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Happenings

Maternal-Child Health Care in Aboriginal Communities

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This paper outlines the imperatives of and growing opportunities for nursing involvement in multidisciplinary and multi-partner research and action to improve maternal-child health care in Aboriginal communities. On ethical grounds (Canadian Nurses Association, 1997; Community Health Nurses Association of Canada, 2003), inequities in access to evidence-based, culturally safe, and family-centred maternal-child health services for rural and remote reserves are of concern for nurses. From a nursing-practice perspective, issues faced by nurses practising in Aboriginal communities have received inadequate attention from nurse scholars. From a population-health perspective, improving perinatal health outcomes could significantly reduce the disparities in health status between Aboriginal and non-Aboriginal people. While the imperatives for action are not new, recent funding opportunities for Aboriginal health research, improvements to leadership and support for nurses working in Aboriginal communities, and the increasing ability of Aboriginal people to lead and facilitate action have created more favourable conditions for research in this area.

The Imperatives for Action

I propose a greater investment of nursing's research expertise in efforts to improve the delivery and outcomes of maternal-child health care in Aboriginal communities, for three reasons: to reduce health-status inequities through "early years" interventions; to address inequities in access to culturally safe, evidence-based maternity care; and to improve support and professional guidance for health-care providers working in Aboriginal communities.

Health-Status Inequities

"Early years" research strengthens the case for nurse-researcher involvement in upstream efforts, showing that improving the quality of prenatal

care, for example, can positively influence the life course of Aboriginal people. A growing body of evidence suggests that the quality of a child's environment during the early years shapes neurobiological, social, and emotional outcomes over a lifetime (Guralnick, 1997; Hertzman, 2000; McCain & Mustard, 1999). Table 1 compares health-status indicators from infancy to adulthood for Aboriginal Canadians with the whole Canadian population. Life-course theory and evidence (Graham, 2002) suggest that weak preventive and health-promoting care in the pre- and postnatal periods may be a significant contributor to an accumulation of poor health outcomes over a lifetime.

Inequities in Access to Culturally Safe, Evidence-Based Maternity Care

Maternal-child health care in First Nations and Inuit communities in Canada falls short of the standards set for the country as a whole. The current practice is to transfer women in late pregnancy for "medically safe births" to a designated tertiary-care medical centre in southern Canada. Aboriginal women must therefore leave their children and the support of their families and communities, sometimes for as long as 2 months, to experience this important life event alone in an unfamiliar environment. As it is currently carried out, evacuation is a "downstream" approach that separates women and birthing from the cultural, personal, family, and community contexts that are so critical to successful pregnancy and a positive birth experience. Lack of protocols for care of women throughout pregnancy, birth, and postpartum, and for co-ordination between the health systems involved, further compromises attempts to provide culturally safe (Polashek, 1998; Ramsden, 1993; Smye & Browne, 2002), health-promoting, person- and family-centred nursing

Table 1 ***Selected Health Indicators for Aboriginal and Non-aboriginal Canadians***

Selected Health-Status Indicators	Aboriginal Canadians	Canadian Population
Infant mortality rate*	1,200	580
Preschool mortality from injury rate*	83	15
Youth suicide rate*	37	7
Percentage never completing high school	64	31
Average annual employment income	$14,055	$26,474

* Rates are per 100,000.

Sources: Assembly of First Nations, 1999; Federal/Territorial/Provincial Advisory Committee on Population Health, 1999.

care (Lindsey & Hartrick, 1996). The disruption in care imposed by relocation to a southern centre compromises the effectiveness of relevant community services such as nutrition programs and programs for the prevention of fetal alcohol syndrome. Medical evacuation, as the major thrust of maternity care, fails to address the root causes of poor health experienced by Aboriginal women and families, and seriously compromises the efforts of Aboriginal people to achieve vitality in their families and communities.

Lack of Support for Health-Care Providers

The First Nations and Inuit Health Branch (FNIHB) (previously known as the Medical Services Branch) of Health Canada is one of the largest providers of health care in Canada — indeed it is the fifth largest "jurisdiction" among provinces and territories. Its annual budget exceeds $1.4 billion. Health services are provided to about 700,000 Canadians of First Nations ancestry on reserves south of the 60th parallel and to Inuit as part of the Territorial health systems north of 60. For First Nations, this includes about 600 communities varying in size and in extent of geographic isolation. Health services are focused on primary care and delivered in community health centres and northern nursing stations, mostly by registered nurses who function in an expanded role in more remote communities. Approximately 1,200 Full Time Equivalents of registered nurses are employed by FNIHB and/or directly by the bands that manage their own health services with funds provided by Health Canada through contribution agreements with FNIHB.

Nursing care in Aboriginal communities has not developed in tandem with mainstream nursing, for a number of reasons. Infrastructure and support for nursing in FNIHB was eroded when the federal government began transferring health services to band control. In anticipation of a different future for the Branch, leadership and support staff in federal headquarters decreased and their relationship to nurses employed by the bands became unclear. Thus organizational support for nurses, who were often working in relative isolation and under difficult conditions, was reduced. For example, opportunities for professional development and access to professional information systems were limited. Given the difficult conditions and perceived lack of professional support, rapid staff turnover and shortages became the norm, particularly in more remote communities. This problem has been exacerbated by the nursing shortage. In some communities more than 50% of nursing positions remain vacant. The nursing staff turnover rate is estimated to be 40% over an 18-month period (K. MacMillan, personal communication, February 2003). As a result, crisis-oriented, primary medical care occupies the lion's share of nursing time. Little nursing time is available for the health promotion

and preventive care that is so critical during the pre- and postnatal periods.

Favourable Conditions for Research

There is a strong imperative for nurses to collaborate in multidisciplinary research focused on improving maternal-child health care in Aboriginal communities. Moreover, recent organizational changes in FNIHB, growing funding opportunities for Aboriginal health research, and recognition of the ability of Aboriginal people to lead and support research and action directed at improved health have created favourable conditions for the conduct of research that can make a difference.

FNIHB Leadership and Support for Nursing

In 2002 FNIHB created an Office of Nursing Services as part of its internal reorganization. An Executive Director – Nursing, engaged to provide executive leadership for nurses employed by the Branch, is leading a "transformation strategy" to improve retention and recruitment of qualified nurses in First Nations communities. Initiatives include a bundle of strategies aimed at development in each of the following areas: leadership capacity, information technology, competency and professional practice, human resource planning and management, and communication and influence (Office of Nursing Services, 2002). One of the projects undertaken as part of the transformation strategy focuses on improving maternal-child health services provided by nurses. Priorities include reviewing and applying current research evidence, examining provincial/territorial public health programming and facilitating improved integration of services, and learning from communities that have been able to implement best practices. To help lay the groundwork for this activity, a review and policy synthesis was completed in 2002 (Smith, 2002).

Funding Opportunities for Aboriginal Health Research

The last few years have seen substantial growth in funding structures and resources to build capacity for Aboriginal health research. For example, the mandate of the Institute of Aboriginal People's Health (IAPH) of the Canadian Institutes for Health Research is to support research addressing the special health needs of Canada's Aboriginal people. Research areas identified by the IAPH relevant to improving maternal-child health care include: "culturally relevant health promotion strategies," interactions among health determinants, determination of the "most effective interventions with Aboriginal populations," "health services research to address the unique accessibility and provider issues such as funding and continuity of care," and "ethics issues related to research, care strategies,

and access to care (e.g., community consent, sensitivity to culture)" (Institute of Aboriginal People's Health, 2003, p. 1). Four regional centres for Aboriginal Capacity and Developmental Research Environments (ACADRE), funded in 2002 and located in Alberta (http://www.acadre.ualberta.ca), Saskatchewan, Manitoba (http://www.umanitoba.ca/centres/cahr/), and Ontario, form the core of IAPH strategic initiatives to build capacity for Aboriginal health research. Further ACADRE grants have recently been announced for Nova Scotia (Canadian Institutes for Health Research, 2003), Ontario, and Northern British Columbia. Current requests for proposals for IAPH funding focus on community-based research and new researchers in Aboriginal health.

In November 2002 the National Aboriginal Health Organization (NAHO) became a decision-making partner of the Canadian Health Services Research Foundation, enabling the application of its funding and priorities to nursing and health services research issues in Aboriginal communities. The Social Sciences and Humanities Research Council has facilitated dialogue and a series of consultations on research and Aboriginal peoples. A summary paper on this process has been drafted (Social Sciences and Humanities Research Council [SSHRC], 2003a). Follow-up with the wider Aboriginal, academic, and government stakeholder communities, to ensure that everyone has had an opportunity to review and respond to the evolving policy and program proposals, is planned for 2003 (SSHRC, 2003b).

Strengths and Desires of Aboriginal Peoples

Significant growth in organizational infrastructure and capacity has been achieved by organizations focused on supporting and developing capacity to take action on the health of Aboriginal peoples. Among these organizations are the NAHO and the Aboriginal Nurses Association of Canada (ANAC).[1] Aboriginal people will continue to advocate, lead, and sustain change towards a health-care delivery system that respects and supports their cultural values and beliefs, responds to the historical, geographical, and intercultural issues that impact on their health, and ultimately facilitate greater self-determination.

[1] The NAHO is "an Aboriginal designed and controlled body [that aims to] influence and advance the health and well being of Aboriginal Peoples through carrying out knowledge-based strategies" (National Aboriginal Health Organization, 2001, p.1). The ANAC "is a non-governmental, non-profit organization that was established out of the recognition that Aboriginal people's health needs can best be met and understood by health professionals of a similar cultural background" (Aboriginal Nurses Association of Canada, 2003, p. 1).

Aboriginal women play a critical role in the development of appropriate, culturally relevant maternal-child health-care services. In a recent review of the published and grey literatures, organization and support of local Aboriginal women emerged as key to the success of sustainable, culturally secure maternal-child health services (Smith, 2002). In Canada, several small, community-based programs that blend traditional values and practices with Western biomedicine have demonstrated positive outcomes, support and acceptance by local women, and sustainability. Notable examples are the Iewirokwas Program and Innulitsivik Maternity.

The Iewirokwas Program operates on the Akwasasne Reserve located in southeastern Ontario, southwestern Quebec, and northern New York State. "The program aims to restore to Mohawk women their power, dignity and self-efficacy in the childbearing years and at birth in all settings." It is developing a community- and culture-based midwifery education program and a practical woman-centred family birth program. It offers information and support to empower women and their families during the prenatal period, inform them of their rights, promote traditional Mohawk birthing rites, and help them make good birthing decisions. It educates local maternity nurses, obstetricians, and hospital staff in traditional Mohawk birthing practices to enable them to better support Mohawk women (Iewirokwas, 2002).

Innulitsivik Maternity, located in Povungnituk in northern Quebec, came about through collaboration between local health-care professionals and the Native Women's Association. It aims to "put the responsibility for organization and provision of women's health care services into the hands of the Inuit women" (Stonier, 1990, cited in Blythe, 1995, p. 15). Inuit women are recruited from local communities and trained to work in collaboration with professional midwives. The Inuit midwives provide most of the basic care, under the supervision of the professional midwives. Traditional practices are interwoven with conventional midwifery care.

Partnerships between researchers and local initiatives are needed to facilitate identification and synthesis of best practices such as those demonstrated by Innulitsivik Maternity and the Iewirokwas Program. Concomitant with the evolution of these and other small, locally developed initiatives are a growing crisis in rural maternity care (Society of Obstetricians and Gynecologists of Canada, 2000), increasing support for a multidisciplinary approach to care, and recognition of an important role for Aboriginal midwifery (K. McGovern, Society of Obstetricians and Gynecologists of Canada, personal communication, February 2003). Collectively, these movements and changes signal an unprecedented

readiness for research and action to improve maternal-child health care in Aboriginal communities.

Matching Imperatives with Opportunities

In the past, research with Aboriginal populations tended to focus on describing health disparities. Aboriginal people have said they are well aware of the health-status disparities and have called for research focusing on action and change regarding priority health issues (Reading & Nowgesic, 2002). Research aimed at improving maternal-child health care directly or indirectly addresses five of the seven priorities identified by national Aboriginal organizations (access to health services including culturally appropriate services; youth issues, particularly mental health and suicide; children's health issues such as fetal alcohol syndrome/fetal alcohol effects; violence against Aboriginal women; and traditional healing). In particular, research is needed to determine the effectiveness, efficiency, feasibility, and community acceptance of targeted interventions to improve maternal-child health outcomes. Examples include service delivery by lay health-care providers and/or traditional midwives; cross-cultural validation of perinatal assessment/screening tools; development of culturally relevant perinatal health indicators in First Nations, Inuit, and Métis communities; strategies to support management of high-risk pregnancies in geographically isolated communities; and identification of best practices for maternal-child health care in Aboriginal communities. A second priority area for nurse researchers is rural and remote nursing.

For example, little research done been done on the impact of nursing educational preparation, vacancies, turnover, and health human resource management practices on key indicators of First Nations and Inuit client and community outcomes. As well as directly benefiting Aboriginal people and nurses working in Aboriginal communities, lessons learned from nursing practice and research with rural and remote Aboriginal communities may be relevant to innovations required in the broader Canadian health-care system. The knowledge needed to implement the primary health-care reforms identified by the Kirby (2002) and Romanow (2002) commissions, and the subsequent commitments set out in the First Ministers' Accord (Government of Canada, 2003), may be informed by an examination of health-services delivery in rural and remote Aboriginal communities.

Conclusion

To summarize, the issues and opportunities involved in improving maternal-child health care in Aboriginal communities is a compelling example of the intersection of gender, culture, and nursing research. Opportunities

to apply nursing research expertise to questions arising from practice in Aboriginal communities are opening up. Funding, leadership, and support for partnership research between Aboriginal people and researchers to address health inequities, access to health services, and professional practice issues are being developed.

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