

community birthing and midwifery will continue to be heard. If midwife-attended birth is to become an option once again in some or all of the communities, the notion of "acceptable risk" must be re-defined.

The experience of the Innulitsivik Maternity demonstrates that a return to community birthing, and the utilization of midwives as primary care-givers, can occur without negative effects on the perinatal mortality rates. Further indicators which bear on the question of "safety" in childbirth, such as the gestational age at which women present for prenatal care, the rates of premature birth, the frequency and degree of intervention in the birth process, and the incidence of perineal trauma all show improvement to date in the experience of the Maternity.[115] The success with which the program has been implemented is attributed to the fact that a team of health care professionals, together with the childbearing women of the community, share responsibility for the decisions which are made. This process of consensual decision-making has fostered greater trust among team members, and has contributed to decisions that are viewed by the caregivers as wiser and safer.

Respondents interviewed for this report were asked to comment on how, and by whom, standards for safe birthing in the communities should be arrived at. The common denominator which emerged in their responses was the need for some mechanism for sharing the responsibility for decision making amongst those providing the service and those making use of the service. Most respondents identified the following players among those who should share in decision making: midwives, including traditional midwives and aboriginal midwives in training; physicians, including consultant obstetricians where appropriate; members of local or regional health boards, and local women themselves. Some respondents mentioned officials from the

Department of Health, as they represent the agency which would ultimately fund the service. One respondent suggested that those who provide medevac services to isolated communities ought to be involved also.

As to what factors or elements must be present in order to support safe birthing in a climate of "acceptable risk", there was some measure of consensus within a fairly broad range of responses. The cornerstones of safe birthing, according to most respondents, must be healthy lifestyles and good prenatal care, well trained and experienced midwives, and an effective risk screening process. With respect to risk screening, some respondents favoured continued reliance on the standard guidelines developed in the past by the Medical Services Branch and Department of Health. Other respondents felt strongly that guidelines for risk assessment must be revised in order to take into account not only physical health status, but also psycho-social risk status, as well as culturally acceptable norms and expectations with respect to birth and birth outcomes. The need to develop risk screening, appropriate within a distinct local or regional context, was also emphasized.

The importance of having experienced midwives, skilled in risk screening and able to make sound judgements on their own, was underscored by most respondents. Bearing on this is the question of how many births must a midwife regularly attend in order to keep her skills sharp. Given the small numbers of births which occur in a year in any given community, some respondents felt that consideration must be given to offering midwifery services in a regional centre where the numbers would then be higher. Mention was also made of the need to ensure that midwives take part in continuing education activities, including periodic clinical refreshers in a high volume birth centre outside of the north.

Opinions differed on just how much technology should be available in the community in order to ensure safe birthing. Provisions for infant resuscitation and the control of maternal haemorrhage were considered bottom-line requirements. And while it was accepted as a given that C-section capability would not be available outside of the secondary hospital setting, vacuum extractors, infant warming tables, and blood in the fridge were all up for discussion. Similarly, the requirement that a plane be on the airstrip, ready for take off at all times, was considered essential by some respondents but not by others. The range of responses elicited in this small survey of opinion clearly supports the case for a multidisciplinary and consensual approach to decision-making.

One further dimension of the debate on safe birthing is the concern about liability in the event that a birth outcome is less than perfect. Aboriginal people talk about accepting a certain inevitable element of risk that accompanies birthing in their communities:

> "We have traditional ways of how to care for us when we are carrying a baby because each life is precious. But we also believe that if a baby dies during delivery or in the process, maybe it happens because it is meant to be. But we are not saying, we don't care about our babies because we want midwifery. We have to take the chance and the risks because there is one Creator and we have a lot of faith and if it is meant to be, it happens."[116]

Non-aboriginal health care providers, however, are not entirely convinced that they will be held blameless in the event that a baby or mother should die. They point out that norms and expectations have changed, even in the north, and that aboriginal people who have become reliant on government health services are no less likely to sue than anyone else. This issue has been raised by the Northwest Territories Registered Nurses Association in its discussion paper on maternal-infant care in the N.W.T., where specific reference is made to the need for legal

support and insurance coverage for nurses who take on the responsibility for providing midwifery care in the communities.[117]

Once again, it is interesting to consider the case of the Innulitsivik Maternity. The midwives are of the opinion that their best protection from liability is the good care they provide, and the good relationships they have developed over time with clients who themselves are informed and accepting of the inherent risks of birthing in Povungnituk. At the same time, they have always been covered by the hospital's insurance, as full members of the professional body of the hospital along with the doctors, dentists, and pharmacists.

What, perhaps, remains the more difficult aspect of the liability issue, for health care providers who come from outside of the community and outside of the culture, is the spectre of moral responsibility which shadows the question of legal responsibility. The comments of this nurse are revealing:

> "I love delivering babies. It is the highlight sometimes for me being in the North. We have had four deliveries in Eskimo Point. Fortunately, all of them have worked out very well. My main concern about delivering babies in the North are the legal implications. Who takes responsibility if something happens?The attitude that God wants it that way is one way of looking at it, but for myself to go home at night knowing that a mother or baby did not make it is just too much for me to carry."[118]

5.6 Financial considerations

The question has been asked whether a return to midwife-attended births in the communities or in regional birthing centres might save the government money in the long run.[119] Money is currently spent on flying women out to hospitals in the north, or even down south, and on the associated costs of boarding those women for weeks while they wait for their babies to be born. Costs are also incurred by the families left behind: childcare costs, wages and/or other forms of household income lost because fathers are unable to juggle childcare and working outside the home, and long distance phone bills. Other costs, which are difficult to quantify, are said to be associated with obstetric evacuation: stress and family tensions exacerbated by the mother's absence, which translate into behavioural problems, health problems, and even family violence.

The Department of Health of the Northwest Territories maintains that regional or community birthing is not cheaper than the current arrangement of sending women out.[120] It is not altogether clear how the Department has come to this conclusion, in view of the fact that the Northwest Territories has very little recent or current experience with elective birthing in the small communities. It would appear that conclusions are already being drawn, based on the high cost of the Rankin Inlet pilot project which includes salaries for a co-ordinator, two nurse-midwives, a maternity worker, renovations to a facility, and a considerable outlay for equipment. It must be recalled that the Rankin Inlet project represents only one approach to community birthing, and has been conceived and developed as an add-on service to the ongoing practice of obstetric evacuation, which remains an option for Rankin Inlet women. It is almost certain, given the parameters of the project and the relatively small numbers of women who are likely to be served by it in the first couple of years, that the service will not prove cost effective in the short term.

By way of contrast, the Innulitsivik Maternity has, since its inception, operated on the funds which had originally been earmarked for a more conventional approach to maternity care. No special pilot project funds were ever sought or provided to facilitate the development of the Maternity. In the first couple of years, the numbers of women from the Hudson Bay region who stayed in the north to give birth at the Maternity increased to 84% (perhaps higher now), thus increasing the cost-effectiveness of the service and reducing the budget spent on transferring women to the south.

Three years ago, in a document internal to the N.W.T. Department of Health, a recommendation was made that the Department undertake a cost-benefit analysis to estimate the potential for savings if community/regional midwifery services were offered and accepted by 75% of pregnant women. Estimated costs were to include the expense of adding one midwife to each community or estimating payment of $1000.00 for midwifery care for each pregnant woman, as well as the costs of providing facilities and creating midwifery positions within the Department, at the territorial and regional levels.[121] To date, it would appear that no such analysis has been undertaken.

Certainly, there is no simple answer to the question of how much the widespread introduction of midwifery services might cost, or save, northern governments. It is clear, however, that several different models of service must be explored over time before any firm conclusions can be drawn. It would appear obvious, for example, that the costs associated with regional birthing centres might be quite different from the costs of offering midwifery services in each community. Similarly, the costs associated with recruiting and maintaining a cadre of nurse-midwives might be quite different from the costs associated with recruiting and training indigenous midwives.

Decisions may have to be made to re-direct some existing funds in order to support innovative services, and to concentrate more funds on providing better care to pregnant women, rather than investing in increasingly sophisticated obstetric technology.

Finally, although the conditions in the north are vastly different from those in the south, the effect which the introduction of midwifery services eventually has on provincial healthcare costs in Ontario, Alberta, and B.C. will, no doubt, be of interest to those who grapple with healthcare budgets in the north.

5.7 Questions of power and control: towards collaborative problem solving and planning

The issue of midwifery in the north has been the subject of much interest, research, and debate for a number of years. It has been talked about in people's homes, in community meetings and in workshops sponsored by one or another organization, in board rooms and in government offices, and even in legislative assemblies. Yet, in spite of all the talk, there has been very little substantive change in policy or in practice. In order to understand this, one must review some fundamental issues related to power and control.

Considering that aboriginal women have had virtually no control over the manner in which northern healthcare services have evolved, it is not surprising that they have experienced a tremendous loss of personal power in the birthplace. From the earliest days of the mission outposts, through the era of the federal Medical Services Branch, and right on into the eventual devolution of health care to the provinces and the Territories, the locus of control has clearly resided outside of aboriginal communities, in the domain of health care professionals and

bureaucrats. The case of Povungnituk and the Innulitsivik Maternity stands out as an exception rather than the rule. The success with which the people of that community were able to lobby for the kind of maternity services they wanted has been attributed, in part, simply to the unique character of the community. In apparently characteristic fashion, community members asserted their position and stood their ground until they achieved their goal.

Elsewhere in the north, aboriginal peoples' control of health care remains either elusive or largely illusory. In Labrador, the control of the Moravian missionaries eventually gave way to provincial authority for health care, which became manifest in the Grenfell Regional Health Services. Policy decisions, made in the late 1970's, that resulted in the evacuation of all pregnant women from the communities for delivery in hospitals were made without consulting the people. Today, women in the communities are still calling for better representation on the regional health board, and consultation on the part of policy makers who make decisions which directly affect the peoples' lives. [122] The Labrador Inuit Health Commission, meanwhile, is making slow progress towards the long-term goal of eventually taking over all health programs, including the nursing stations, under a Community Health Department of the Labrador Inuit Association.

In the Yukon, health care in the communities is still provided directly by the Medical Services Branch of the federal Department of Health and Welfare. Transfer of health services to the Yukon government has begun, but still has a long way to go. The role and authority that First Nations will have in the delivery of health care in the Yukon remains to be negotiated, and is linked to the manner in which land claims are ultimately settled.

In the Northwest Territories, the devolution of health services from the Federal to the territorial

government began in 1982 and was concluded in 1988. O'Neil suggests that aboriginal organizations, both Inuit and Dene, went along with devolution of health care, despite prevailing uneasiness that the process would undermine the special relationship of aboriginal peoples and the Crown, because of the extent of popular dissatisfaction with an intractable colonial medical system.[123] The promise of greater local control through regional health boards, however, has not been fulfilled in the way it was envisaged. Peter Ernerk, a former MLA from the Keewatin region, points out an all too familiar paradox:

> "How can the people of the Keewatin region successfully feel that they have the authority to deliver health matters when the chairman of the Keewatin Health Board is a regional director, directed by the Minister in Yellowknife to deliver the services? How can we have such power? How can they think they're actually delivering devolution to the communities? How can they think that they're transferring authority and decision making power from Yellowknife to the communities?"[124]

Indeed, there is an increasingly widespread perception that the real power rests, not with appointed regional health boards, or even with elected members of the Legislative Assembly, but rather with the senior management level of an entrenched bureaucracy in the capital.

With respect to midwifery, the Government of the Northwest Territories has thus far effectively retained control by identifying the Nursing Services Division of the Department of Health as the gatekeeper for all communication and decisions related to the issue. Past efforts on the part of public interest groups to obtain government support for a broad-based task force on midwifery have not met with support.[125] Even the efforts of independent groups, such as the Science Institute of the Northwest Territories, to foster open dialogue amongst the major stakeholders have been effectively discouraged by the Department of Health.[126] Other groups, such as the N.W.T. Status of Women Council, while acknowledging the importance of the issue, have expressed serious doubts about the likelihood of being able to access funds to support a task

force or broad-based working group. Lynn Brooks, Executive Director of the Status of Women Council, points out that not only are other departments of the Territorial government not going to tread on the Department of Health's turf, but even federal agencies such as the Secretary of State's Women's Program are unwilling to fund initiatives which might challenge the Territorial Department of Health's monopoly on the midwifery issue.[127] Even Health and Welfare Canada's special North of 60 research fund, which was used by Pauktuutit to aid in the documentation of traditional Inuit midwifery knowledge, is no longer available.

Thus, the flow of information about midwifery in the north is severely restricted, and potential stakeholders continue to address the issue in isolation from one another. In particular, aboriginal women have little access to information about midwifery options and developments elsewhere, and have few opportunities to work creatively together to generate a realistic vision of midwifery as it might exist in today's north. The N.W.T. government's work in the area of furthering midwifery remains restricted to the piloting of a nurse-midwifery project.

Clearly, the issue of midwifery in the north will not be adequately addressed until aboriginal women are themselves full participants in the discussions. This assumes, first of all, that aboriginal women identify the issue as being important enough to work on. While midwifery may not be a priority for women in all communities, consensus as to its importance need not be achieved right across the north before work can begin in various regions. Indeed, local initiatives on a small scale may provide the most promising vehicles for resolving the many complex issues currently under debate. The key to success will lie in the determination, even the militancy, of women who are tired of being told by others where and how and with whom to have their babies.

In order for northern women to participate fully in the process of developing viable midwifery options, the locus of control must shift away from government departments of health and towards communities of childbearing families. In this sense, midwifery is no different from many other issues which are currently challenging northern aboriginal peoples to define local mechanisms for problem-solving and self-government. There is no blueprint which fits for all aboriginal communities or first nations, and thus the models for regaining local control of health will vary considerably from one community to another. The key will be for aboriginal women who care about midwifery to find ways of keeping the issue visible amidst the plethora of competing health priorities.

Access to information is vital if aboriginal women are going to be able to participate on an equal footing with health professionals and policy makers in the development of midwifery options. In order for women to obtain and to share amongst themselves the information they need, they must gain access to resources which are not controlled by the government departments of health which clearly have their own agendas. Forums for creative and collaborative problem-solving, whether they be local working groups or large scale task forces, must be supported both politically and financially. Ultimately, government health agencies must recognize and affirm the rights of aboriginal women to play an active role in determining the most appropriate forms of maternity care.

Finally, midwives in the north must begin to search for common ground amongst themselves. This will present quite a challenge, as evidenced by the experience of midwives in other parts of Canada who have worked to overcome the barriers created by the designations of

"nurse-midwife" and "lay-midwife". In the north, the further dimension of traditional aboriginal midwifery will heighten the challenge, as women of extremely diverse backgrounds and orientations will grapple with questions about the essential nature of midwifery, and try to arrive at a comfortable meeting place.

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

i) The medicalization of childbirth in the north has created a climate of dependency on medical services, and resulted in a monopoly on the provision of maternal health care which has effectively disempowered aboriginal women and alienated them from their traditional birth culture.

ii) The practice of midwifery, with its emphasis on the promotion of healthy pregnancy and normal birth within the context of family-centered care, has the potential to impact positively on the health, both physical and psycho-social, of aboriginal people in the north. The experience of the Innulitsivik Maternity to date has already demonstrated such a potential.

iii) For aboriginal women, the return to midwifery is not just about promoting the physical health and safety of mother and infant. It is also about the empowerment of women, the strengthening and healing of families and communities, the preservation of culture and identity, and the restoration of a greater degree of self-reliance among aboriginal people.

iv) Definitions of "acceptable risk" in relation to birthing in northern communities are best arrived at by consensus among the childbearing families and health care providers in those communities. Given the opportunity to participate fully in decision-making, on an equal footing with health care professionals, aboriginal women are capable of making choices about their own maternal health care that are sound, safe, and appropriate for themselves and their families.

v) In most regions of the north, government departments of health retain effective control over maternal health services, and apparently favour the maintenance of the status quo, i.e. the medicalization and hospitalization of birth, and the practice of obstetric evacuation. Governments and their affiliated health care agencies have done very little to promote open discussion about midwifery among northerners, and are very cautious about lending any support to the practice of midwifery.

vi) Within governments in the north, there is a strong tendency to view the practice of midwifery as a speciality of nursing, and the issue of midwifery as a matter which falls within the realm of nursing services administration. This reflects the legacy of the northern health services which at one time employed many foreign trained nurse-midwives. This approach to midwifery, however, is not in keeping with current developments in the profession of midwifery in other parts of Canada, and also does not support the training of community-based aboriginal midwives.

vii) Aboriginal women and other women who are calling for the renewal of midwifery in the north are either absent or under-represented in the power structures that retain control over maternal health services. There does not exist an organized "midwifery lobby" or other obvious

mechanism for consolidating and advancing the views of the many individual women across the north who are interested in a midwifery option in health care. Most women in the north have had few, if any, opportunities to become informed about, or to engage in dialogue on, the midwifery issue. Thus, in most regions of the north, public opinion on the issue remains diffuse and ineffective as a source of pressure to effect change in policy or legislation. (The example of the Keewatin region, where the Keewatin Inuit Association has lobbied actively for midwifery in the region, is an exception to this rule.)

viii) Any serious effort to revitalize midwifery in the north must incorporate, among its fundamental goals, the training and employment of aboriginal midwives, and the preservation and enhancement of indigenous midwifery traditions. The education of indigenous midwives must strive to remove barriers created by distance, language, culture, and prior educational experience, while ensuring that core competencies are developed and demonstrated.

ix) The revitalization of midwifery in the north can only truly occur within the context of local control and increased self-reliance in health care among aboriginal people. This calls for the recognition of aboriginal peoples' authority to manage their own health care, a willingness on the part of aboriginal people to assume greater responsibility for health care, and the availability of the resources and technical support required in order to fulfill that responsibility.

x) In turn, the revitalization of midwifery can itself contribute significantly to the empowerment of aboriginal people which, in turn, fosters greater self-reliance. Just as the erosion of self-reliance has occurred over time, so the restoration of self-reliance and personal power will take time to achieve.

xi) Ongoing developments in midwifery legislation and practice in other parts of Canada are of relevance to the north. However, as midwifery legislation and regulatory mechanisms are developed in the north, care must be taken to ensure that they reflect the unique cultural, geographic, economic, and political conditions of the north. In particular, consideration must be given to the emerging jurisdictions and authority of aboriginal self-government.

6.2 Recommendations

The following recommendations are generic, in the sense that they may be acted on by Federal, Provincial, Territorial, or First Nations governments, as well as non-governmental organizations. In some cases, they may also be acted on by individuals, and in particular by aboriginal women. Indeed, the implementation of all of these recommendations will depend, in no small measure, on the proactive efforts of aboriginal women themselves to effect change and to once again reassert their power in the birthplace.

1) Give full support to the efforts of aboriginal women, throughout the north, to preserve and enhance their indigenous midwifery traditions, including the training of aboriginal midwives.

2) Create access to the resources needed by aboriginal women in order to research and explore the potential of midwifery as it relates to their needs and aspirations at the local and regional levels.

3) Support and facilitate communication amongst aboriginal women, and other interested women, throughout the north so that information and ideas concerning midwifery may be freely exchanged. If deemed appropriate by women themselves, support the work of an inter-disciplinary task force mandated to address questions related to the recognition and implementation of midwifery in the north.

4) Ensure the direct involvement of aboriginal women, at local and regional levels, in decision-making with respect to the kind of maternal/infant health care that is appropriate for their communities. Support the developmental efforts of communities and regions which favour the inclusion of midwifery in their health care service.

5) Ensure the direct input of aboriginal women in the development of any legislation, regulatory policies, or standards of practice relating to midwifery in northern jurisdictions.

6) Ensure the direct involvement of aboriginal women in the development and implementation of training programs for midwives in the north.

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123 O'Neil: 1988b *op cit*

124 Dickerson, Mark O.
1992 Whose North: Political Change, Political Development, and Self-government in the Northwest Territories. UBC Press, Vancouver 1992

125 Correspondence from Shelly Howell, Yellowknife Caucus of the National Association of Women and the Law, to Jeannie Marie-Jewell, Minister Responsible for the Status of Women, January 15, 1990.
Response from Jeannie Marie Jewell, Minister Responsible for the Status of Women, April 10, 1990, and response from Nellie Cournoyer, Minister of Health, May 24, 1990.

126 Correspondence from Elaine Berthelet, Assistant Deputy Minister for Community Health, Government of the Northwest Territories to Anna Buss, Science Administrator, Science Institute of the Northwest Territories, May 7, 1992.
Response from Anna Buss, May 14, 1992

127 Personal conversation with Lynn Brooks, Executive Director of the N.W.T. Status of Women Council, October 21, 1993

APPENDIX A: PERSONS INTERVIEWED

Bertha Allen
President, Native Women's Association
of the N.W.T.,
Inuvik, N.W.T.
September 21, 1994

Moira Benoit
Skookum Jim Friendship Centre,
Whitehorse, B.C.
July 12, 1993

Elaine Berthelet
Assistant Deputy Minister of Health,
Government of the N.W.T.,
Yellowknife, N.W.T.
July 6, 1993

Lynn Brooks
Executive Director,
N.W.T. Status of Women Council,
Yellowknife, N.W.T.
July 5, 1993

Rosemary Brown
Regional Nursing Officer,
Keewatin Regional Health Board,
Rankin Inlet, N.W.T.
July 14, 1993

Theresa Chulack
Nurse in Charge,
Pond Inlet Health Centre,
Pond Inlet, N.W.T.
September 22, 1994

Charles Dent
MLA Yellowknife South,
Member of the Legislative Assembly
Special Committee on Health and Social Services,
Yellowknife, N.W.T.
July 6, 1993

Martha Greig
Researcher and consultant
on traditional midwifery for
Pauktuutit (Inuit Women's Association),
Ottawa, Ontario
August 10, 1993

Karen Hilliard
Executive Director,
NWT Registered Nurses Association,
Yellowknife, N.W.T.
July 6, 1993

Betsy Jackson
Director of Health and Social Services,
Council of Yukon Indians,
Whitehorse, Yukon
June 30 and August 11, 1993

Barb Kemeny
Midwife, Innulitsivik Maternity,
Povungnituk, Quebec
July 14, 1993

Pierre Lessard
Consulting Obstetrician and Gynecologist,
Stanton Yellowknife Hospital,
Yellowknife, N.W.T.
July 5, 1993

Minnie Letcher
Health Director,
Dene Nation,
Yellowknife, N.W.T.
July 13, 1993

JoAnn Lowell
Childbirth educator
and consumer advocate,
Yellowknife, N.W.T.
July 5, 1993

Maureen Morewood-Northrop
Acting Director of Nursing Services,
Department of Health,
Government of the N.W.T.
July 7, 1993

Ron Pearson
Manager of Health Transfer,
Department of Health,
Government of the Yukon,
Whitehorse, Yukon
June 29, 1993

Peter Roberts
Administrator,
Grenfell Regional Health Services,
Charles S. Curtis Memorial Hospital,
St. Anthony, Newfoundland
July 13, 1993

Judy Rothenberger
Acting Regional Nursing Officer,
Mackenzie Regional Health Board,
Yukon, N.W.T.
July 6, 1993

Dorothy Schiller
Assistant Deputy Minister of Health,
Government of the Yukon,
Whitehorse, Yukon
November 5, 1993

Brenda Thomas
Researcher on traditional aboriginal midwifery,
Ontario Native Women's Association,
Niagra Falls, Ontario
July 12, 1993

Aani Tulugak
Administrator,
Innulitsivik Maternity
Povungnituk, Quebec
July 12, 1993

Maggie Webb
Community Health Advisor,
Labrador Inuit Health Commission,
Nain, Labrador
October 19, 1994

APPENDIX B: INTERVIEW FORMAT

MIDWIFERY IN THE NORTH

A. Traditional / aboriginal midwives

1. Are you aware of any traditional aboriginal midwives still practising in your region (territory)? Please elaborate: who, where, how frequently, outcomes?

2. Are you aware of traditional midwives or elders in your region who still have traditional knowledge about pregnancy and birth? Has their knowledge been documented in any form?

3. What role do you think traditional midwives could play in the provision of maternity care today or in the future?

4. What role do you see, today or in the future, for aboriginal women in the north who are interested in being midwives? How might these women become midwives?

B. Current Issues

5. Are aboriginal women and their families satisfied with the way in which maternity care is currently provided in the north? With which aspects are they satisfied/dissatisfied? How do they demonstrate or communicate their satisfaction or dissatisfaction?

6. There has been a great deal of talk about a return to birthing closer to home, in the small communities. In your opinion, what would constitute culturally acceptable, safe birthing in the communities? What factors or elements must be present?

7. No doubt, different people have different opinions about what constitutes "safe birthing" or "acceptable risk". In the end, how should standards for safe birthing be arrived at, and by whom?

8. Ontario, Alberta, and B.C. are at various stages in the process of recognizing midwifery as an autonomous, self-regulating profession, with both direct-entry and post-nursing options in education. Midwives in these provinces will eventually be serving as primary care-givers to women with "low-risk" pregnancies and normal births, both in and out of hospitals. Their services will be integrated into the publicly funded health care system. Do you think a similar approach should be taken in the north, or do you favour different parameters for midwifery in the north? (Elaborate: scope of practice; education and accreditation; regulation).

9. What is required in order to arrive at the situation you have just described (above)? How can the outstanding issues be resolved? How can the barriers be removed? (Elaborate on the process and resources that may be required.)