The Community as Provider: Collaboration and Community Ownership in Northern Maternity Care

La communauté en tant que fournisseur: Collaboration et propriété collective en soins de maternité dans les régions nordiques

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ABSTRACT

Across Canada, researchers and maternity care leaders have identified a crisis in maternity care due to a shortage of skilled providers (obstetricians, family physicians, midwives). For the remote Inuit communities of Nunavut this crisis is about a lack of local maternity care and childbirth brought about by the erosion of local capacity and participation in planning and provision. These communities face difficulties recruiting, training and retaining skilled providers. They also experience a lack of consistency in providers and services within and across Aboriginal communities in Canada, and system dependence on the evacuation of women in remote communities for childbirth.

System dependence on evacuation for childbirth has effectively removed childbirth from Nunavut families and communities. Across Nunavut, efforts to return childbirth to communities have been challenged by a lack of mobilization of providers and communities, concerns about safety, and relationships between communities, providers, decision-makers, and various levels of government.

From November 2002 to December 2004, through a qualitative consultative methodology we examined current maternity care across ten Nunavut communities and their visions for change. We found that a return of childbirth to communities is thus, not simply about hiring more providers and developing local training. This return will require a rethinking of relationships between and collaboration among communities, providers, and levels of government to determine, plan and implement sustainable maternity care for remote, Inuit communities.

While collaboration is crucial to providing sustainable maternity care in remote, Inuit settings, we argue that multidisciplinary collaboration needs to be reframed to include the community. Moreover, we find that collaboration becomes all the more complex in the context of community ownership and historical relationships between traditional and non-traditional providers.

KEY WORDS

Remote maternity care, community participation, collaboration

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RÉSUMÉ

Les chercheurs et chefs de file en soins de maternité affirment qu'il y a présentement une crise en soins de maternité à cause d'une pénurie de fournisseurs compétents (obstétriciens, médecins de famille, sages-femmes) et ce, dans tous le pays. Dans les communautés Inuits du Nunavut, cette crise se traduit par une pénurie en soins de maternité et en parturition due à l'érosion à l'échelle locale de la capacité et de la participation à la planification et à l'offre. Ces communautés ont de sérieux problèmes à recruter et conserver des fournisseurs de soins compétents. Elles font aussi face à une pénurie de fournisseurs autochtones et la formation des Inuits est inadéquate. De plus, il n'y a pas de consistance en ce qui a trait aux soins et services offerts par les fournisseurs dans les communautés autochtones du Canada. Il est aussi très difficile de procéder à l'évacuation des femmes en travail des communautés éloignées dû à la dépendance envers le système.

La dépendance du système par rapport à l'évacuation pour l'accouchement a vraiment éliminé l'accouchement des familles et communautés du Nunavut. Les efforts à ramener les accouchements dans la communauté nunavutmiuk sont mis au défi par le manque de mobilisation des fournisseurs et des communautés, les préoccupations en matière de sécurité, ainsi que les relations entre les communautés, fournisseurs, preneurs de décision et différents paliers de gouvernement.

Une étude méthodologique qualificative en consultation qui s'est déroulée de novembre 2002 à décembre 2004 nous a permis d'étudier les soins de maternité de dix communautés du Nunavut, ainsi que de connaître la vision de ces dernières en ce qui a trait aux changements à apporter. Nous constatons que de ramener les accouchements dans la communauté ne consiste pas qu'à embaucher plus de fournisseurs et à développer la formation à l'échelle locale. Ce retour demandera une réflexion quant aux relations et à la collaboration entre les communautés et les fournisseurs et différents paliers de gouvernements en vue de déterminer, planifier et mettre sur pied des soins de maternité viables pour les communautés Inuits éloignées.

Il ne va pas sans dire que la collaboration est essentielle si on veut fournir des soins de maternité viables en régions Inuits. Nous croyons fermement que la collaboration multidisciplinaire doit être recadrée pour y inclure la communauté. En outre, nous croyons que cette collaboration est encore plus complexe dans le contexte de la propriété collective et des relations historiques entre les fournisseurs traditionnels et non traditionnels.

MOTS CLÉS

Soins de maternité en régions éloignées, participation communautaire, collaboration

Cet article a été évalué par des pairs.

Introduction

Across Canada, researchers and maternity care leaders have identified a crisis in maternity care. This crisis is most often described as a lack of continuity of care due to a shortage of skilled providers (obstetricians, family physicians, midwives)[1, 2, 3, 4] For remote Inuit communities however, the crisis involves both a lack of provider continuity and a lack of sustainability brought about by the erosion of local capacity. Local participation in governance and provision has also been diminished. Remote Inuit communities face difficulties recruiting and retaining skilled providers. Furthermore, access to education for Inuit is limited and therefore there are few Inuit care providers. There is a lack of consistency in providers and services within and across First Nations, Inuit and Métis communities in Canada coupled with health system dependence on the evacuation of women in remote communities for childbirth.[5, 6, 7, 8, 9, 10, 11]

The evacuation of women for childbirth has effectively removed childbirth from Nunavut families and communities. This process began with the earliest introduction of the Canadian health

care system, i.e. the arrival of nurse-midwives, nursing stations, and physician-attended births, and eventually led to the evacuation of women to hospitals in regional or southern centres.[12] Across Nunavut, efforts to return childbirth to northern communities and to ensure Inuit participation in care are challenged by a lack of mobilization of providers and communities, concerns about safety, and relationships between communities, providers, decision-makers, and various levels of government. As First Nations, Inuit and Métis communities work to increase local control and participation in health services, the role of communities to return childbirth has become even more important.

From November 2002 to December 2004, through a qualitative consultative methodology, we examined current maternity care across ten Nunavut communities. We found that health policy and practice have colonized the communities. Evacuation has marginalized community involvement in health care planning and provision while leaving the community unfit for childbirth. A return of birth to the communities will require a rethinking of relationships between the communities, levels of government and health providers to discover how they can collaborate to make change. In the context of the remote community, it is participation and collaboration within and between communities that will ensure the sustainability and continuity of a comprehensive array of services. Moreover, we find that notions of collaboration must be rethought in the context of community control.

In maternity care research and policy development, multidisciplinary collaboration has been hailed as an essential component when addressing provider shortages, improving outcomes and lowering costs to the system To communities, enhancing local participation and collaboration has been thought particularly beneficial for remote, rural, and marginalized communities.[13] Collaboration is most simply defined as "working together in partnership". [14] Barriers to collaboration include jurisdictional issues, flawed regulatory and funding mechanisms, a lack of policy development in professional associations and regulatory bodies, medico-legal concerns and a lack of awareness about various models of care.[13] We suggest that an additional barrier is that the concept of collaboration is often poorly defined and assumed synonymous with networking, coordination, and cooperation.[14] In this paper, we address collaboration in the context of the Inuit struggle to return childbirth to their communities and how the community fits in the collaborative care approach.

Study Context

The participation of Inuit midwives or traditional birth attendants in perinatal care and childbirth has disappeared from Nunavut communities. Currently, nurses are the primary health care providers in Aboriginal communities across Canada. Prior to the introduction of physicians, and nurses through the 1960's and 70's, childbirth took place in large family groups.[5] As communities settled, births increasingly took place in nursing stations and government policy was to hire nurses also trained as midwives. Over the past few decades, with the practice of evacuation for childbirth, nurse-participation in local birthing, apart from pre- and post-natal care has almost disappeared as new policies (e.g., the evacuation policy) on birthing for remote communities have been established. This has occurred despite a thorough review of evacuation policies and recommendations to return childbirth to the communities.[15-18] This highlights both the lack of policy interest as well as the persistence of the Inuit communities. It suggests that gaps in maternity care were not simply symptoms of a transitional moment as Inuit modernized but exist due to more deeply rooted and systemic issues.

Health services planners and decision makers in the North are working to address continuity of maternity care. In many parts of the world, expanding the role of nurses and midwives has improved access to services in rural and remote areas.[19] Moreover, many First Nations, Inuit and Métis communities across Canada have a long history of traditional midwifery and many are calling for a rebirth of this tradition.[20-25] In the early 1990s, in response to Inuit lobbying for childbirth in the community and the high cost of evacuation for childbirth, the Government of the Northwest Territories supported the implementation of a

midwifery-based birthing centre in Rankin Inlet as a pilot project. In 1995, this centre's status changed from a pilot project to a full program with a staff of three midwives, two Inuit maternity care workers and a clerk interpreter. Currently, the birthing centre serves the Kivalliq region allowing many Kivalliq women to give birth closer to home. This approach to maternity care, where midwives and maternity care workers provide care for low-risk birth, consulting and referring to hospital and obstetric services where necessary, has been recommended for the 'developing world' as a means of providing continuity of care and as a site for education of skilled attendants.[26]

In February, 2002, the Government of Nunavut's (GN) Minister of Health and Social Services identified the expansion of community-based midwifery across the territory as a long-term priority. The Rankin Inlet Birthing Centre has since been expanded to a regional service and the territorial government is working to establish more birthing centres while supporting the development of local education for and hiring of maternity care workers across the territory. Although the Rankin Inlet Birthing Centre provides services to women throughout the perinatal continuum, its existence has historically been threatened by high staff turnover and lack of community involvement. Moreover, while this birthing centre resulted from community demand, it is a regional government initiative that has struggled for community input and involvement. Many providers and communities wonder how an expansion of current services will enhance local participation in care.

Partnerships and collaboration between providers, planners, consumers and communities have become key words in efforts to provide continuity and quality of health care.[27-29] Models of community-based maternity care involving collaboration between midwives and obstetricians have been linked to improved outcomes, lower cesarean section rates than standard hospital care, and lower costs in the the provision of perinatal services. [30-32] Moreover, collaborative practice involving midwives has been identified as particularly important for providing and improving continuity of maternity care in Indigenous communities and rural and remote areas.[2, 29, 33]

At the same time, the rebuilding of community control of health services has become particularly important for First Nations, Inuit and Métis communities across Canada. The Innulitsivik Maternity located in Puvirnituq, Nunavik began in 1986 as a community-based centre and is staffed by registered and community midwives as well as maternity care workers. Registered midwives from southern Canada and other countries provide support. The Maternity offered the first formal Aboriginal midwifery education program in Canada, recognized by the Inuulitsivik Health Centre and the regional government. Local Inuit women are the core of the midwifery service. They often begin as maternity workers, then become community midwives, and then, if desired, registered midwives. Moreover, the majority of women in the community give birth at the Maternity and one success of this Maternity has been the development of two additional maternities in Inukjuak and Salluit. The Six Nations Tsi Non WI Ionnakerastha (the Place They Will Be Born) Maternal and Child Centre is a community-based birth and training centre. Unlike the Rankin Inlet Birthing Centre, this centre is controlled by the Six Nations on the Grand River community and blends traditional Aboriginal and contemporary midwifery services and programs.

The Tsi Non WI Ionnakerastha and the Nunavik maternities are based on models of community ownership and involve collaboration among providers. These models work to reframe the community as an equal partner but the emphasis remains on community-control. Communities face significant challenges in working with providers and decision-makers as equals. For instance, registration in l'ordre des sages femmes for graduates is currently being negotiated by Innulitsivik maternity and the provincial government.

Collaborative practice requires increased coordination, more complex interactions, mutual respect and recognition, non-hierarchical structures, leadership commitment and addressing

obstacles such as resistance to change, professional allegiances, and lack of support for midwives.[30, 35, 36]

Collaboration within a model of Indigenous community ownership raises questions about the role of the community as well as how community is defined. It demands that we consider what is meant by collaboration and collaborator. While collaboration is crucial to providing sustainable maternity care in remote, Inuit settings, multidisciplinary collaboration needs to be reframed to include the community.

Research Approach and Methodology:
This research developed out of discussions with researchers, communities, Inuit-representative organizations and territorial government. From these discussions there emerged the need to better understand how Nunavut communities were perceiving existing maternity care and possibilities for change. These discussions gave rise to the following question: What do gaps in maternity care, their contributing factors, and local visions for change tell us about characteristics of sustainable, midwifery-based maternity care for Nunavut communities?

To answer this question we approached health policy and programs in Nunavut as social phenomena that arise out of and within particular social, political and institutional contexts.[37] Through qualitative exploration, we examined assumptions that underlie the maternity care crisis in Nunavut and the implications of these for new models of care and their implementation. In addressing maternity care we treated it as a web of governance including levels of government, communities, and providers and the relationships between them. From this approach, maternity care policy, planning, and delivery become expressions of those relationships and the assumptions, perspectives and contexts that shape them.[36, 37]

Communities:
This research took place largely in the Kivalliq region of Nunavut from November 2002 to December 2004. The presence of the Rankin Inlet birthing center in this region, the only birthing centre in Nunavut, allowed for an exploration of how such a service could be built upon. With seven communities ranging in population size from 400 to 2400, the Kivalliq (known also as Keewatin) region has a population of 7,557 and lies north of Manitoba, east of the North West Territories, south of the Kitikmeot region, and west of the Hudson Bay. We also visited two communities of the Kitikmeot (Cambridge Bay and Taloyoak) and Qikitaani (Iqaluit and Pond Inlet) regions of Nunavut. The Kitikmeot borders the Kivalliq region as well as the Northwest Territories and it has the smallest population. The Qikiqtaani (or Baffin) region has the largest population (14,372) and is the most Eastern of the three. It encompasses Baffin Island as well as some of the Islands to the north west approximately half of Nunavut's land mass (twice the size of the two other regions). This region is home to Iqaluit, the capital city of Nunavut, and the territory's only hospital.

Inuit carving:
Eli Elijassiapik, sculptor
Private collection

Table 1: Participant List

Participant Description	Identifier	# That Participated in Interviews & Workshops*
Community Health Nurses Nurses working in a nursing station or health centre	CHN	7
Nurses-in-Charge Senior nurses in a nursing station or health centre	NIC	8
Community Health Representatives	CHR	5
Maternity Care Workers	MCW	2
Non-Inuit midwives working North of 60 and trained in university-based program in Southern Canada or another country (Australia, New Zealand, England)	Northern Midwife	5
Inuit midwives trained through apprenticeship in community	Inuit Midwife	3
Elders: Inuit considered by the community to be of a certain age (usually older than 55) and holding particular kinds of knowledge and experience and authority	Elder	16
Educators working in a community-based prenatal nutrition, prenatal or postnatal initiative	Perinatal educator	5
Coordinators of community-based family support or resource program (such as Headstart or Healthy Moms Healthy Babies)	Family resource coordinator	3
Physicians working in the North either stationed in one community or rotating between communities	Northern Physician	4
Consulting obstetricians based in Winnipeg, Manitoba	Obstetrician	1
Local Inuk between the ages of 18 and 55 with children living at home	Inuit mother or father	25 women 9 men
Local non-Inuk, long-time northerner, between the ages of 18 and 55 with children living at home	Non-Inuit mother or father	6
Senior level government decision-makers	Decision-Maker	2
Health program planners and/or administrators with regional, territorial or federal government	Planner	3
Other (Southern Midwife, Nurse)		2

** These numbers reflect only those participants who consented to having their discussions recorded (either verbally or in writing). We also spoke with dozens of other Inuit mothers and fathers. While we do not quote them, their discussions also inform the results of this research.*

Study Design:

This study is grounded in a qualitative, participatory methodology employing three primary methods: (1) semi-structured, in-depth interviews; (2) community consultation workshops, and (3) document analysis of public planning and policy documents on maternity care in Nunavut and elsewhere. Consultations and interviews were conducted by university- and community-based researchers in partnership with community-based advisors. Study participants included community health representatives (CHRs), Elders, physicians, midwives, prenatal program providers, mothers and others (see Table 1). The research team met, by teleconference, prior to and following community visits to explore results of these consultations. The research team read interviews paying attention to dominant themes and then shared these with the project partners. This process informed community visits and final analysis. Through analysis of interviews, community consultations, and documents, we considered the ways in which maternity care was talked about, organized, and addressed by various stakeholders as well as visions for change.

Results

Through the course of this study, maternity care and its planning and provision emerged as very fragmented and disparate. Participants suggested that building stronger relationships and partnerships between stakeholders is crucial and they emphasized the role of the community in planning and provision.

A. Fragmented maternity care planning and provision

There has been little consistency in perinatal programming and provision has been largely dependent on local initiatives. Baker Lake, for instance, has several programs that support maternal-infant health in the community. Both the Pre-natal Nutrition Project and Healthy Moms Healthy Babies (both federally-funded programs) have been longstanding programs in the community due to the continuity of leadership. The continuity of leadership strengthens capacity for ongoing funding applications which in turn helps to ensure the continued existence of these programs. Several community members suggested that the success and connectedness of some Baker Lake programs is due partly to the quality of relationships within the community and a broad sense of community strength. Community leadership,

however, was not consistently supported in any formal way by funding or broader territorial or federal planning efforts.

While some communities have several resources for pregnant women and their families, other communities do not. Providers might be hired and funding might be granted, but there is often no funding for infrastructure and no support for workers and programs. Programs exist in relative isolation from one another, from community health centres, and regional and territorial programs. Local programs survive from funding to funding (through territorial and federal funding programs) and long-term sustainability is threatened by staff turnover, lack of leadership and support. A nurse explains her effort to run a prenatal program in addition to her work as a nurse in the community:

> *I tried to run the prenatal nutrition program here in [the community]. I got funding and I managed to make it through the year. I had about 10 women and it was a very popular course, everybody enjoyed it, they loved coming. It was exhausting for me because I would finish a day of work and then do another three hours between start and finish of this prenatal class. It was definitely beneficial to the ladies, but I just couldn't continue it. Plus I was also finding the funding, finding a place to hold the class that night. . . (Nurse-in-Charge)*

Several nurses-in-charge (NICs) explain that the pregnant women in their communities receive regular prenatal clinical assessments but they do not have time to address perinatal education. Moreover, nurses and CHRs often do not have the expertise in perinatal education. As a result, pregnant women receive a lack of meaningful communication with providers:

> *When I was going to deliver my youngest one, they told me I was high risk. I didn't understand what high risk was. I thought the baby was high. They thought the cord was around the baby's neck. (Inuit mother, Baker Lake)*

Local women stated that they do not get support from one another as they might have in the past and feel rather isolated during pregnancy. And providers and planners vary in their understanding of available maternity care and of alternative approaches to maternity care. Community Health Nurses (CHNs) are aware of other perinatal programs in their communities (such as Prenatal Nutrition Programs) and some are aware of Inuit Midwives. Many providers, however, do not know where the local expertise lies and find it difficult to create the necessary bridge between their work and that local expertise.

Many suggest that a midwifery-based approach to perinatal care would address provider shortages and would be more suitable for communities because of the specific expertise of midwives and the long tradition of Inuit midwifery. There are, however, several structural barriers to practice in Nunavut which exacerbate recruitment and retention problems. Currently, midwives in Nunavut practice outside of any midwifery legislation. This has implications for their abilities to become insured as midwives. And it speaks to the past lack of commitment and support for midwifery practice at a territorial level. The Government of Nunavut (GN) has recently supported efforts to develop a Nunavut Association of Midwives. This territorial effort, however, is evolving within a broader national context where structural barriers to full utilization of midwifery remain, despite continued growth and development of the profession in many parts of Canada. These barriers include lack of legal recognition in some parts of the country and lack of recognition for midwifery as a fundable position on First Nations reserves.[7] To overcome these barriers, the federal government (primarily through the First Nations and Inuit Health Branch of Health Canada), the Society of Obstetricians and Gynecologists of Canada (SOGC), several provincial and territorial governments, and First Nations, Inuit and Métis representative organizations and communities are working to address recognition, legislation, and access. With the absence of mechanisms to engage local communities and maternity care activists, however, communities find it difficult to participate in territorial and national planning processes. Community members point to the need for their own involvement in the development of education and training and in the planning and provision of services.

In discussing the development of local education, community involvement arises as an important issue.

We need training programs where we don't just come to you or to university. We also need input of people from here, who have been delivering babies for years afters years, on their own. (Elder, Coral Harbour)

In 2004 the territorial government made a commitment to develop maternity care worker (MCW) education across the territory and hire MCWs for communities. The GN has partnered with Manitoba's Aboriginal Midwifery Education Program and has appointed local people to develop its own MCW education with two students who began September, 2005. Participants suggested that this education must link with further education. Moreover, if this education initiative is not part of a broader, more comprehensive and long-term approach to maternity care in Nunavut, newly-trained providers may find themselves working in isolation and without support.

B. Stakeholder Relationships: Where is the Community?

Community members perceived various problems associated with the arrival of "outsiders", i.e. maternity providers from outside the community. For example, women being sent out for delivery instead of having children in the community, which has always been our practice.

"[Childbirth] was taken away from us, instead of enbancing it. They shouldn't have taken it away, they should have supported what we had." (Inuit mother)

When talking about maternity care, study participants point to a divide between the strong and widely held collective memory of an Inuit history of birthing in the North and an imposed southern approach to childbirth. Inuit participants share a strong sense of their history of birthing as a people. Many participants tell stories about their parents' experiences, their own births and the births of their children.

"My mother delivered when they were hunting on the land. When they were out caribou hunting she delivered a baby. That's how brave and capable they were" (Inuit Midwife, Pond Inlet)

"When you are in labour for the first time, it is a little frightening. And it is your first time being with Elder women it's a little scary. I was supported by the women and delivered by Inuit women. The way they position you is very different. It is much more comfortable." (Elder, Pond Inlet)

Participants did not speak about health centres as community-based but as being from or of the South and as non-Inuit or Qallunaat. When asked about current maternity care, many participants struggle to find the words to talk about it often unaware of terms such as "maternity care" or "maternal-child health". Communities differ widely in their experiences of and access to maternal-child health services. There is little awareness of any shared perception of a current maternity care strategy or program.

This divide between North and South, Inuit and non-Inuit contributes to a second element of maternity care talk – the lack of dialogue between communities and institutions that govern and provide for certain services and programs. Health care is administered from a regional level and communities have few means of participating in planning and provision. Many communities have active Health Committees and some current capacity through already established community-based prenatal initiatives and early childhood and parenting resources. Arviat's community wellness committee, for example, has persisted in its decades-long effort to bring birthing back to Arviat and to ensure sustainability of perinatal care. Initiatives such as these, however, are often overlooked at regional planning levels and there is little integration of services. This lack of integration meant that new services and programs are often not developed with existing services in mind.

The reliance on evacuation has for some, made the local context unfit for childbirth, marginalizing local community-based practice and expertise. In her exploration of birthing in Northern Manitoba, Shirley Hiebert found that the evacuation policy has contributed to a fear of birthing locally for some Aboriginal women.[6] Similarly, some participants

feel that their communities are no longer safe places for childbirth. One Inuit mother explains:

"Even though it's not the 'Inuit way' to have a baby in a hospital, lots of women feel safer." (Inuit mother, Rankin Inlet).

Most Nunavummiut, including many Elders, have given birth with physicians or obstetricians attending all or some of their births in a hospital in Iqaluit, Winnipeg, Churchill, Ottawa or Yellowknife. This process of making birth a hospital event has contributed to a fear of non-physician care and of birthing locally. One northern physician explains the difficult position he finds himself in when considering the possibility of local birth:

"I know it's very frustrating to women who have to leave perhaps even at 36 weeks to go down south. . . But having done about 1200 deliveries, my concern is what happens if things go wrong. You can do the risk stratifications nicely for high risks and low risk but there are still low risk people, one out of 30 times, suddenly the heart drops and right then you have half an hour to get to the plane, a two hour flight. . . Obviously, they've been doing that in Rankin for a long time. We just have to accept that." (Northern physician)

While local confidence in community-based knowledge and expertise has been eroded, Nunavummiut still hold onto a strong sense of capability within and across their communities. Local women continue to resist the marginalization of the local and the imposition of southern approaches and continue their efforts to develop approaches that fit the remote, largely Inuit communities of Nunavut.

"Babies born in the community are considered special babies. . . Some women try to fool us, they lie about their last period so we have to try to get them out for an ultrasound."(Nurse-In-Charge)

At the same time, local Inuit feel that they have little say in program development and implementation.

"When we have been told too many times that "we can't do this and that", it seems to be the dead end… When you are told that constantly, it becomes a way of ignoring you. Therefore, we in the north have to start pushing harder for what we believe in." (Elder, Coral Harbour)

C. Visions for change:

"Why can't you have babies in places where you live? Even in small communities, like Bay Chimo, Bathurst, Gjoa Haven. Why should they have to fly them somewhere?" (Inuit father, Cambridge Bay)

This participant points to the importance of place in Nunavummiut notions of birth and to the politics of place. Across communities, study participants identified the return of childbirth to communities as crucial to both the sustainability of maternity care programs and the survival of their communities.

When talking about community birthing, many participants refer to the importance of community both as the place of birth and as a resource or source of support for birthing. The community is referred to as a stakeholder in childbirth just as providers, women and their families. Some point out that when women are able to have their babies in their communities with skilled attendants the positive outcomes are numerous, as one new mother in Rankin Inlet explains:

"I was able to have people around with me. My mom was there. There was no question I wanted my mom there. She's been through everything with me. I wanted the baby's father there. He wanted to be there. And the father's mother because she wasn't there for her first grandchild. . . I had lots of support." (Inuit Mother, Rankin Inlet)

Discontinuities in perinatal programs and services, the lack of dialogue among providers and communities, and the success of the Six Nations and the Nunavik maternities suggest that the sustainability of a maternity care approach will depend partly upon the commitment and sense of ownership at the community level. It must emerge out of local perceptions of maternity care. It needs to build on local capacity to bring birth back to the community. To foster collaboration and partnerships policy-makers, planners and providers must recognize and support the range of providers involved in maternity care: traditional midwives, southern-trained midwives, nurses, perinatal educators and resource providers, maternity care workers, Elders, family physicians and consulting obstetricians. There needs to be recognition of roles and expertise, collaborative education

curricula, awareness of northern and remote practice, peer support, legislation and regulation, and remuneration processes that fit northern, remote practice.

Recognizing the community as a provider and re-centering Inuit knowledge and experience will require that maternity care be informed by Inuit Qaujumajatuqanjut (IQ). IQ is defined as Inuit traditional knowledge, expertise and experience. However, this definition fails to capture the breadth of the term as well as the evolving, fluid quality of this knowledge, expertise, and experience. Reducing IQ to the ways in which things were done long ago risks the oversimplification of IQ and its role in maternity care governance. An IQ-led governance could be equated to the gathering of stories about birthing on the land. While IQ certainly includes these ways, participants describe IQ as an ever-evolving, all-encompassing approach to life that is rooted in Inuit history and experiences of living on the land, colonialism, includes the settlement of communities and the imposition of Western European religions and southern Canadian health care. One Elder suggests that in order to appreciate the evolving nature of IQ we should think of it as Inuit experiences rather than traditional knowledge.

> *"Whenever someone says "Inuit Qaujimajatuqangit", I asked myself what are Inuit qaujimajatuqangit? I personally think, the name should change. It should change to Inuit Atursimajangit (Inuit experiences). It would be much better to identify exactly what the Inuit traditions are." (Elder)*

Based on a long history of traditional midwifery, experience with the midwives at the Rankin Inlet Birthing Centre, and a growing awareness of the growth of midwifery in Nunavik, many participants see a model based on midwifery practice as an appropriate approach to providing this continuum of care. They see this midwifery, however, as part of a broad community-based approach that includes various providers. The centrality of nursing in current Aboriginal health care and the salience of midwifery in the provision of maternity care for Aboriginal communities suggest that we need to consider both in any strategies to address the current maternity care crisis.

While study participants point to the need for local birthing centres there is widespread understanding that everything cannot be done locally and there is desire to couple Inuit expertise with non-Inuit expertise. There is also demand for integration of services and programs and linkages with provider resources such as those available to Kivalliq family physicians through the J.A. Hildes Northern Medical Unit (NMU) at the University of Manitoba. While regions operate separately when it comes to health care and draw on different resources maternities should be part of an overall territorial program. Local maternity care activists are working to develop a territorial midwifery association, legislation, regulation, and education program. Moreover, the governance of hospitals and health centres in which the midwives work need to include southern and Inuit midwives as part of the decision process. Otherwise they can be marginalized and services can struggle to survive or grow.

Discussion

The results of this study support other research and evaluative processes that recommend collaboration, sustainability, cultural relevance, and community-based services and education as important elements of new maternity care models for remote and Aboriginal communities. We found that in the context of the remote community, it is, ultimately, participation and collaboration within and between communities that will ensure the sustainability of a comprehensive array of services. This combination of participation and collaboration is necessary to return birth to remote communities. This is not simply about community-involvement but community ownership and participation in a partnership with other stakeholders as equals. Such a partnership challenges researchers, decision-makers, planners, providers, and communities to overcome obstacles that are rooted in the colonialist history that underlies the current health care system.

Aboriginal communities have long struggled to bring birth closer to home and evidence supports community-based maternity care for rural and

remote communities.[21-25] Moreover, evidence shows that maintaining community-based maternity services for rural and remote communities improves obstetric and neonatal outcomes.[23, 29] We found that community-based means community-ownership. Programs need to develop out of and be sustained by the communities that need them. As a community-based, community-driven approach, programs need to be flexible and fit the differences as well as the similarities across communities. Policies and programs must build on and foster local capacity (education, infrastructure, experience and expertise, and mobilization to make change). Inuit-representative organizations can play important roles in fostering local capacity and the quality of relationships with municipal, regional, territoria, and federal levels of government will have implications for community involvement.

While community ownership is crucial to sustainability, so is collaboration, both within and beyond the community. As participants suggested, the remoteness of Nunavut communities requires collaborative partnerships that provide access to a comprehensive range of services. Collaboration within the context of Inuit community ownership, however, will be complex. This context demands attention to what collaboration means to all partners and where the community fits into collaborative care partnerships. Who are the collaborators and what are their roles? What are the goals of collaboration? How can equity among collaborators be achieved? Do partners respect and recognize others in the collaborative relationship as equals?

In outlining a hierarchy of partnership, Himmelman[14] placed networking at the bottom as the least formal partnering for sharing information. Coordinating (exchanging information and altering activities) and cooperating (coordinating and sharing resources) are the next two, while collaborating is at the top and involves a partnership aimed at altering activities where partners exchange information, share resources and enhance the capacity of the others.[14] This type of partnership requires equity among partners and respect and recognition of each other. In the context of Northern Aboriginal maternity care, this will require a rethinking of how stakeholders contribute to marginalization of certain kinds of knowledge and types of providers, such as traditional Inuit midwives as well as southern trained midwives. In addition, it will require a rethinking of collaborative care to include the community as one of the many provider types.

In order to streamline maternity care discouse, we must address barriers between providers, researchers, communities, and decision-makers. Clearly defined roles (federal, territorial/provincial, regional, community) will enable a comprehensive approach that must be informed by an increase in the evidence base to provide services and care that fit remote, Inuit communities. Moreover, any successful approach to maternity care has to be rooted in a commitment at all levels of government to address legislation, regulation and infrastructure that make community-based program planning possible and provide the necessary environment for continuity of providers.

Community as collaborator will depend on the development of mechanisms for community involvement in collaborative partnerships. Stakeholders must recognize maternity care as delivered by various kinds of providers including traditional and southern trained midwives, nurses, maternity care workers, perinatal educators and resource providers, Elders, as well as family physicians and obstetricians. Moreover, the development of provincial/territorial and federal support for midwifery and expanded nursing practice would facilitate the kind of maternity care northern communities have identified as necessary.

Recognition of IQ, local knowledge and history as well as local capacity are central to developing sustainable programs. New territorial efforts are slowly making local education and births closer to home possible. In late 2003 the Rankin Inlet Birthing Centre hired a second MCW and the regional DHSS is now supporting the development of MCW education, and potentially midwifery education, to be offered at Nunavut Arctic College. With the possibility of territorial expansion and

collaboration with Manitoba's Aboriginal Midwifery Education Program, Nunavut could eventually see local education for midwives. Moreover, efforts to develop a territorial program and establish birthing centres in other regions may succeed in bringing childbirth closer to communities. It is not clear, however, how efforts across regions are connected or how communities are involved in developing program direction and implementation.

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