Reclaiming Birth: Understanding Access to Maternity Services and Supports for Metis Women in Northern Manitoba

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Authors:
Julianne Sanguins
Sheila Carter
Judy Mayer
Julyda Lagimodiere
Leanne Kosowan
Punam Mehta
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Health & Wellness Department
Manitoba Metis Federation
Room 201 – 150 Henry Avenue
Winnipeg Manitoba R3B 0J7
Telephone: (204) 586-8474

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The results and conclusions in this report are those of the authors and no official endorsement by the Manitoba Network Environment for Aboriginal Health Research (s), or other parties, is intended or should be inferred.

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Executive Summary

This report resulted from the need to further understand prenatal and maternity services and supports in northern Metis communities. This information will be used to advise Manitoba Health, the Northern Health Region, and the Manitoba Metis Federation on how they might adapt health programs, services, and policies to better meet the needs of Metis women living in northern Manitoba. This project was a collaborative effort between the Manitoba Metis Federation–Health & Wellness Department, Manitoba Metis Federation The Pas and Thompson Regions, and the University of Manitoba.

In Section 1, an overall introduction to the project and research team is presented. In Sections 2 and 3 we offer insight into the Metis, the Manitoba Metis Federation, and the Health & Wellness Department. The Manitoba Metis Federation Health & Wellness Department (MMF–HWD) conceptual model and approach to ways of knowing are described. In Section 4, a literature review is presented to acquaint readers with themes that have been identified in the larger literature. Section 5 offers a synopsis of the methodology and methods used for this study. A description of protocol for entry into the community is given. Stories and experiences from focus groups with Metis women in four northern communities, and interviews with professional health care providers within the Northern Health Region formed the basis of our community-based participatory research data collection. Data were analyzed by the Collective Consensual Data Analytic Procedure (CCDAP) using coded cards to categorize the data into themes. Ethical considerations, knowledge translation including engagement of Knowledge Networks (locally-based discussion tables between MMF Region staff and the corresponding Health Region staff), and limitations of the study are all described.

In Section 6 experiences of study participants are provided. After a description of the study sample, the experiences of Metis women regarding prenatal and maternity services and supports are presented. Following this, the perspectives of health service providers are given to further our understanding of the experiences faced by Metis women. Issues of northern living weaved through many of the experiences: distance, local availability of health care services, and financial costs of accessing pre- and post-natal care. Program and service needs were discussed in depth. While there were some strong interprofessional linkages identified there were also gaps in programs and services. Other, more sensitive areas, that emerged were: experiences of racism/unprofessionalism experienced by Metis women, attitudes towards Metis Child & Family Services, and violence against women. Health care providers discussed their concerns about Metis teen pregnancy and birth experiences. Finally, in Section 7, the key findings of the study are highlighted.

This research highlighted the experiences of Metis women living in northern Manitoba and the associated influences of this knowledge on policy making and health services delivery, which will ultimately influence the health and wellness of the Metis population. This study adds to a growing body of literature on northern pre- and post-natal health services, while creating a space for information on unique experiences of the Metis women within the Northern Health Region.
Section 1: Introduction

1.1 Research Context

Until recently there was little knowledge of access to maternity services and supports for Metis women in Manitoba. In 2011, a gap in knowledge about prenatal and maternity services for Metis women was identified by Regional Knowledge Networks in The Pas and Thompson. In order to support program and policy responses, and to best support this population, further information related to Metis access to prenatal and maternity services and supports in Manitoba is essential. This report provides an initial examination of this important health issue.

Funding was secured from the Manitoba Network Environments for Aboriginal Health Research (NEAHR). Two members of the Research Team are from Manitoba Metis Federation (MMF): one from MMF The Pas Region and one from MMF Thompson Region. These community collaborators played an important role in the community-based participatory research process.

1.2 The Manitoba Metis Federation

The Manitoba Metis Federation (MMF), founded in 1967, is the “democratic and self-governing body of the Manitoba Metis community” (Manitoba Metis Federation, 2013). The MMF strives to develop and maintain its capacity to act collectively to successfully promote, protect, and advance the political, social, and economic interests of Metis in Manitoba. The MMF negotiates with provincial and federal governments to access funding to provide a wide range of programs and services.

Within the MMF, the Health & Wellness Department (HWD) was established in 2005. The Health & Wellness Department is one of several departments within the Manitoba Metis Federation addressing health, education, and social needs of its members. The Manitoba Metis Federation Health & Wellness Department (MMF–HWD) provides knowledge development, knowledge translation, and supports knowledge implementation for health planning that is focused on health promotion and wellness. The MMF–HWD is committed to improving the health and well being of Metis people in Manitoba. Using a Metis culture-based holistic health framework, the MMF–HWD builds Metis health planning capacity, develops and implements a Metis health research agenda, and acts as a Metis health ‘expert authority’ to advise the health system.

1.3 Background of the Research Team

The Principal Investigator on this study was Dr. Julianne Sanguins. She is an Assistant Professor in the University of Manitoba’s Department of Community Health Sciences and an Adjunct Professor at the Manitoba Centre for Health Policy. Dr. Sanguins is an RN and holds a PhD in Nursing. Dr. Sanguins is also the Knowledge Development Manager in the MMF–HWD and manages academic aspects of all studies that occur in the department.

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1 A Knowledge Network is a locally-based discussion table comprised of members from the Manitoba Metis Federation and Regional Health Authorities.
Sheila Carter is the Director of the MMF–HWD. Ms. Carter has been co-investigator or community collaborator on all of the studies that have occurred in the department, providing expertise in health program and policy development. In this project, Ms. Carter was a member of the team from the project’s inception, and participated in study design and analysis.

Judy Mayer is the Vice-President of MMF The Pas Region, Minister of the Metis Community Liaison Department, and Minister of Metis Child and Family Services. This is the second study in which she has been involved as a community collaborator. As part of her active role on the research team, Ms. Mayer participated in study design and analysis, facilitated entry into the communities, and provided important direction on knowledge translation.

Leanne Kosowan was the Assistant Director of the Manitoba Metis Federation Department of Health and Wellness. Leanne holds a Masters degree in Human Ecology. In this study, Leanne contributed her expertise with the Metis Life Promotion framework to help develop the research questions for our data collection tool and was part of the review of the report.

Julyda Lagimodiere is the Vice President, Manitoba Metis Federation Thompson Region and holds the portfolio of Minister of Justice. This was her first study as a community collaborator. Ms. Lagimodiere facilitated entry into communities, participated in data analysis, and provided important direction on knowledge translation.

Punam Mehta was a research coordinator in the Health & Wellness Department. Punam holds an MSc in Community Health Sciences and has studied midwifery at the University of British Columbia. She currently is enrolled in doctoral studies at the University of Manitoba. For this particular study she facilitated recruitment, data collection and analysis, and created the first draft of this report.

1.4 Goal and Objectives of this Study

The overall goal of this research was for the MMF and the University of Manitoba to develop an understanding of access to prenatal and maternity services and supports for Metis women in northern Manitoba. Based on initial discussions held by The Pas Knowledge Network, as well as anecdotal experiences of Metis citizens in the region, the overarching research question guiding this inquiry was: “What are the experiences of Metis women with accessing prenatal and maternity care in their own communities?”

Specific objectives of this study were:

- To identify and describe existing supports (programs and services) for pregnancy and maternity service for Metis women within the provincial health care system
- To identify and describe existing supports (programs and services) for wellness in pregnancy and maternity service for Metis women in the Northern Health Region
- To identify and describe existing governance structures that support wellness for pregnancy and maternity service for Metis women in the Northern Health Region

1.5 Overview of Sections

Section 1 provides an introduction to the report.
In Sections 2 and 3, the reader is provided with an overview of the Manitoba Metis Federation as well as the MMF–HWD and its holistic approach.

In Section 4 a comprehensive literature review is given to familiarize the reader with current concepts related to maternal health services. In particular background information on prenatal and maternity health providers, issues of northern maternity care, women’s experiences in pregnancy and childbirth, and Northern Manitoba programs for pregnant women during pregnancy and birth are reviewed.

The study design is fully described in Section 5, including the Community-Based Participatory Research approach; criteria for choosing the study area; participant recruitment; ethical considerations; data collection methods (focus groups and key informant interviews using the Metis Life Promotion Framework©); data analysis process (Collective Consensual Data Analytic Procedure); knowledge translation process; and limitations of the study.

Research findings are reported and discussed in Section 6. Several themes were identified from the focus group sessions with Metis women accessing prenatal care and maternity services and support in the Northern Health Region. These included: impact of pregnancy, building and strengthening Metis families and community, and ‘being Metis’. Themes that emerged from discussions with health care providers included: health professionals, inequitable programs and service, Metis women’s birthing experiences, health and social services, and how to influence policy, programs, and services adaptation for Metis. In some cases the themes identified by focus group participants and health care providers were complementary; in other cases there were differences in reported and perceived/experienced services.

Finally, in Section 7, the objectives are revisited. Key findings of the study are highlighted describing the contribution of the present study to the larger body of knowledge on prenatal care and maternity services and supports, while emphasizing knowledge gained about unique experiences of Metis women accessing prenatal care and maternity services and supports in the Northern Health Region.

1.6 Summary

Metis citizens from MMF The Pas and MMF Thompson Regions identified a need for further information related to prenatal and maternity services in their communities. They wanted to know what existed in those communities to support Metis women during these important periods of their life and what was needed to improve these experiences for them. While there was a lot of consistency with the prevailing discourse in the literature, in some focus groups new ideas were expressed. These experiences add to a larger body of knowledge which exists regarding prenatal and maternity health care and services in Manitoba and Canada. Several recommendations arose from this study and the outcomes will augment information that has until only recently been known anecdotally. Current and reliable information collected in a Metis-specific holistic manner can help inform Manitoba Health, and the Manitoba Metis Federation, on how to adapt health programs, services, and policies to better meet the needs of Metis women and their families. The results will be shared with MMF The Pas and MMF Thompson Knowledge Networks and communities involved. Working in collaboration, we can improve the health and wellness of Metis in Manitoba.
Source: David Scott. Reprinted with permission
References

Section 2: The Metis People in Manitoba

Adapted from work by Dr. J.G. Bartlett and Ms. S.R. Carter

2.1 The Metis

The Metis are descendants of early 17th-century relationships between North American Indians and Europeans (Sprague & Frye, 1983). The Metis coalesced into a distinct nation in Manitoba in the late 18th century with unique values, tradition and language. After the 1885 fall of Batoche, “Metis were denied a separate identity and ignored for a century” (McMillan, 1995, pp. 312–313). By 1967, with the formation of the Manitoba Metis Federation, the Metis in Manitoba were again asserting their capacity to advocate and function in a collective manner. In the 1982 amendment to the Canadian Constitution, Metis were named as one of the three Aboriginal peoples of Canada (Government of Canada, 1982).

2.2 Metis Population Demographics

Metis constitute 32.3% of Aboriginal peoples in Canada and numbered 451,790 in 2011 (Statistics Canada, 2013a). Metis are the fastest growing Aboriginal group in Canada, with an increase in population of 91% between 1996 and 2006 (Statistics Canada, 2008). Increased rates of self-identification related to increased sense of safety (verbal communication, Bartlett, 2011) and pride associated with Metis identity, as well as higher fertility rates are largely responsible for this change in demographics (Adams, Dahl, & Peach, 2013).

The number of Metis living in Manitoba is 78,835 with 58.76%, or 46,325 living in Winnipeg (Statistics Canada, 2013b). In the Metis Atlas, the most recent data available for northern Manitoba, the total population of Metis was 8,177 compared to 62,548 all other Manitobans (Martens, Bartlett et al., 2010).

In addition to being the fastest growing Aboriginal group, Metis are a younger population with 25.4% of the population under the age of 15 (compared to 19.1% of other Manitobans). In 2006 only 9.1% of the Metis population was 65 years of age or older compared to 13.9% of other Manitobans (Martens, Bartlett, et al., 2010).

Between the years 1996-2005 there were 126,303 live births in Manitoba, of whom 8.6% were Metis (Sanguins et al., 2013). Metis mothers had a higher proportion of live births between the ages of 15-19 years (13.9% vs. 9.1%), and 20-29 years (62.3% vs. 51.8%) compared to other Manitoban women; they had a lower proportion of live births between 30-39 years (22.9% vs. 37.0%), and 40+ years (0.7% vs. 1.8%). While historically Metis had large families, contemporary Metis families are smaller. The percentages of Metis women with 0 births, 1-2 births, and 3-4 births were similar to those of other Manitoban women with the same parity [(37.0% vs. 38.0%), (49.6% vs. 48.5%), and (9.6% vs. 9.4%), respectively]. Metis women were less likely to have 5+ live births than other Manitoban women (2.3% vs. 3.0%). In both the urban and rural areas of Manitoba, all women showed increasing linear trends for birth rate from the highest to the lowest maternal income quintiles (Sanguins et al., 2013).

In the following figure (2.2.1) we display the distribution of Metis across the province.
Figure 2.2.1: Villages, Towns, Cities, or Unorganized Territories Where Metis Live in Manitoba, 2012
2.3 Study Communities in Northern Manitoba

Each of the study communities is located in the Northern Health Region. The Northern Health Region is the organizing body for healthcare in northern Manitoba, excluding Churchill. It was formed in 2012 by the merger of the former Burntwood and Nor-Man Health Authorities. The Northern Health Region is the largest geographical health region in Manitoba and covers two-thirds of the province (Northern Health Region, 2013).

The Northern Health Region consists of three distinct types of communities: 1) Urban centers (Thompson and Flin Flon); 2) Towns (The Pas, Gillam, Grand Rapids, Leaf Rapids, Lynn Lake, Snow Lake), rural municipalities (RM of Kelsey), and 1 LGD (Mystery Lake); and 3) Numerous hamlets and cottage settlements making up "unorganized territories", 26 First Nations communities and 16 Aboriginal and Northern Affairs communities (Northern Health Region, 2015). Aboriginal and Northern Affairs communities are communities that, under the Northern Affairs Act, are “incorporated and form a separate governmental body consisting of a mayor and council in order to sustainably manage and oversee the interests of the community” (Government of Manitoba, 2012, n.p.). The Metis communities in this region typically fall in the latter category.

The Northern Health Region provides the administration of health care services in northern Manitoba but there are jurisdictional concerns for residents that can create challenges for accessing care (Northern Health Region, 2013). While a variety of health care providers offer care to the communities, access to services may vary depending on a number of factors including Treaty status, registration for social assistance programs, or eligibility for old age pension security benefits. The delivery of these services varies depending on the care provider and accessibility, especially in remote communities; this jurisdictional issue creates gaps in follow-up care and continuity of care for its residents.

Metis obtain services from provincially-run health centers of the Northern Health Region. Unlike First Nations people they do not receive any additional health benefits or services from the federal government. In most First Nations communities, health professionals employed by the local health authority provide community health services, and health professionals from either the Northern Medical Unit, First Nations Inuit Health Branch or Northern Health Region provide physician services. Metis citizens are eligible to access on-reserve federal services if residing in a community adjacent to a First Nation community serviced by the federal government, but we know that this does not always occur for our citizens. Other northern communities are serviced by provincial nursing stations managed by Manitoba Health, with additional services provided by the Northern Health Region. Jurisdictional ambiguities and resource limitations have led to gaps in service availability for Metis citizens (Bent, Havelock, & Haworth-Brockman, 2007).

A challenge the residents of the Northern Health Region encounter is that many communities do not have year-round all weather road access. Access to services and travel issues are major concerns for Metis citizens. Residents of these communities rely on rail, boat, or air service to travel. This access has significant implications for residents in myriad ways including access to education, employment, financial resources, social and health services. Other issues identified by the Northern Health Region include isolation and remoteness, income inequality, transfers of government funding, housing, and access to healthy foods (Northern Health Region, 2015).
References


Section 3: Building Metis-Specific Knowledge

Adapted from work by Dr. J.G. Bartlett and Ms. S.R. Carter

3.1 Introduction

The Manitoba Metis Federation–Health & Wellness Department (MMF–HWD) undertakes Metis-specific health research and implements a province-wide process to enhance the use of this research. In this section we provide an overview of Manitoba Metis Federation (MMF), the MMF–HWD’s use of a Metis-specific lens to build knowledge, and the use of Knowledge Networks to 1) disseminate Metis-specific information; and 2) to engage communities and partners in service and program changes. More complete details can be found in Chapter 2 of the Health Status & Health Services Utilization Study hereafter referred to as the Metis Atlas (Martens, Bartlett, et al., 2010).

3.2 The Manitoba Metis Federation

The Manitoba Metis Federation (2010) requires that to be an Individual Member or Child Member 2 of the Manitoba Metis Federation one must:

1) Self-identify as Metis;
2) Show an ancestral connection to the Historic Metis Community; and
3) Be accepted by the contemporary Metis Community.

For 43 years, the MMF has acted collectively to promote, protect, and advance the political, social, and economic interests of Metis citizens in Manitoba. The MMF negotiates with governments to access funding for programs and services that are better able to meet Metis citizens’ cultural norms.

The MMF has seven regions and a home office, along with a number of associated affiliates. Twenty-one representatives and a president are elected every four years by citizens of the Manitoba Metis Federation as the MMF governing body. Each region elects a VP and two other Board members; all members are eligible to elect the President. The MMF governing body leads, manages, and guides the strategic direction, objectives, and policies of the Federation and its subsidiaries. The President is the Chief Executive Officer, leader, and MMF spokesperson. The MMF has an Executive Director responsible for overseeing the day-to-day operations of the Federation.

3.3 Manitoba Metis Federation–Health & Wellness Department

The MMF–Health & Wellness Department (MMF–HWD) was created in July 2005 as a Metis-specific ‘health knowledge authority.’ The Manitoba Metis Federation Health & Wellness Department provides knowledge development through its chronic disease surveillance program and other funded research programs, knowledge translation via Region Knowledge Networks, and serves as the Metis Health Authority in Manitoba. Through knowledge development and translation the Manitoba Metis Federation Health & Wellness Department (MMF-HWD) supports knowledge implementation for health planning with Regional Health Authorities that is focused on health promotion and wellness. The MMF-HWD is committed to improving the health and well being of Metis people in Manitoba.

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2 ’Child Member’ is a new addition by majority vote on a Resolution at the 2009 MMF Annual Assembly.
Over time the Department has solidified a vision of ‘a well Metis community’ with its mission of ‘creating and facilitating the use of knowledge’ to contribute to improving Metis health status. The MMF–HWD is focused on four main strategies intended to move department activity toward its vision. These include:

- Using a Metis culture-based holistic wellness framework;
- Building Metis health planning capacity;
- Implementing a Metis health research agenda; and
- Developing as a Metis ‘Health Knowledge Authority’ to advise the health system.

Figure 3.3.1: MMF–HWD Strategies

For the MMF–HWD, the Metis Atlas was the foundational research setting the stage for a range of new research and related activities intended to positively impact the health and well-being of Metis citizens in Manitoba. The research team used the Metis Population Database (MPDB) developed for the Metis Atlas for aggregated demographic data for this ‘Reclaiming Birth’ study.

3.4 Culturally Coherent Metis ‘Methodology’ or Lens for Wellness

3.4.1 Ways of Knowing

The MMF–HWD approaches all departmental activities from a Metis-specific perspective. This Metis lens is rooted in the integration of our historic Indigenous and European ancestries to become a unique Metis ‘way of knowing’. Adapted from work by Burton-Jones (1999), the MMF–HWD considers the inclusion of both ‘ways of knowing’ – Indigenous and Western - as appropriate for Metis. This Metis ‘way of knowing’ is holistic, including: Narrative (our story, spiritual); Experience (our experience, emotional); Data (our research, physical); and Information (our synthesis of the first three, intellectual). This simple
approach is used to demystify research, and to ensure each of our activities is approached holistically (See Figure 3.4.1).

**Figure 3.4.1: Holistic Research Model**

The MMF–HWD adapted a holistic framework originally developed for use in an urban Aboriginal community health centre (Bartlett, 1995). The framework was renamed the Metis Life Promotion Framework© (MLPF©) for use with Metis. The MLPF© includes finding balance among 16 important areas that help to determine ‘how our life unfolds’. These 16 areas—that is, the 16 ‘Determinants of Life’—include: spiritual, emotional, physical, and intellectual; child, youth, adult, or elder (senior); individual, family, community, and nation; cultural, social, economical, and political (See Figure 3.4.2). It is critical to keep in mind that the MLPF© is a tool for holistically organizing thoughts and information—it does not ‘represent’ Metis culture.

**Figure 3.4.2: Metis Life Promotion Framework© Determinants of Life©**

Health can be considered a balance of:
In 1996, the framework was adapted to consider ‘Wellness’ (Bartlett, 2004). The 16 ‘Determinants of Life’ were grouped as eight ‘Wellness Areas©’, which made it easier to think about the determinants for health planning and interpretation of research findings. MLPF© Wellness Areas© naturally flow around the spokes of a Red River cart, representing constant motion and change.

Although not explicitly an accepted Metis lens, this tool allows every person engaged in Metis-related health planning to undertake a process whereby they learn ‘how to create’ Wellness Areas© based on their own life experiences. The Wellness Areas© can be used for individuals, families, or groups as well as distinct diseases. Figure 3.4.1 is used to illustrate the use of the Wellness Model for an individual’s birthing experiences.

**Figure 3.4.3: Wellness Model for Examining Reclaiming Birth**

![Wellness Model](image)


**Table 3.4.1: Wellness Areas© Question Type**

<table>
<thead>
<tr>
<th>WELLNESS AREA©</th>
<th>QUESTION: How experiences with accessing prenatal and parturient services affect my:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nature</td>
<td>Sense of who I really am as a person?</td>
</tr>
<tr>
<td>Identity</td>
<td>Experience of how others see me or how I want others to see me?</td>
</tr>
<tr>
<td>Development</td>
<td>Sense of age/ability to express the child, youth, adult, and elder parts of me?</td>
</tr>
<tr>
<td>Relationships</td>
<td>Ability to respect and care for others?</td>
</tr>
<tr>
<td>Networks</td>
<td>Ability to interact with others?</td>
</tr>
<tr>
<td>Supports</td>
<td>Body, and my ability to work and be involved in community?</td>
</tr>
<tr>
<td>Environment</td>
<td>Cultural, social, economic, and political influence?</td>
</tr>
<tr>
<td>Governance</td>
<td>Ability to choose my destiny and future?</td>
</tr>
</tbody>
</table>
3.5 Knowledge Translation

Knowledge Translation (KT) means using what we know from research to influence what gets done in health and social programs and services to improve health. Using KT for this study maximizes benefit for Manitoba Metis citizens. Combining experiential knowledge with the findings from the *Metis Atlas* has resulted in a more holistic base of information to provide direction to Knowledge Networks to work toward improving the health and wellbeing of Metis in Manitoba.

Knowledge dissemination is an essential part of KT and a critical process enabling translation of evidence into policy and practice (Canadian Institutes for Health Research, n.d.). Such knowledge dissemination places emphasis on ‘action’, providing decision-makers with tools to create processes that will help to improve the overall health of Metis in Manitoba.

The findings will be examined at The Pas and Thompson Region Knowledge Network discussion tables in order to identify gaps in services as well as areas in which things are being done well in order to influence program and service delivery by both the Northern Health Region, and the Manitoba Metis Federation. Knowledge Networks provide an ideal venue for knowledge dissemination by encouraging mutual learning and knowledge exchange (Canadian Health Services Research Foundation, 2005). At this level this study will have the most impact—in influencing health policy and programs in Manitoba to improve services for Metis women living in northern areas. For a more detailed description of this process see Chapter 2 in the *Metis Atlas* (Martens, Bartlett, et al., 2010).

The study results are being used to produce this report for the MMF and the funder. We will have opportunity to confirm and build on these ideas as we continue to engage with Metis citizens in Manitoba in future research and in knowledge mobilization activities with regional Knowledge Networks. Information will be disseminated to the communities in a newsletter, in public sessions, and at the MMF Region and Annual General Assemblies.

The information will also be used by other Knowledge Networks throughout the province to consider access issues within their jurisdiction. This grassroots use of the outcomes enables identification of issues that are locally driven and relevant within the local context. Given that decision makers sit at the Knowledge Network table, this process offers a unique and strategic approach to Knowledge Translation. Any policy issues arising from this study will be brought to the monthly meeting between MMF-HWD and the provincial representatives of Aboriginal and Northern Health Office (ANHO) for discussion.

3.6 Summary

The Manitoba Metis Federation Health & Wellness Department has a well-established partnership with Manitoba Health, and has further developed that partnership through Knowledge Networks with the Regional Health Authorities. These partnerships ensure Metis involvement in decision-making within the health system around health planning, and policy, program and service delivery. Working within these partnerships, specific needs for knowledge are identified. The Health & Wellness Department is ideally placed to respond and create Metis-specific health knowledge for further use by the Knowledge Networks, as well as for others interested in Metis health. Use of our conceptual model ensures that both Indigenous and Western knowledge are used, marrying our stories and experience with data and facts in order to create as holistic and accurate findings as possible.
In the case of this study *Reclaiming Birth: Understanding Access to Maternity Services and Supports for Metis Women in Manitoba* the need for the study was identified by the Region Knowledge Networks. Members of the Manitoba Metis Federation were members of the research team. Results will be shared with the study participants, study communities, the Northern Health Region, and within the larger community of individuals interested in Metis health.
References


Section 4: Literature Review

4.1 Pregnancy and Prenatal Care

The health and well-being of women during pregnancy, childbirth, and postpartum is known as maternal health (Souza et al., 2013). All preventive and curative services introduced to the mothers during these periods collectively represent a continuous process of development for mothers and their expected infants (Romano, Cacciatore, Giordano, & LaRosa, 2010). For the purpose of this report it has been divided into three phases.

4.1.1 Prenatal Care

The antenatal or prenatal care period is the time from conception to birth (Ota et al., 2012). Having adequate, comprehensive prenatal care is one of the most important factors in ensuring the future health of infant and mother (Hediger, 2011). Historically, prenatal care for Metis women involved a diet based on ‘country’ foods (beaver, muskrat, rabbit), support of the community, particularly other women, and involvement of the local midwife in their pregnancy and delivery (Infinity Consulting, & National Aboriginal Health Organization, 2010).

Contemporary prenatal care involves visits and assessments with a maternity care provider. In Canada it is recommended that prenatal care consist of at least six prenatal visits (Wilson, et al., 2013). A common prenatal visit includes complete/updated history, pelvic exam, fetal heart rate monitoring, obstetrical ultrasound, genetic testing, blood pressure, glucose testing, and preparation for labour and delivery (Cunningham et al., 2010a; Fraser & Cooper, 2009). Throughout pregnancy, the fetus is monitored for adequate growth and also screened for genetic and congenital anomalies (Cunningham et al., 2010a; Fraser & Cooper, 2009).

The first prenatal visit is considered the most important in prenatal care as it provides an opportunity for maternal health care providers to engage women in preventative care and ideally should occur between 11 - 13 weeks of pregnancy (Nicolaides, 2011; Wilson et al., 2013). Aims of the first visit are threefold: assess the health of the mother and fetus; establish the gestational age of the fetus; and in collaboration with the mother develop a plan for continued prenatal care (Cunningham et al., 2010a). Preventative recommendations include diet (Lucas, Charlton & Yeatman, 2014), use of tobacco (Cunningham et al., 2010a), multivitamins including iron and folic acid (Lucas et al., 2014), and drug/alcohol consumption during pregnancy (Cunningham et al., 2010a; Jones, Bailey, & Sokol, 2013). It is also recommended that prenatal care providers complete a domestic violence screening tool (Cunningham et al., 2010a).

In Winnipeg Manitoba, Aboriginal women (including Metis) were five times less likely than non-Aboriginal women to access prenatal care that met the Society of Obstetricians and Gynecologists’ guidelines (Heaman, Gupton, & Moffat, 2005). Factors influencing adequate prenatal care included lower family income, unemployment, education, single-parent families, immigrant status, smoking during pregnancy, and Aboriginal ethnicity. In other studies, the highest rates of inadequate prenatal care in the province were reported in northern Manitoba and inner-city Winnipeg (Heaman et al., 2007; Heaman et al., 2012). Specifically, it was found that the highest rates of inadequate prenatal care were among women in the lowest average income, recent immigrants, Aboriginal women (including
Metis), single parent families, women with fewer than nine years of education, and women with higher rates of smoking. Heaman et al. (2014) identified several barriers to accessing prenatal care in inner-city women (including ‘Aboriginal’) in Winnipeg. They reported significantly higher feelings of depression (33% vs. 4.4% in controls) and concerns about apprehension of their infant as factors that increased the likelihood that a woman would not seek prenatal care. Fear of child apprehension was also cited by Denison, Varcoe, & Browne (2013) as influencing Aboriginal (including Metis) women’s decisions to access health care of any type for themselves. First Nations, Metis and Inuit women may have had negative experiences with child protection services that may impact their interaction with the health care system (Wilson et al., 2013). One other barrier to accessing prenatal care that has been identified is intimate partner violence (Cha & Masho, 2014).

4.1.2 Pregnancy-Related Complexities

Most women experience healthy pregnancies with few, if any, untoward occurrences. There are more complex pregnancies that require ongoing observation and at times intervention by skilled care providers to ensure mother and fetus experience good outcomes. Included in these are gestational diabetes, hyperemesis gravidarum, hypertension disorders of pregnancy, multiple pregnancy, false labour, and preterm birth. Women experiencing any of these conditions require more intensive prenatal care (Fraser & Cooper, 2009; Hediger, 2011).

**Gestational Diabetes**

Maternal gestational diabetes mellitus (GDM) alters the intrauterine environment for fetal development that may affect risk factors for chronic disease later in life (Ben-Haroush, Yogev, & Hod, 2004). Women who develop GDM are believed to have a compromised ability to adapt to the multiple metabolic changes occurring in pregnancy. Gestational diabetes mellitus is estimated to be found in almost 4% of all pregnancies – even up to 14% in some populations (American Diabetes Association, 2005). In Canada, rates of GDM have increased from 40.8/1000 deliveries in 2004/05 to 54.5/1000 in 2010/11 (Public Health Agency of Canada, 2014a).

Gestational diabetes is a temporary condition; typically once women with gestational diabetes have given birth, their blood sugar returns to normal levels however they are likely to develop gestational diabetes in subsequent pregnancies (Holmes, Casey, Lo, McIntire, & Leveno, 2003). Moreover, there is a greater likelihood they will develop Type 2 diabetes within five years of the initial diagnosis of gestational diabetes (Ben-Haroush et al., 2004; Kim, Newton, & Knopp, 2002; Lauenborg et al., 2004; O’Sullivan, 1984). Women with gestational diabetes are more at risk for preeclampsia, premature rupture of membranes, and delivery by cesarean-section (Xiong, Saunders, Wang, & Demianczuk, 2001). The rate of gestational diabetes in Metis women in Manitoba is unknown.

Screening for gestational diabetes typically occurs between 24 and 28 weeks of gestation (Adams, Alexander, Kirby, & Wingate, 2009; Thompson et al., 2013). The preferred method for screening as suggested by the Canadian Diabetes Association Clinical Practice Guidelines Expert Committee is beginning with a 50 gram glucose challenge test with a blood glucose testing one hour later (Bernstein & Van Buren, 2013; Thompson et al., 2013). This test will assist in determining further action for screening. If results are above ‘normal’ levels (>7.8 mmol/L), then a 75 gram glucose challenge (GTT) is done with blood sugar levels measured at 1, 2, and 3 hours post-glucose load (Bernstein & Van Buren, 2013). The first line of
treatment for women with gestational diabetes is dietary changes and glucose monitoring (Thompson et al., 2013). If after two weeks of dietary change blood sugar levels continue to be consistently high (> 7.8mmol/L one hour after eating) then pharmacological interventions such as insulin will be recommended (Thompson et al., 2013). Women with gestational diabetes will need to be monitored closely throughout labour and delivery to ensure blood sugar levels that are in a safe range - not too high or too low - and should be screened between 6 weeks and 6 months postpartum to detect the development of more permanent diabetes (Thompson et al., 2013).

Complications for an infant whose mother has gestational diabetes include higher rates of high birth weight (American Diabetes Association, 1999; Cunningham et al., 2010a; O'Sullivan, 1984; Xiong et al., 2001), preterm delivery (Xiong et al., 2001), the potential for developing Type 1 diabetes (Dornier, Plagemann, Neu & Rosenbauer, 2000) and earlier onset of Type 2 diabetes (Dabelea et al., 2008; Dabelea, Knowler, & Pettit, 2000). Comprehensive prenatal screening and monitoring are important approaches to identify and support women.

There is an association between mothers with gestational diabetes who breastfeed and reduced likelihood of childhood obesity (Arenz, Rückerl, Koletzko, & von Kries, 2004). Obesity in childhood has been linked to the development of Type 2 diabetes (D’Adamo, & Caprio, 2011).

Hyperemesis Gravidarum

Prenatally, women typically experience nausea and vomiting which typically abates by 22 weeks (Lacroix, Eason, & Melzack, 2000; Quinlan, & Hili, 2003). Often it is the first indication of pregnancy. Although an uncomfortable occurrence that may result in mild dehydration it is not life threatening (Adams, Alexander, Kirby, & Wingate, 2009; Gadsby & Barnie-Adshead, 2011). The cause of nausea and vomiting in pregnancy has not been clearly determined but it is suggested that it may be due to rising levels of hormones human chorionic gonadotrophin and estrogen (Cunningham et al., 2010a).

A more severe condition, hyperemesis of pregnancy, occurs in about 1% of pregnancies (Fell, Dodds, Joseph, Allen, & Butler, 2006). Hyperemesis gravidarum is an extreme form of nausea and vomiting characterized by dehydration, weight loss (up to 5%), and ketonuria (Bernstein & VanBuren, 2013). Extreme cases of hyperemesis gravidarum may result in hospitalization to mitigate imbalances in fluids and electrolytes (Bernstein & VanBuren, 2013). In these instances, intravenous therapy, antiemetics, and parenteral nutrition, if needed, are administered (Bernstein & VanBuren, 2013). In order to monitor and support women, it is important that ongoing assessment of nausea be part of comprehensive prenatal care.

Hypertensive Disorders of Pregnancy including Preeclampsia

There is a spectrum of hypertensive disorders of pregnancy ranging from hypertension, preeclampsia and eclampsia (Williams, 2011). Hypertension in pregnancy is defined as a diastolic blood pressure that exceeds 90 mmHg (Public Health Agency of Canada, 2014b). It can be categorized as either pre-existing or newly developed with pregnancy (gestational). It is reported that even a slight increase in blood pressure may be indicative of preeclampsia and can lead to complications for both mother and fetus due to restricted blood flow to the placenta.
Preeclampsia is a serious condition that affects about 4% of pregnant women (Ananth, Keyes & Wapner, 2013; Creasy, 2013). Preeclampsia is a complication distinguished by increased maternal blood pressure diagnosed after 20 weeks gestation and signs of damage to other organ systems including the kidneys (Williams, 2011). Preeclampsia is characterized as increased blood pressure (systolic blood pressure > 140 mmHg or diastolic blood pressure > 90 mmHg) accompanied with proteinuria that has newly developed with pregnancy (American College of Obstetricians and Gynecologists Task Force on Hypertension, 2013). While the exact cause of preeclampsia is unclear preeclampsia is believed to be caused by increased hormones of pregnancy or immune response to the fetus (Fraser & Cooper, 2009). Preeclampsia is a leading cause of maternal morbidity, mortality, and preterm birth (Royal College of Obstetricians and Gynaecologists, 2010). Preventive measures such as dietary changes including reduced sodium intake, supplementation with calcium, fish oil, or antioxidants, have been proposed but none have been found effective (Cunningham, Leveno, Bloom, Hauth, Rouse, & Spong, 2010b).

In Canada in 2010/2011 the rate of women diagnosed with gestational hypertension (i.e., did not have before they were pregnant) with proteinuria was 46.3/1,000 deliveries (Public Health Agency of Canada, 2014b). Rates varied with age, with higher rates being seen in women 40+ years of age. Overall rates of pre-eclampsia remained stable between the years 2004/2005-2010/2011 ranging from 12.3 to 11.5/1,000 deliveries (Public Health Agency of Canada, 2014b).

Untreated preeclampsia can lead to eclampsia. Women with eclampsia can experience severe seizures followed by pulmonary edema and in rare cases, death (Cunningham, 2010b). In Canada rates of eclampsia decreased from 1.5 to 0.8/1,000 births between the years 2004/2005-2010/2011 (Public Health Agency of Canada, 2014b).

Hypertensive disorders place women at an increased risk for placental abruptio and associated hemorrhage, acute renal dysfunction, disseminated intravascular coagulations, and HELLP syndrome (hemolysis, elevated liver enzymes, and low platelets) (Hauth et al., 2000; Zhang, Meikle, & Trumble, 2003). Women with hypertensive disorders of pregnancy demonstrate higher risk for developing thromboembolism, hypertension and death from cardiovascular disease (Bellamy, Casas, Hingorani, & Williams, 2007; Samuels-Kalow et al., 2007; van Walraven, Mamdani, Cohn, Katib, Walker, & Rodger, 2003).

Identification of hypertensive disorders of pregnancy is achieved by screening asymptomatic women at routine prenatal visits. Management of preeclampsia involves ongoing maternal and fetal monitoring, and blood work (Royal College of Obstetricians and Gynaecologists, 2010). Clinical practice guidelines suggest that women at high risk of developing preeclampsia should be treated prophylactically with low dose Aspirin starting at 12-20 weeks of gestation (Royal College of Obstetricians and Gynaecologists, 2010). Those at high risk are women with any of the following: autoimmune disease, chronic hypertension prior to pregnancy, pre-gestational diabetes, preeclampsia in previous pregnancies, BMI prior to pregnancy > 30 kg/m2, or pregnancy with assisted reproductive therapy (Wong, Groen, Fass, & van Pampus, 2013). Of the aforementioned factors, a previous history of preeclampsia is the strongest single predictor of recurrence (Wong et al., 2013).

If symptoms worsen such as an extreme increase in blood pressure, induction of labour at >34 weeks of gestation is recommended (Cunningham et al., 2010b). Hospitalization may be required for women who are <34 weeks gestation but who demonstrate significant...
symptoms (increased blood pressure or abnormal fetal testing). Treatment for these women includes continual fetal monitoring, treatment for hypertension administration of steroids and Magnesium Sulfate for seizure prophylaxis (Cunningham et al., 2010b). In women whose symptoms continue to worsen, and to ensure the health of mother and the infant, early delivery is recommended. Monitoring should be continued up to 10 days postpartum and hypertensive medications prescribed as needed (Sibai, 2012).

If a woman has had preeclampsia in one pregnancy there is a high likelihood that she will develop it in subsequent pregnancies (Mostello, Kallogjeri, Tungsiripat & Leet, 2008; Sibai, Mercer & Sarinoglu, 1991). Dildy et al. (2007) found that women with a prior history of preeclampsia were seven times more likely to develop it in a future pregnancy than other women. Women with a history of preeclampsia in pregnancy may be at an increased risk of developing cardiovascular disease later in life (Bellamy, Casas, Hingorani, & Williams, 2007). For all these reasons it is important that counselling and screening in future pregnancies be part of focussed care.

Multiple Pregnancies

Multiple pregnancies are classified as ‘high risk’ by the Canadian Society of Obstetricians and Gynecologists as both the pregnant woman and the infant have potential for significant complications prenatally and postnatally (Barrett & Bocking, 2000). No single cause can explain multiple pregnancies. Multiple pregnancies are thought to be a result of a combination of environmental, genetic, dietary, and iatrogenic (medically-caused) factors. Multiple pregnancy has a familial incidence and it is believed that certain women have a genetic or familial predisposition to conceive of multiple fetuses (Fajolu, Ezeaka, Adeniyi, Iroha, & Ergi-Okwaji, 2013). Drugs used to stimulate ovulation such as clomiphene citrate have been implicated in causing multiple pregnancies (Sugaya & Hiroi, 2012). Also, the increasing use of assisted reproductive techniques (e.g., in-vitro fertilization, artificial insemination, and intra-cytoplasmic sperm injection) have played a role in rising rates of multiple pregnancy (Min, Claman, & Hughes, 2006; Wong, Emerson, & Mocanu, 2012).

Women with multiple pregnancy are prone to a higher risk of gestational diabetes, hypertension with pregnancy, polyhydramnios (excess amount of amniotic fluid), preeclampsia (toxemia of pregnancy), preterm labour, postpartum hemorrhage, and birth injuries than single pregnancy mothers. Also, fetuses involved in a multiple pregnancy are more liable to intrauterine growth retardation, respiratory distress syndrome (due to preterm labour before lung maturation), fetus-to-fetus transfusion syndrome, birth injuries, infant mortality, and post-natal malnutrition (Brown, Shrim, & Mallozzi, 2013; Wong, Emerson, & Mocanu, 2012). For these reasons it is important for women with multiple pregnancy to be followed closely throughout their pregnancies.

The rate of multiple births increased from 2.8% to 3.2% of all live births in Canada and from 2.3% to 2.8% in Manitoba during the period of 2006-2010 (Public Health Agency of Canada, 2013). Stillbirth rates among multiple births were excessively higher than among single births in Canada (15.5 vs. 7.1 per 1,000 live births) and in Manitoba (21.5 vs. 8.8 per 1,000 live births) (Statistics Canada, 2013). In Manitoba, rates of single and multiple pregnancies for Metis women were similar to those of other Manitoban women: 97.5% vs. 97.6% for single births and 2.5% vs. 2.5% for multiple births (Sanguins et al., 2013a).
Intimate Partner Violence

Violence against women is a social problem (Cherniak, Grant, Mason, Moore, & Pellizari, 2005). Intimate partner violence (IPV) during pregnancy includes abuse that may be physical, psychological, and/or sexual (Wathen, 2012). It may also include “environmental, social, financial, sexual, spiritual or ritual abuse” (Cherniak et al., 2005, p. 368).

The annual prevalence of IPV in Canada is estimated at 6%-7% a year (Statistics Canada, 2011a). It is suggested that this is considered an under-estimation due to underreporting (Cherniak, Grant, Mason, Moore, & Pellizari, 2005; Johnson, 2005). While typically IPV occurs when a couple is living together, research suggests that IPV may begin after relationships have ended (Hotton, 2001; Johnson, 2005; Johnson & Hotton, 2003). In the 1999 General Social Survey on Victimization, 40% of women reported that they had experienced violence after their marriage or common-law relationships had ended (Hotton, 2001). For those who had previously reported IPV, 24% stated that the assaults became more severe (Hotton, 2001). IPV is not limited to live-in relationships: 6% of incidents of IPV towards women were by an ex-spouse; 8% of women reported being abused by an ex-boyfriend (Sinha, 2013a). Both women and men are at risk of violence from those they date. In 2011, at least 631 per 100,000 unmarried women over the age of 15 were victims of dating violence; this represented a 60% higher rate than for those who were ever married (Sinha, 2013b).

Canadian Aboriginal women are up to 4 times as likely to experience male intimate partner violence compared to other women (Brownridge, 2008; Perreault, 2011). While not Metis-specific, 57.2% of Aboriginal women in Manitoba/Saskatchewan compared to 18.5% of non-Aboriginal women in Canada reported IPV (Cohen & Maclean, 2003). Aboriginal women in Canada who experience IPV are more likely to report injuries compared to non-Aboriginal women (59% versus 41%). Even more concerning, 52% Aboriginal women are also more likely to report fearing for their lives compared to 31% of other Canadian women (Brennan, 2011).

Aside from the emotional costs to the individual, family, and community, the economic costs of intimate partner violence in Canada in 2009 were estimated at $7.4 billion annually (Zhang, Hoddenbaugh, McDonald, & Scrim, 2009).

Not all those who are victims of intimate partner violence will experience this during pregnancy (Daoud et al., 2012). In Daoud et al.’s work, 6% of women reported abuse prior to pregnancy, 1.4% while pregnant, and 1% postpartum. While rates of IPV during pregnancy may be less there is some suggestion that the violence experienced by those who are pregnant is more frequent and more severe when compared to those who are not victims of IPV in pregnancy (Brownridge et al., 2011; Taillieu & Brownridge, 2010).

There are a variety of direct health impacts of intimate partner violence [IPV] during pregnancy including maternal effects, pregnancy effects and fetal effects (Cherniak et al., 2005). Maternal effects may include delayed prenatal care (Cha & Masho, 2014; Dietz et al., 1997; Van Parys, Verhamme, Temmerman & Verstraeten, 2014), insufficient weight gain (Cherniak et al., 2005), maternal infections (Cherniak et al., 2005), exacerbation of chronic illness (Cherniak et al., 2005), and maternal stress. Maternal depression (Almeida et al., 2013; Chambliss, 2008; Desmarais et al., 2014; Flach et al., 2011; Urquia et al., 2011) and Post Traumatic Stress Disorder are the most commonly recorded impacts on maternal mental health, often occurring comorbidly (Basile et al., 2004; Jordan et al., 2010).
IPV is a leading cause of injury in pregnancy women (Mendez-Figueroa et al., 2013). Pregnancy effects may include abdominal trauma (Cherniak et al., 2005), miscarriage (Cherniak et al., 2005; Taft & Watson, 2007), antepartum hemorrhage (Cherniak et al., 2005), premature rupture of the membranes (Cherniak et al., 2005), premature labour and birth (Rodrigues, Rocha & Barros, 2008; Shah & Shah, 2010), placenta abruptio (Cherniak et al., 2005; Van Parys et al., 2014), and complications during labour (Cherniak et al., 2005).

Intimate partner violence also impacts the health of the fetus. Fetal effects including low birth weight (Shah & Shah, 2010; Van Parys et al., 2014; Webster, Chandler, & Battistutta, 1996), fetal injury (Cherniak et al., 2005; Van Parys et al., 2014), and fetal death (Cherniak et al., 2005).

Violence against women during pregnancy is an important public health concern (World Health Organization, 2010). Prenatal visits would seem to be an appropriate space and place for assessment and discussion of this to occur. Despite recommendations from many professional organizations including the American College of Obstetricians and Gynecologists (2012) and the Society of Obstetricians and Gynecologists of Canada (Cherniak et al., 2005), screening is not consistently done (Bailey, 2010). In a Canadian study only 42% of physicians and 32% of nurses screened for IPV on a routine basis (Gutamanis, Beyon, Tutty, Wathen, & McMillan, 2007). In another study it was found that 66% of Scottish midwives surveyed asked their clients about IPV (Barnett, 2005). It is suggested that many physicians and obstetrician-gynecologists screen for IPV on prenatal visits only when overt warning signs are observed (Deshpande, & Lewis-O’Connor, 2013). Notwithstanding this, there is consensus that screening for risk of IPV is essential throughout pregnancy to identify risk factors – particularly evaluation of partner’s alcohol abuse, level of perceived stress, and social supports (Muhajarine & D’Arcy, 1999) - and to intervene as soon as possible (Cha & Masha, 2014; Shah & Shah, 2010).

In a randomized trial Kiely, El-Mohandes, El-Khorazaty, & Gantz (2010) found that women who were randomized to the intervention (individually tailored counselling), and who experienced minor IPV, were less likely to have recurrent episodes of IPV during pregnancy and postpartum. Those with severe IPV had significantly reduced rates postpartum. Another group of researchers used two different interventions in a randomized clinical trial. The first intervention was a brief nurse-led case-management session. The second intervention was a simple wallet-sized referral card. After two years there was no difference between the two groups – both reported reductions in threats of violence and fewer assaults. Importantly, both group reported increased use of safety behaviors and used community resources less frequently (McFarlane, Groff, O’Brien & Watson, 2006). After conducting a systematic review, Van Parys et al. (2014) suggested that home visitation programs or counselling interventions demonstrated moderate effect to decrease rates of IPV but questioned the consistency of studies. Clearly this is an area that requires further examination.

False Labour

During pregnancy, women may experience false labour or ‘Braxton-Hicks’ contractions. Braxton Hicks contractions are named after the obstetrician who first reported this occurrence in 1872 (Cunningham, 2010c). These contractions are often considered normal as they assist a woman’s body to give birth (Fraser & Cooper, 2009). The contractions begin at 6 weeks after conception but often are not felt until near the end of the pregnancy.
Women describe these as contractions that occur irregularly, are uncoordinated, and may be painful and/or painless (Cunningham, 2010c; Meguerdichian, 2012).

Braxton Hicks contractions can be easily confused with true labour (Cunningham et al., 2010c). After 30 weeks, the intensity of these contractions can increase and patients may describe a greater firmness in their lower abdomen (Cunningham et al., 2010c). Unlike true labour, these contractions are associated with no changes to the cervix although the close to the estimated date of confinement (delivery date) there may be some cervical ‘ripening’ (Cunningham et al., 2010c). External monitoring can be performed. The reading will not demonstrate the increase in the frequency or duration of the uterine contractions that would be seen in true labour (Henderson & Mallon, 2006). Discomfort from Braxton Hicks contractions will resolve without intervention but women can be counselled to manage the contractions with adequate hydration, rest, and analgesia if needed. Women can consult with their maternity care provider if they are uncertain about their contractions (Meguerdichian, 2012).

4.1.3 Complications of Later Pregnancy

Managing complications that arise in late pregnancy require prompt assessment of the mother and fetus as well as an understanding of protocols for appropriate triage and treatment (Meguerdichian, 2012). These complications may include placenta previa, placenta abruption or preterm birth.

Placenta Previa

Compared to a typical pregnancy, in placenta previa the placenta implants partially or fully in the lower part of the uterus resulting in the placenta either completely covering the internal cervical os, partially covering it, marginally abutting it, or occupying a low lying position with no cervical contact (Oyelese, & Smulian, 2006). Placenta previa occurs in 0.3% to 0.5% of pregnancies (Iyasu, Saftlas, Rowley et al., 1993; Rosenberg, Pariente, Sergienko et al., 2011). Placenta previa is a common incidental finding seen in 4% of regular second-trimester ultrasound studies and only 0.4% by the time all pregnancies reach term (Bhide, & Thilaganathan, 2004; Faiz, & Ananth, 2003; Rosenberg, Pariente, Sergienko et al., 2011). In many cases, low-implanting placentas move away from the cervix and toward the better-vascularized uterine fundus as the pregnancy proceeds (Oyelese, & Smulian, 2006).

No specific causes of placenta previa have been clearly identified. Factors that do seem to increase the risk of placenta previa are: advanced maternal age; multiparity; cigarette smoking; previous caesarean sections; chronic hypertension; multiple gestations; and previous uterine surgery (Faiz, & Ananth, 2003; Rosenberg, Pariente, Sergienko et al., 2011). Uterine scarring has also been proposed as a factor (Oyelese, & Smulian, 2006).

Painless, bright red vaginal bleeding at or after the end of the end of the second trimester is the primary characteristic of placenta previa (Oyelese, & Smulian, 2006); although typically painless, this bleeding can be concomitant with active labor contractions in more advanced pregnancies. The initial blood loss is rarely acute unless the placenta is further disrupted by instruments touching the cervix or a pelvic exam, which can cause severe hemorrhage (Sakornbut, Leeman, & Fontaine, 2007). Placenta previa must be considered in all women in late pregnancy presenting with vaginal bleeding to their care provider (Meguerdichian, 2012). It is essential that an ultrasound study be performed. Ultrasound, particularly transvaginal ultrasonography, is the diagnostic modality of choice for localizing and identifying placenta
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previa (Meguerdichian, 2012). When performed by properly trained personnel, ultrasound is safe and does not lead to an increased risk of bleeding (Nguyen, Nguyen, Yacobuzzi et al., 2012; Timor-Tristsch & Yunis, 1993). For women with persistent vaginal hemorrhage, immediate cesarean delivery is necessary.

For most women, prolonged hospitalization may not be required, particularly if the bleeding is controlled and not persistent. A woman is usually discharged if the following parameters are met: the bleeding has ceased, the fetus is healthy, and the woman and her family understand the possibility of complications and are prepared for immediate transport to hospital. In properly selected patients, there appears to be no benefit to inpatient versus outpatient management of placenta previa (Mouer, 1994; Neilson, 2003). Moreover, as shown by Drost and Keil (1994), outpatient management may also be more cost effective. They found a 50% reduction in hospitalization and maternal costs, as well as a 40% reduction in costs for mother–infant pairs when outpatient was compared with inpatient management.

Significantly, there are no differences in maternal or fetal morbidity rates with outpatient versus inpatient observation (Cunningham et al., 2010d). Wing and colleagues (1996) reported preliminary results from their randomized clinical trial of inpatient versus home management of 53 women with a bleeding previa from 24 to 36 weeks. Maternal and perinatal morbidities were similar in each group, but home management saved $15,000 per case in 1996 dollars. Despite this, 62% of these 53 women had recurrent bleeding, and 52% needed expeditious caesarean delivery.

Placenta Abruptio

Placenta abruptio refers to the partial or complete separation of an implanted placenta after the twentieth week of pregnancy and prior to delivery (Hall, 2009; Tikkanen, 2010). Bleeding may be undetected eventually escaping through the cervix (Baron & Hill, 1998). This hemorrhage causes compression of the intervillous space – the area from which a fetus is fed while in the uterus - and ultimately there will be placental tissue damage (Hall, 2009). In severe placenta abruptio, the uterus becomes severely contracted, the woman experiences a hypotensive crisis, and fetal mortality becomes a possibility (Hall, 2009).

A woman with placenta abruptio typically presents as having painful, third-trimester bleeding which if untreated could result in fetal death and maternal complications (Meguerdichian, 2012). Vaginal bleeding occurs in 80% of cases and is usually dark in colour. Other commonly seen symptoms of placenta abruptio are contractions, and back or abdominal pain or tenderness (Tikkanen, Nuutila, Hiilesmaa, Paavonen, & Ylikorkala, 2006). Women with placenta abruptio may also have nausea, vomiting, and experience a reduction in fetal movement (Meguerdichian, 2012).

There are a variety of physiological reasons which may account for placenta abruptio. The placenta may not have attached properly to the wall of the uterus. There may be poor blood circulation within the placenta; the placenta may not have developed properly or is damaged (Kramer, Usher, Pollack, Boyd, & Usher, 1997; Tikkanen, Nuutila, Hiilesmaa, Paavonen, & Ylikorkala, 2006).

Risk factors associated with placenta abruptio are related to health of the mother (internal) as well as external factors. Internal factors include having a history of placenta abruptio, maternal hypertensive disease (for example preeclampsia or pre-existing hypertension),
abdominal trauma, abnormalities of the placenta, insufficient Folate intake, premature rupture of membranes, and blood disorders such as thrombophilia (a blood clotting disorder) (Hall, 2009; Tikkanen, 2011). External risk factors are cigarette smoking and use of cocaine or other vasoconstrictive drugs (Hall, 2009; Tikkanen, 2011).

Treatment is dependent on the condition of the mother and fetus (Meguerdichian, 2012). Severe abruptio placenta requires that the mother be stabilized and the baby delivered as soon as possible (Hall, 2009).

**Preterm Birth**

Pre-term birth is defined as the birth of an infant before 37 weeks of gestation (Public Health Agency of Canada, 2008). Globally, preterm birth accounted for 11.1% of all live births for a total of 14.9 million births in 2010 (Blencowe et al., 2012) and rates continue to increase (World Health Organization, 2012). In spite of the dramatic advances in obstetrical care, and the improvement in access to maternal and newborn services, preterm birth remains the leading cause of neonatal and infant mortality in Canada and the United States (Ananth, Joseph, Oyelese, Demissie, & Vintzileos, 2005; Public Health Agency of Canada, 2008). In Canada, the rate of preterm birth increased from 7.0% in 1995 to 8.2% in 2004 (Public Health Agency of Canada, 2008). Explanations for this trend include increases in obstetric interventions (i.e. medically indicated labour induction and/or cesarean delivery), multiple births, younger maternal age, older maternal age as well as increases in the use of ultrasound-based estimates of gestational age. In Manitoba, the rate of preterm birth was 8.3% of live births in 2004 and decreasing slightly to 7.9% in 2007 (Public Health Agency of Canada, 2008; Statistics Canada, 2012). In the 2012 Perinatal Services and Outcomes report women in the Burntwood Health Region (now part of the Northern Health Region) had some of the poorest birth outcomes in the province of Manitoba including higher rates of stillbirth, infant mortality rates and higher rates of preterm birth (Heaman et al., 2012).

Preterm birth is closely associated with infant death. With the exception of infants with congenital anomalies, 60-80% of infant deaths are related to preterm birth or its complications (Public Health Agency of Canada, 2008). In Canada, causes of mortality of preterm infants are ordered as follows: acute respiratory failure, gastrointestinal complications, immunologic deficiencies, central nervous system hemorrhage, long-term motor disorders, and growth problems. Cause-specific infant mortality of preterm infants include congenital anomalies (5.3 per 10,000), maternal complications (1.6 per 10,000), intrapartum hypoxia/birth asphyxia (2.0 per 10,000), intrauterine infections (0.4 per 10,000), SIDS (0.7 per 10,000), and injury (0.1 per 10,000) (Ananth et al., 2009).

Comprehensive and consistent prenatal care has been found to be an important intervention for preterm birth. In one U.S. study, researchers found a 2.8 increased rate of relative risk of preterm birth in African-American and Caucasian women who had not had prenatal care (Vintzileos, Ananth, Smulian, Scorza, & Knuppel, 2002). They also observed an inverse relationship between the number of prenatal visits and gestational age at delivery.

**4.1.4 Intrapartum Care**

Intrapartum care refers to the care of a woman in labour at term (weeks 37-42). Intrapartum care is divided into first, second, and third stages of labour (Rankin, 2012).
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The first stage of labour begins as the muscular contractions of the uterus gradually open up the cervix in preparation for childbirth (Baby Center, 2016). These contractions may be stimulated by the release of a hormone called oxytocin from the pituitary gland (Cunningham et al., 2013). There are three distinct phases in the first stage: early labour, active labour and transition (Baby Center, 2016). In early labour, contractions are irregularly spaced, with length and intensity varying. At this point the cervix opens up to 4 centimeters (Fraser & Cooper, 2009; Midwives Collective, n.d.), thins out and shortens in preparation for delivery (Fraser & Cooper, 2009). In this phase the woman may feel cramping or tightening, and may have increased vaginal discharge, diarrhea, bloody show, loss of mucous plug, and ruptured membranes (Fraser & Cooper, 2009). Comfort measures for the woman during this early point are rest and having a bath or shower (Midwives Collective, n.d.). She should be encouraged to stay in the moment and focus on her breathing and the process (Midwives Collective, n.d.).

When the labouring woman enters active labour her contractions become more regular at 3 - 5 minutes apart and last 60 - 70 seconds (Midwives Collective, n.d.). The cervix dilates up to 8 centimeters (Midwives Collective, n.d.). She will be feeling the contractions strongly and will have increased bloody show (Midwives Collective, n.d.). She may be getting tired and scared (Midwives Collective, n.d.). Comfort measures for women during this phase are to vary their position frequently alternating periods of activity such as walking and resting (Midwives Collective, n.d.). They should be given continued encouragement to stay in the moment and focus on their breathing and the process (Midwives Collective, n.d.). At this point their health care providers should be alerted. If she is having a hospital birth she should be at the hospital; if she is having a home birth with a midwife, the midwife should be paged (Midwives Collective, n.d.).

In transition, contractions are only 2 – 3 minutes apart or less and last between 60 - 70 seconds (Midwives Collective, n.d.). At this point the labouring woman may be feeling shaky, cold, hot, and nauseated (Midwives Collective, n.d.). She may feel increased rectal pressure and will continue to have increased bloody show (Midwives Collective, n.d.). Typically women have an increased need for emotional support at this time as they may be feeling that they cannot deliver the baby (Midwives Collective, n.d.). Comfort measures during transition are frequent position changes, alternating periods of activity such as walking and resting (Midwives Collective, n.d.). Women should be given continued encouragement to stay in the moment and focus on their breathing and the process (Midwives Collective, n.d.).

The second stage of labour begins with full dilation of the cervix and ends with the birth of the baby (Cunningham et al., 2010e). During labour, uterine contractions occur in the uterine musculature and are regulated by the hormones of estrogen and progesterone (Fraser & Cooper, 2009). Parturition is the process by which the baby is born which includes strong uterine contractions and cervical stretching, helping to force the fetus through the birth canal (Fraser & Cooper, 2009). The second stage is regulated by a positive feedback loop in which uterine contractions push the baby and stretch the cervix while the strongest contractions occur at the top of the uterus which forces the baby towards the cervix (Fraser & Cooper, 2009). Women in the second stage of labour will feel the urge to push, accompanied by a stretching or burning feeling in their perineum (Midwives Collective, n.d.). They will feel the baby as it descends (Midwives Collective, n.d.). This stage may take anywhere from 10 minutes to 3 hours (Midwives Collective, n.d). A woman who has had previous deliveries may require only two or three pushes to deliver her infant; a woman who
has never had children, has a smaller pelvis or a larger fetus, or is not able to fully push because of fatigue or sedation, may have a much longer second stage and require more pushing (Cunningham, 2010e). To assist women during this phase, position changes can hasten the descent of the infant’s head. She should be offered directions for pushing (Midwives Collective, n.d.).

The **third stage of labour** refers to the period immediately after delivery, until gentle expulsion of the placenta (Baby Centre, 2016; Begley, Gyte, Devane, McGuire, & Weeks, 2011). Shortly after the birth of the baby the placenta is delivered and involves two phases: separation and expulsion. Separation occurs as the uterine cavity reduces in size shearing the placenta from its wall. Expulsion is completed by continued uterine contractions that expel the placenta (Fraser & Cooper, 2009). The woman may continue to feel contractions (Midwives Collective, n.d.). After birth, there is a sudden drop in estrogen and progesterone and a surge of prolactin which promotes milk secretion from the mother’s breasts (Fraser & Cooper, 2009). The sign to release or ‘let down’ of milk is stimulated by oxytocin, a hormone controlled in the hypothalamus of the brain which is then induced by suckling and crying of the baby (Fraser & Cooper, 2009). After the placenta is delivered the fundus of the uterus should always be assessed by palpation to ensure it is well contracted and firm. If it is not firm, vigorous fundal massage may be indicated (Cunningham, 2010d).

Complications that can arise in the third stage of labour are retained placenta or postpartum hemorrhage (Cunningham et al., 2010d). Severe hemorrhage can result in an obstetrical emergency. Active management of the third stage of labour such as massaging the fundus of the uterus supplemented by medication can reduce the risk of postpartum hemorrhage (Leduc et al., 2009).

**Uterine atony** or failure of the uterus to contract properly following delivery is the most common cause of post partum hemorrhage (Cunningham et al., 2010d). There are several reasons that a uterus may not contract. An overly distended uterus is likely to be atonic post partum. Women with large infants, multiple fetuses, or with an excess of amniotic fluid (polyhydramnios) are more likely to have uterine atony. A woman who has a labour that is either very active or has had barely effective contractions is also likely to bleed excessively from atony. Likewise, labours that are started or supplemented with oxytocics are more likely to be followed by atony and hemorrhage. Multiple previous pregnancies may be a risk factor for uterine atony. Another risk is if the woman has had a prior postpartum hemorrhage. Finally, attempts to hurry the delivery of the placenta may precipitate atony. This may be because constant kneading and squeezing of the uterus may result in incomplete placental separation and increased blood loss (Cunningham et al., 2010d).

While seldom cased by placenta fragments, **retained placenta** may also be a cause of postpartum hemorrhage. Although immediate postpartum hemorrhage is seldom caused by retained placental fragments, a remaining piece of placenta is a common cause of bleeding **late** in the time between delivery and when the uterus returns to its original size. Inspection of the placenta after delivery should be a routine practice, and if a portion is missing, further uterine exploration and fragment removal is essential, particularly if continuing postpartum bleeding occurs (Cunningham et al., 2010d).

A number of medications can be given to assist the uterus to contract postpartum. In many delivery suites, after the placenta has been delivered, oxytocin is given intramuscularly. This or other oxytocics will prevent most cases of uterine atony. If bleeding persists,
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methylergonovine intramuscularly is given to stimulate the uterus to contract (Cunningham et al., 2010d).

Supports during Labour and Delivery

In addition to the emotional support provided by partners, friends and family, labour and childbirth can be supported by a variety of pain management techniques including: breathing exercises, water therapy, labouring in a tub, acupuncture, acupressure, hypnosis, inhaled analgesia, intravenous and intramuscular opioids, nitrous oxide, epidural relief and/or narcotics. Additionally, Caesarean section might be required during labour and birth if concerns are detected with the mother or there are signs of fetal distress noted on external fetal monitoring (Fraser & Cooper, 2009; Liston, Sawchuck, & Young, 2007).

4.1.5 Postpartum Care

During the postpartum period women are able to access a variety of provincial, regional and local services and supports. These include counselling and support regarding breastfeeding, nutrition, healthy environments, and early childhood education (Wilson et al., 2013). Access is dependent on the resources available in her community as well as the practices of different care providers. An obstetrician/gynaecologist will book an appointment for the new mother at their office and if there are no health concerns then she will be seen at six weeks postpartum for a final visit. If the woman has had a midwife-assisted birth the midwife will make regular visits to a woman’s home during the first six weeks of the postpartum period (Winnipeg Regional Health Authority, n.d.). If a woman had an episiotomy or caesarean section she may need additional physical and emotional support during this period. Furthermore, the emotional and psychological changes that occur during and after birth as a woman transitions into motherhood may result in postpartum depression (Fraser & Cooper, 2009).

Postpartum Depression

It is estimated that more than 10% of women experience depression during pregnancy, and more than 15% of women experience depression during the postpartum period. If symptoms start during the pregnancy, it is called antenatal or antepartum depression. If symptoms start after the baby is born, it is called postnatal or postpartum depression. Together, these illnesses are referred to as perinatal depression (Gaynes et al., 2005; Wisner, Parry, & Piontek, 2002).

Symptoms of perinatal depression may include persistent sadness, anger, or worry (Wisner, Parry, & Piontek, 2002); poor social functioning (Murray, Cooper, & Hipwell, 2003); loss of enjoyment or interest in things (Wisner, Parry, & Piontek, 2002); lack of interest in the baby (Wisner, Parry, & Piontek, 2002); increased or decreased eating and sleeping habits (Wisner, Parry, & Piontek, 2002); feelings of intense guilt (Wisner, Parry, & Piontek, 2002); frequent bouts of crying (Wisner, Parry, & Piontek, 2002); difficulty concentrating or making simple decisions (Wisner, Parry, & Piontek, 2002); and feelings of hopelessness (Wisner, Parry, & Piontek, 2002). Some women experience emotional withdrawal and excessive concern about pregnancy and parenting (Murray et al., 2003) and in some cases the mother has thoughts of harming herself or her baby (Wisner, Parry, & Piontek, 2002). Infants of depressed mothers are less likely to be breast fed (Cooper, Murray, & Stein, 1993), more likely to experience
poor interactions (Williams & Carmichael, 1985) and are at increased risk of developmental delay (Cogill, Caplan, Alexandra, Robson, & Kumar, 1986).

In the Canadian Maternity Experiences Survey, 7.5% of women reported depressive symptoms postpartum; and 15.5% reported that they either had been diagnosed or treated for depression prenatally (Public Health Agency of Canada, 2014c). In this group, higher rates of physical or sexual abuse, smoking, alcohol consumption and use of non-prescription drugs were reported compared to those who were not depressed (Public Health Agency of Canada, 2014c). In that study, younger or older age, lower income and unemployment were associated with postpartum depression in the women who reported Intimate Partner Violence; in the comparison group, age was not a factor but similarly employment, income, and immigrant status predicted PPD in the comparison group (Janssen, Heaman, Urquia, O’Campo, & Thiessen, 2012).

Depression often goes unrecognized by women or their health providers (Johanson, Chapman, Murray, Johnson, & Cox, 2000; Lee, Yip, Leung, & Chung, 2000; McGill, Burrows, Holland, Langer, & Sweet, 1995). In many women who are diagnosed with postpartum depression, symptoms actually begin in pregnancy, but these symptoms may be attributed to normal changes in emotions and energy due to being pregnant (Wisner, Parry, & Piontek, 2002). As a result many women do not receive treatment for depression (Andersson at al., 2003) despite the potential risk for harm that exists. Bowen, Stewart, Baetz, & Muhajarine (2009) found a prevalence of 29.5% of depression antenatally. In that study prevalence rates of depression did not differ significantly between Aboriginal and all other women, but the Aboriginal women were significantly more likely to have thoughts of self-harm. Suicide has been found to be the leading cause of maternal death (Oates, 2003). In one study the rate of depression reached a peak of 8.3% at 32 weeks of gestation, and gradually decreased to a rate of 5.4% at 32 weeks postpartum (Fergusson, Horwood, & Thorpe, 1996). Others cite rates of 14.5% of new depressive episodes prenatally, with an additional 14.5% of women experiencing PPD within three months of delivery (Gaynes et al., 2005).

These studies challenge the prevailing belief that depression is more commonly found in the postpartum period. Heaman et al. (2012) found that Manitoban women who experienced anxiety or depression during pregnancy were eight times more likely to experience anxiety/depression disorders after pregnancy. Heaman et al. (2012) suggested that health care providers should intervene at an earlier time and not focus solely on treating depression postpartum. For Metis women in the Northern Health Region the prevalence of postpartum depression is unknown.

There are numerous risk factors for perinatal depression/anxiety disorders including a previous episode of mental illness (e.g. anxiety, depression, bipolar, OCD); family history of mental illness especially if it was a perinatal mental illness; lack of support in caring for an infant; stress related to either marriage or intimate relationship, finances, or health; giving birth to multiples (twins, triplets, etc.); or recent significant life changes such as moving, change in employment, or death of a loved one. Other risk factors include having a baby who is seriously ill or a high needs or demanding baby (Wisner, Parry, & Piontek, 2002).

Unlike perinatal depression, perinatal anxiety often involves excessive worries or fears about something terrible happening to her baby, herself, or someone close to her. Increased anxiety during the perinatal period is as common as perinatal depression. Although women
often realize their fears are exaggerated or unrealistic, it can be hard to stop thinking about them. If excessive worry or fear is taking up a lot of a mother’s time and energy, and interfering with her quality of life, she might have an anxiety disorder (Wisner, Parry, & Piontek, 2002).

Some women experience a lot of physical symptoms of anxiety such as: shortness of breath; chest pain or tightness; feeling their heart pounding; lightheadedness; shaking; sweating or chills; nausea; numbness or tingling. If these physical symptoms come on suddenly and are accompanied by an overwhelming sense of fear, it’s called a panic attack. If a woman experiences a panic attack for the first time during pregnancy or in the postpartum period, she may be afraid that she is having a heart attack or a stroke, because the physical symptoms can be so overwhelming (Wisner, Parry, & Piontek, 2002).

Psychosis is a term used to describe different types of symptoms that involve losing touch with reality. Psychotic symptoms can include seeing, hearing, smelling, feeling, or tasting things that are not really there. The most common types of hallucinations in psychosis are auditory (hearing things such as voices), visual (seeing images); and delusions – beliefs that are not based in reality. For example, some women with postpartum psychosis believe that others are trying to steal or harm their baby when this is not actually the case (a paranoid delusion); disorganized thinking – periods of confusion, trouble putting thoughts together or making sense to others, trouble with memory (Wisner, Parry, & Piontek, 2002). Postpartum psychosis usually comes on rapidly within the first four weeks postpartum and is a very serious condition that requires immediate medical attention (Wisner, Parry, & Piontek, 2002).

Prenatal appointments provide opportunity for effective screening and identification of women at risk of poor mental health in the prenatal period. There are also occasions to identify women who may benefit from early intervention to reduce risk of PPD within a community setting (Tough, 2009). Clarke (2008) studied the rate of postpartum depression in a sample of Metis and First Nations women in Saskatchewan. The Postpartum Depression Screening Scale (PDSS) (Beck & Gable, 2000) and the Edinburgh Postnatal Depression Scale (EPDS) (Cox, Holden, & Sagovsky, 1987) were compared for validity and predictive value for PPD in First Nations and Metis women. Consistent with other literature, in Clarke’s (2008) sample, 17% of the participants were diagnosed with postpartum depression. Clarke found that while both instruments demonstrated utility as general screening tools, the EPDS yielded better predictive value than the PDSS. Moreover, the EPDS is a time-efficient measure that can be quickly scored and interpreted by maternity care practitioners and is available without cost. Clarke (2008) suggests that health care practitioners offer screening for women who may be at risk of developing postpartum depression.

Using the Edinburgh Postnatal Depression Scale, Bowen & Muhajarine (2006) found that 27% of women enrolled in a Saskatchewan Better Mother, Better Baby prenatal outreach program had major depression with a higher prevalence of depression symptoms found among Aboriginal women (Metis & First Nations) compared to non-Aboriginal women. They also found that the EPDS is a quick and easy tool to screen for depressive symptoms observing that the EPDS can facilitate increased communication between women and their maternity care providers.
Treatment and support for women experiencing perinatal depression/anxiety disorders includes increasing social support; attending support groups; counselling; improving self-care (e.g. sleep, nutrition, exercise); talk therapy; and medication (Wisner, Parry, & Piontek, 2002).

In Manitoba, aside from the formal health care system, there are resources for women experiencing postpartum depression. One such resource is the Post Partum Depression Association of Manitoba (n.d.). This program provides care for women and families experiencing crisis or needing help accessing resources. In addition to providing a list of low-cost or free counselling available across the province, there is a website featuring crisis lines, support groups, self-help guides, and an online version of the Edinburgh Postnatal Depression Scale that women can download and use to assess themselves. In Winnipeg the Women’s Health Clinic and Nest Family Centre offer postpartum support workshops and support groups. The Mood Disorders Association of Manitoba (MDAM) (n.d.) offers a 1-800 postpartum ‘Warmline’ to field calls from those in distress or with questions. The MDAM also hold free peer-led support groups in Interlake/Gimli, Norman, Brandon, and Thompson areas.

4.2 Aspects of Maternal Health Care

4.2.1 Measures of Maternal Health

Infant mortality is the death of an infant before its first birthday (0-364 days). The rate of infant mortality (IMR) in a population is considered one of the most important markers for child health in the world (Meehan, Beck, Mair-Jenkins, Leonardi-Bee, & Puleston, 2014). Infant mortality is also an indicator of the quality of health care services designed for maternal and child health (Konstantinidou et al., 2011). Infant mortality rate (IMR) paints a picture of accessible prenatal care and the related health services use in a population (Manitoba Centre for Health Policy, 2008).

There are gross inequalities in IMR between populations. For example, IMR ranges from as high as 165 per 1,000 live births in Afghanistan to as low as 5 per 1,000 live births in Canada (Joseph, 2011). In Canada, the crude IMR has declined over time from 6.40 to 4.90 per 1,000 between 1991 and 2003 (Public Health Agency of Canada, 2008). In Manitoba, IMR in 2009 was higher than the overall national rate of infant mortality in Canada (6.3 vs. 4.9 per 1,000 live births) (Statistics Canada, 2012). There are many social and economic factors linked to infant mortality including: maternal health, maternal level of education, and socioeconomic factors (Gokhale, Rao, & Garole, 2002; Peña, Wall, & Persson, 2000).

There are higher rates of infant mortality amongst Indigenous peoples of Australia, Canada Aotearoa/New Zealand and the United States when compared to the rest of their populations (Smylie, Crengle, Freemantle, & Taulii, 2010). It is suggested that this can be linked to sharing “the experiences of being minority populations in economically prosperous countries...[where] economic, social, and health care resources have been unequally distributed between the Indigenous and non-Indigenous populations” (Smylie et al., 2010, 8).

In Canada, there has been much research on infant mortality in some Aboriginal groups (Stout & Harp, 2009). Such studies have illustrated the disparities when comparing First Nations and Inuit populations with the general Canadian population. Smylie et al. (2010) used First Nations and Inuit data that could be accessed reliably. However, until recently there has been little research that focuses on infant mortality in Metis (Kermode-Scott, 2009). A Study of Infant Mortality and Birth Profiles in Metis in Manitoba identified that there were
880 infant deaths between the period of 1996-2005 in Manitoba, of whom 7.30% were Metis infants (Sanguins, Bartlett, Mehta, Bassily, & Hoeppner, 2013a). Maternal conditions and perinatal complications accounted for 9.4% of the deaths, with congenital anomalies accounting for 26.6% of deaths, prematurity 9.38% and SIDS 9.4%; the remainder of the deaths were due to a variety of different causes.

4.2.2 Place/Site of Delivery

Place of birth is important for a woman’s birth experience. The Society of Obstetricians and Gynaecologists of Canada recommended that women who live in rural or remote communities should receive quality maternity care that is family-centred and culturally sensitive as close to home as possible (Miller et al., 2012). Medicalization of birth that requires travel during pregnancy and birth has effectively played a large role in removing birth from Metis families and communities (Infinity Consulting & National Aboriginal Health Organization, 2010). In the context of health care and especially of maternity care, cultural competence for First Nations, Metis and Inuit women means that the whole person, both mother and baby, must be considered not only physically, but also within spiritual, emotional, cultural, and historic contexts (Foster, 2006). The emotional and cultural importance of a Metis woman delivering in her own community is well-known (Couchie & Sanderson, 2007). Unfortunately, it is more common that rural and northern women have to leave their homes (and their children) to deliver their babies in urban hospitals because of lack of facilities or any other services in their local communities (Skye, 2010). The loss of traditional birth practices in rural and northern communities has had a lasting impact on the physical, spiritual, emotional and psychological birth experiences of Metis women and their families (Skye, 2010). The Society of Obstetricians and Gynaecologists of Canada recommends that “Health professionals should support and promote the return of birth to rural and remote communities for women at low risk of complications. The necessary involvement of community in decision-making around the distribution and allocation of resources for maternity care should be acknowledged and facilitated” (Wilson et al., 2013, p.S4).

The Manitoba Centre for Health Policy classifies ‘place of birth’ as either urban or non-urban. Place of birth in non-urban centres includes rural and remote communities in which traditional midwives were once the primary practitioners of care delivery. In one study both Metis and all other Manitoban women of urban residence gave birth in urban facilities (97.8% and 98.66%, respectively). For those living in rural or non-urban areas, most Metis and all other Manitoban mothers gave birth at their local rural areas (56.13% and 51.39%, respectively), but there was a significant portion of non-urban Metis and all other Manitoban mothers who had to travel at the time of labour seeking medical services at urban facilities (41.59% and 46.90%, respectively) (Sanguins, Bartlett, Mehta, Bassily, & Hoeppner, 2013a). Maternity care in the north must be meaningful for communities and build upon local capacity (Health Council of Canada, 2012). Reclaiming birth into the communities could have a profound effect for Aboriginal families including Metis, First Nations, and Inuit (Society of Obstetricians and Gynaecologists of Canada, 2010).

Site of birth is important for a woman’s birth experience. The Manitoba Centre for Health Policy classifies site of birth as either in-hospital or out-of-hospital. Prior to the development of modern obstetrics many women were able to give birth at home and in their own communities, often by the local community midwife (Couchie & Sanderson, 2007). Ideally,
the choice of place of birth either at home or through midwife-led or obstetric care unit should be guided by informed choice discussions between the woman and her health care provider (O’Cathain, Thomas, Walters, Nicholl, & Kirkham, 2002).

Hospital birth has become routine practice. Hospitals are viewed as ‘secure’ places of birth due to availability of highly trained health professionals, advanced diagnostic techniques, emergency services, and highly-equipped delivery suites. However, there is another choice for labouring women. Delivery at home attended by a midwife has been consistently shown to be a safe option. “Midwifery has a demonstrated evidence of successful birth outcomes as measured by birth weight and mortality among the low risk maternity population” (Tough, 2009, p.4).

Cheyney et al. (2014) reported on a study of midwife assisted-births in the United States. Among the population of almost 17,000 women who planned home births, 89.1% gave birth at home. For the remainder the reason for transfer to the hospital were largely for failure to progress. Only 4.5% of all the women required oxytocin augmentation and/or epidural analgesia. There were 93.6% spontaneous vaginal births, 1.2% assisted vaginal births, and 5.2% of the women required cesarean sections. With a midwife assisted birth 87% of the women who had a trial of labour and attempted vaginal birth after cesarean section were successful. Few of the mothers or newborns needed to be transferred to the hospital postpartum (1.5% and .9% respectively). The majority (86%) of newborns were exclusively breastfeeding at 6 weeks of age. Results of this study may be skewed. Most of the women in this sample were Caucasian, college-educated, married, and were able to pay out-of-pocket if midwifery was not covered under their health insurance (Cheyney, Bovberg, Everson, Gordon, Hannibal, & Vedam, 2014).

Another study comparing the outcome of planned home births with registered midwives to hospital births with physicians or midwives found that women in the planned home-birth groups were significantly less likely than those who planned a midwife-attended or physician-attended hospital birth to have obstetric interventions (e.g., electronic fetal monitoring), adverse maternal outcomes (e.g., third- or fourth-degree perineal tear), and postpartum hemorrhage (Janssen et al., 2009). In that study, newborns in the home-birth group were less likely than those in the midwife-attended or physician-attended hospital-birth groups to require resuscitation at birth or oxygen therapy beyond 24 hours, develop meconium aspiration (meconium aspiration is an asphyxia of the fetus due to inhalation of amniotic fluid containing fetal stool into the respiratory tract), or need admission to a hospital after labour (Janssen et al., 2009). Although the Janssen et al. study provided evidence of the high quality and the good outcome of home planned births attended by registered midwives, the study did not adjust for the severity and complexity of births conducted in each of the study groups. In other words, physicians in the hospitals tend to manage complicated high risk deliveries whereas registered midwives delivering at home tend to deal with low risk deliveries. As with most studies of home birth, the study by Janssen and colleagues was limited by the possibility - if not the likelihood - of self-selection by participants to a home-birth option. Any differences in outcomes between the study groups may therefore be attributable to differences in the characteristics of the groups themselves (McLachlan & Forster, 2009).

It is clear that there is a difference of opinions about the optimal and safest place of delivery for women. Even recognizing that home birth is a choice for some (or even the majority of) women, the resources to accomplish this are quite limited (McLachlan & Forster, 2009). It is
suggested that while more research is needed, the “available evidence supports planned home birth for women at low risk who are cared for by qualified midwives with access to medical backup” (McLachlan & Forster, 2009, p. 359).

The Society of Obstetricians and Gynaecologists of Canada “strongly support the return of birth to rural and remote communities for women at low risk of complications” (2010, p.1187). This can be accomplished by ensuring women are provided with knowledge about the risks and benefits about giving birth in their home community, respecting the right to choose where they will give birth, ensuring support of community leaders and elders, and involving women in planning for birth (Society of Obstetricians and Gynaecologists of Canada, 2010). Both the health care system and funding agencies must be well informed about the health needs of the population (Couchie & Sanderson, 2007). We believe this study will provide context for care providers and decision makers to understand Metis-specific health needs regarding maternal health. Rural practitioners’ training must include necessary assessment and intervention skills such as neonatal resuscitation and care of neonates (Miller et al., 2012). Protocols must be established to guide routine and emergency maternity care (Couchie & Sanderson, 2007). These policies and procedures will support communication, planning, development of trusting relationships and strong links between caregivers in the community and referral centres (Society of Obstetricians and Gynaecologists of Canada, 2010). On an ongoing basis women must be monitored and evaluated for risk. There needs to be consistent documentation and annual review as well as reporting back to community (Society of Obstetricians and Gynaecologists of Canada, 2010).

Communities and health organization must agree to work collaboratively to change existing programs including promoting midwifery care and midwifery training (Couchie & Sanderson, 2007). Finally, it is suggested that midwives be identified as the primary source of maternity care in the community (Couchie & Sanderson, 2007). Recognizing there is diversity among Metis women, it is important to support the right of women to choose the health care provider with whom, and site of delivery where, they are most comfortable.

In Canada, rates of hospital deliveries decreased slightly from 99.4% in 1995 to 98.4% in 2011, and out-of-hospital deliveries increased from 0.6% to 1.6% between 1995 and 2011 (Statistics Canada, 2013). This suggests that availability of midwifery and health care services in some of the local communities favours the tendency of rural inhabitants to depend on their local services rather than travelling to a hospital. Manitoba followed the same pattern as the Canadian population showing a slight decreasing trend of in-hospital deliveries (99.6% in 1995 vs. 98.6% in 2011) and an increasing trend of out-of-hospital deliveries (0.4% in 1995 vs. 1.4% in 2011) (Statistics Canada, 2013). In Manitoba, Metis had a similar crude percentage of in-hospital births compared to all other Manitobans (99.81% vs. 99.78%) and a similar crude percentage of out-of-hospital birth compared to all other Manitobans (0.19% vs. 0.22%) (Sanguins, Bartlett, Mehta, Bassily, & Hoeppner, 2013a).

### 4.2.3 Maternity Care Providers

Primary prenatal health care involves care delivered by a provider in the appropriate setting. Primary prenatal health care can be provided by family doctors, but it also includes nurses, midwives, dietitians, pharmacists, mental health professionals, therapists, obstetricians and many others in different and diverse environments including hospitals, community clinics and homes (Janssen et al., 2009).
Some authors suggest that Canada is in the midst of a maternity care crisis characterized by a shortage of skilled providers (Harris et al., 2012; Klein, Johnston, Christilaw, & Carty, 2002; Society of Obstetricians and Gynaecologists of Canada, 2010). Overcoming the shortage of maternity care providers in Canada relies upon improved inter-professional collaboration between obstetricians, physicians, and registered midwives (Peterson et al., 2007; Wilson et al., 2013). There are many barriers to inter-professional maternity care in Canada which are rooted in provider’s differences in attitudes towards labour and birth (Klein et al., 2009) as well as remuneration structure, liability issues, rivalry, and lack of mutual respect (Peterson, Medves, Davies, & Graham, 2007). Interprofessional collaboration is a key factor to reclaiming birth for Metis women in northern Manitoban communities. To bring birth back to the community or to ‘reclaim’ it, Metis, First Nations, and Inuit women and families require access to more holistic and culturally appropriate care (Wilson et al., 2013).

**Rural Physicians**

The decreasing number of rural physicians hampers the delivery of health care services to patients in rural communities as does the infrequent opportunity to use specialized skills (Kornelson & Grzybowski, 2005). To entice new graduates from medical programs to work in rural and northern areas of the province, the University of Manitoba medical school offers incentives for medical school graduates (Government of Manitoba, 2012).

One of the main challenges faced by rural physicians is a heavy workload caused by providing 24-hour coverage (Grzybowski, Kornelson, & Cooper, 2007). Rural maternity care requires greater collaboration among all health care providers to help reduce physician workload. In addition, some rural physicians find it difficult to keep their obstetrical skills current due to low number of births in rural communities (Grzybowski, Kornelson, & Cooper, 2007). To ensure safety, these providers have opted for a ‘no primip’ (first time pregnancies) policy which means they will not accept women who have never previously had a baby as a patient (Grzybowski, Kornelson, & Cooper, 2007). In order to increase numbers, rural physicians can be provided with ongoing educational opportunities to maintain their obstetrical skills in low-birth settings (Kornelson & Grzybowski, 2005).

**Midwives**

In Michif, the traditional language of the Metis people, a midwife is “la faam kaa kaachitinaat li bebii”, which means “the woman who catches the baby” (National Aboriginal Health Organization, 2008, p.10). Prior to European contact, Aboriginal midwives were central to the social, political, and cultural landscapes of their people (Carroll & Benoit, 2001). Birth was a sacred event to celebrate the arrival of a new spirit (Infinity Consulting & National Aboriginal Health Organization, 2010) and each childbirth connected women to their foremothers, and families to whole communities (Benoit, Carroll & Eni, 2009). In early Metis trading communities there was typically one woman who was in charge of the reproductive health of the women. This woman was usually childless and became a ‘godmother’ to most of the children born from births she had assisted (Heritage Community Foundation, 2010). Aboriginal midwives were trained through an apprenticeship model in which mothers taught their daughters ceremonies and practices of their vocation (National Aboriginal Health Organization, 2008). Traditional practices of midwifery were extinguished in Metis communities in the mid-nineteenth century (Lawford & Giles, 2012; National Aboriginal Health Organization, 2008); however, memories of Metis midwives are still alive.
and strong among Metis seniors in Manitoba (Infinity Consulting, & National Aboriginal Health Organization, 2010; verbal communication, Metis Elder George Fleury).

The renaissance of midwifery in Manitoba has occurred slowly as registered midwives have become integrated into, and funded by, the provincial health care system (Kreiner, 2009). In Manitoba the Midwifery Act includes a provision for a standing committee to advise the College of Midwives on issues related to midwifery care to Aboriginal women (Manitoba Health, 1998; National Aboriginal Health Organization, 2008).

Most commonly in Canada, registered midwives are trained through a direct-entry model. Distinct from midwives who are educated as nurses, a direct-entry midwife is educated in the discipline of midwifery using self-study, apprenticeship, a midwifery school or a university-based program (National Aboriginal Health Organization, 2008). Registered midwives are trained to recognize and promote normal physiological birth (Kennedy & Shannon, 2004) and follow a holistic practice based on three principles: continuity of care, choice of birthplace, and informed consent (Canadian Association of Midwives, n.d). Contemporary Aboriginal midwives blend modern midwifery care with traditional teachings and ceremonies. In this way, Aboriginal midwives are able to offer culturally-relevant contextualized care to women in their communities (Kreiner, 2009).

Birth outcomes among low risk women with midwives compared with similar low-risk women with family physicians were found to have no differences in perinatal, neonatal, or serious morbidity (Hutton, Reitsman, & Kaufman, 2009). Moreover, birth satisfaction was higher among those who were able to complete their birth at home under the care of a registered midwife (Janssen, Carty, & Reime, 2006).

Across Canada there has been a gradual increase in the number of women receiving care from registered midwives. Midwifery was recognized as a funded health care in Manitoba in 2000. In Manitoba, the rate of deliveries by registered midwives has doubled over time from 2.5% to 4.7% between 2001/02-2007/08 (Heaman et al., 2012). There are currently 53 practicing midwives and 15 non-practicing midwives in Manitoba (Oral communication, College of Midwives of Manitoba, December 20, 2014). The demand for this care continues to outstrip the availability of midwives.

The lack of availability of midwifery programs in the province of Manitoba impacts on the number of midwives in the province. Since 1999 four different programs have been proposed with only two programs actually receiving funding (Thiessen, 2014). In total they have yielded a total of ten graduates although several students continue to be in training.

Another barrier for the practice of midwives is the cost of professional liability insurance. Practicing midwives in Manitoba must carry insurance upwards of $14,000 per year (National Aboriginal Health Organization, 2008).

In addition to the barriers noted above, barriers to increasing numbers of Aboriginal midwives include lack of Aboriginal midwifery training programs and a lack of understanding of Aboriginal midwifery by other health care professionals (SOGC, 2013).

A resource which exists to support Aboriginal midwives in Canada is the National Aboriginal Council of Midwives (NACM). NACM’s goal is excellence in reproductive health care for Inuit, First Nations, and Metis women. NACM has about 70 First Nations, Inuit and Metis members from across Canada. As an organization NACM advocates for the “restoration of midwifery education, the provision of midwifery services, and choice of
birthplace for all Aboriginal communities” (National Aboriginal Council of Midwives, 2014, n.p.).

Wilson et al. (2013) wrote “All health professionals should acknowledge and respect the role that Aboriginal and Traditional midwives have in promoting the sexual and reproductive health of women and should be aware that this role is not limited to pregnancy and delivery, but often extends beyond the birth year” (p. S3). Metis women believe that the re-emergence of midwifery by training Aboriginal women is an important step toward culturally competent and holistic care (Infinity Consulting, & National Aboriginal Health Organization, 2010; National Aboriginal Health Organization, 2008).

**Primary Care Nurses**

Primary care nurses are often the first point of contact with the health care system in northern and remote communities (Donald et al., 2010; Vukic & Keddy, 2002). Primary care nurses assess the health situation (including immediate threats to life, acute trauma, or illness) and determine the need for care (Hutchison, Abelson, & Lavis, 2001). Primary care nurses coordinate emergency medical transportation, non-urgent care such as prenatal health care, health assessments, family care and follow-up, and referral cares with other health care providers. The nursing station model of health care delivery is currently based on offering an initial assessment of a client’s health needs. Primary care nurses can decide to initiate health services independently or with another health care provider such as physician or specialist (Lavoie & Gervais, 2011). Often they are Nurse Practitioners (Donald et al., 2010). Metis women in rural and remote northern Manitoba communities seek prenatal care and postpartum care largely from community-based primary health care nurses.

### 4.2.4 Breastfeeding

The World Health Organization and UNICEF recommend that infants breastfeed exclusively until at least the age of six months for a variety of reasons (World Health Organization and UNICEF, 2003). These include improved oral health (Government of Manitoba, 2013a; Wall, 2013), decreased rates of some infectious diseases in breastfed babies (Wall, 2013), reduced risk of obesity and Type 2 diabetes in offspring (Government of Manitoba, 2013a), improved early childhood development (Government of Manitoba, 2013a, Wall, 2013), and a strengthened maternal-child bond (Labbock, 2003).

Infants who have been breastfed for the first several months of their lives have been shown to have better overall dental health (Government of Manitoba, 2013a). “Caries occur as a consequence of diet, oral hygiene and cariogenic bacteria in the mouth” (Tough, 2009, p.9). Rates of caries vary between populations. In one study caries was found in 68% of American Indian/Alaska Native children aged 2-4 years (compared to 11% of Caucasian children) (U.S. Department of Health and Human Services, 2000). Infant formulas have been shown to have significant cariogenic potential (Bowen, Pearson, Rosalen, Miguel, & Shih, 1997; Nainar & Muhumed, 2004).

Breastfeeding has been shown to offer protection against infectious disease (Duijts, Jaddoe, Hoffman, & Moll, 2010). Specifically, breastfeeding has been shown to protect against respiratory and gastro-intestinal tract infections in infants when compared to those who have never breastfed (Duijts et al., 2010; Duijts, Ramadhani & Moll, 2009). There is a dose/duration-response effect reported with those solely breastfed infants demonstrating lower rates of illness when compared to those who were partially breastfed or breastfed for a
shorter period of time (Dujits et al., 2010). Breastfeeding may also confer protection against infections of the throat, ear and sinuses beyond infancy (Li, Dec, Li, Hoffman, & Grummer-Strawn, 2014). In a meta-analysis spanning 30 years of published literature, the authors concluded that infants who breastfed for at least 3 months had a reduced risk of otitis media (Uhari, Mantysaari, & Niemala, 1996). Duncan et al. (1993) found that infants that were solely breast-fed for at least four months had half as many episodes of acute otitis media than did those who had not breastfed at all, and 40% fewer than those who were supplemented in that time period. Independent of other risk factors such as socioeconomic status or maternal smoking, the rate of recurrent otitis media infections was 10% for breastfed babies compared to 20.5% in infants who had breast-fed for less than 4 months. Chronic health conditions reported for Metis children aged 6-14 include allergies (19%), asthma (15%), and ear infections (9%) (Janz, Seto, & Turner, 2009). Public health messaging promoting longer-term duration of breastfeeding may mitigate these rates.

Breastfeeding during infancy is also associated with a reduced risk of Type 2 diabetes in offspring (Owen, Martin, Whincup, Smith, & Cook, 2006; Steube, Rich-Edwards, Willett, Manson, & Michelle, 2005). Previously it has been found that Metis in Manitoba have a significantly higher rate of diabetes compared to all other Manitobans (12.0% vs. 8.9%) (Bartlett, Sanguins, Carter, Hoepnner, & Mehta, 2010) thus support for breastfeeding may provide an important primary prevention approach to the future development of diabetes.

Breastfeeding is associated with decreased risk of infant mortality from SIDS (Hauck et al., 2011; Vennemann et al., 2009). While some sources claim partial or exclusive breastfeeding were found to have an effect on rates of SIDS (Vennemann et al., 2009) others report the effect is stronger when the baby is solely breastfed (Hauck et al., 2011). It is recommended that infants be breastfed for at least six months, and up to a year to maximize the protective effect (Hauck et al., 2011).

Breastfeeding has been associated with improved early childhood development (Government of Manitoba, 2013b; Wall, 2013). Bier, Oliver, Ferguson, & Vohr (2002) followed 39 premature infants to determine influence of human milk on cognitive and motor development. When assessed at 3, 7, and 12 months (adjusted age), infants who had received human milk scored higher in cognitive testing at 12 months and motor testing at 3 and 12 months. In another study exploring the effect of breastfeeding on infant development, premature infants who had been fed breast milk at least 75% of the time showed better motor maturity and were more alert during social interactions (Feldman & Eidelman, 2003). Breastfeeding has been shown to affect later childhood development as well. In one study with age- and gender-matched cohorts of children aged 5-13, higher rates of breastfeeding were found in those who did not experience nighttime enuresis compared to those who were incontinent at least twice a week (Barone et al., 2006). The association between breastfeeding and cognitive ability was measured for a cohort of 7-8 year olds (Horwood, Darlow, & Mogridge, 2001). It was found that there was both better verbal and performance IQs associated with infants who had been breastfed for eight months or longer. In a meta-analysis, Anderson, Johnstone & Remley (1999) concluded that even after adjusting for cofactors such as maternal education and socioeconomic status, infants who had been breastfed were more likely to score higher on tests for cognitive development. Further they suggested that the benefits increased with duration of breastfeeding. Positive effects in adulthood have been shown by at least one study which found higher scores on verbal,
performance, and full scale IQ tests in two samples of young adults who had been breastfed (Mortenson, Michaelson, Sanders, & Reinisch, 2002).

Finally, breastfeeding is purported to be associated with strengthening the maternal child bond (Else-Quest, Shibley Hyde & Clark, 2003; Labbock, 2003). Else-Quest, Shibley Hyde and Clark (2003) found that “breast-feeding mothers reported more attachment and infant reinforcement at 4 months but not at 12 months” (p. 512) post-delivery and suggested that if early breastfeeding has a positive effect on maternal bonding these feelings are stronger earlier in the postpartum period, and decrease until they are absent by 12 months post-delivery. In fact, they conclude stating “the current data do not support the claim that breastfeeding dyads necessarily have higher quality relationships. Instead, they support the claim that bottle feeding mothers can provide care that is good enough to maintain a high quality mother-infant relationship” (Else-Quest, Shibley Hyde & Clark, 2003, p. 514). Other findings were reported by McKee, Zayas, & Jankowski (204) and Fergusson & Woodward (1999). The former found in their sample of urban low-income Afro-American and Hispanic women that the mother’s sense of closeness with breastfed babies was higher than with their bottle fed babies, while the latter group reported that children who had been breastfed for a longer duration were more likely in later adolescence to report higher level of parental attachment and felt their mothers were more caring compare to those who were bottlefed.

There are benefits to the mother for breastfeeding (Sguassero, 2008). Breastfeeding immediately after delivery results in the release of oxytocin a hormone that helps the mother’s uterus to contract resulting in less loss of blood (Labbock, 2001). In the short term, breastfeeding is believed to delay a woman’s return to fertility (McNeilly, 2001). Frequent feeding postpartum - 10-12 times a day at a minimum - suppresses fertility (Labbok, 2001). Even after a regular menstrual cycle has resumed frequent breastfeeding is associated with decreased fertility (Labbok, 2001).

Over the long term, women who have breastfed demonstrate a reduced risk of developing premenopausal cancers of breast and ovary (Harder, Bergmann, Kallischnigg, & Plagemann, 2006; Health Canada, 2014; Labbok, 2001). In the Long Island Breast Cancer Study project, factors that increased the risk of developing for breast cancer were family history of breast cancer, low parity, being older at birth of first child and little or no breastfeeding (Gammon, 2002). The protective factor against breast cancer was related to length of breastfeeding (Gammon, 2002).

Breastfeeding may reduce the risk of spinal and hip fractures post-menopause (Labbok, 2001).

In Canada, “[b]etween 2005 and 2009/2010, the rate of breastfeeding initiation remained stable between 87% and 88%, while the rate of exclusive breastfeeding for six months increased significantly from 20.3% to 25.9%” (Public Health Agency of Canada, 2014, p. 13). In Manitoba, Martens, Bartlett et al. (2010) found that those women who were older at first birth and had higher incomes were more likely to breastfeed. Moreover, the likelihood of women breastfeeding was influenced by parity – the higher the parity, the less likely a woman would be to breastfeed. They also identified that breastfeeding rates for Metis newborns were lower compared to all other newborns in Manitoba (76% vs. 81.7%). Additionally, breastfeeding initiation rates were lower for Metis women in The Pas (60.3% vs. 76.0%) and in Thompson (67.0% vs. 76.0%) MMF Regions compared to all other Metis women in Manitoba (Martens, Bartlett, et al., 2010).
Recent results from the United Kingdom estimated that treatment for four acute diseases in children (gastrointestinal and lower respiratory tract infections, acute otitis media in infants, necrotizing enterocolitis in preterm babies) costs the UK at least £89 million annually (Pokhrel et al., 2014). The 2009–2010 value of lifetime costs of treating maternal breast cancer was estimated at £959 million. Supporting mothers to exclusively breastfeed until 4 months could be expected to reduce the incidence of three childhood infectious diseases and save at least £11 million annually. Doubling the proportion of mothers currently breastfeeding for 7–18 months in their lifetime is likely to reduce the incidence of maternal breast cancer and save at least £31 million at 2009–2010 value (Pokhreli et al., 2014).

In 2006, the Government of Manitoba developed a provincial strategy and framework for breastfeeding. The purpose was to set a measurable mandate for the RHAs and other funded health care organizations to focus improvements on breastfeeding as a key health issue, and to improve reporting on those issues to increase accountability. The program has achieved good results in terms of skill development and increased rates of breastfeeding (Government of Manitoba, 2013a). In 2013 the strategy was updated. The aims are now fourfold: 1) Increase breastfeeding initiation and exclusivity rates at discharge from hospital, birth centre, or following home birth; 2) Increase the rates of exclusive breastfeeding to 6 months and continued breastfeeding to 2 years and beyond 3) Narrow the gap between breastfeeding initiation, exclusivity and duration between northern and southern Manitoba, urban, rural and isolated communities as well as between different socio-economic groups; and 4) Achieve Baby Friendly Initiative accreditation in Manitoba birthing hospitals, birth centres and community public health offices” (Government of Manitoba, 2013a, p.1).

4.3 Issues of Northern Maternity Care

Where you live influences your health. Eighty-one percent of Canada’s population lives in urban geographies; 19% live in rural geographies (Statistics Canada, 2011b). Reduced access to maternity care in rural and remote settings is a challenge for pregnant women in accessing prenatal care services such as routine blood work, ultrasounds, or specialist appointments (Wilson et al., 2013). Historically Metis have had a strong emphasis on family as a support system—the process of medical transportation for childbirth adds additional stress for a mother who experiences labour, delivery and recovery in isolation. The societal, community, and individual costs associated with medical transportation procedures and subsequent health consequences for Metis women in northern Manitoba are unknown.

Centralization of health services in Canada has brought both positive and negative effects. Rural maternity care services are in decline in Canada (Graves, 2012). Maternity care in Manitoba is generally centralized in hospitals in urban centres (Carroll & Benoit, 2001)—with potential consequences to rural mothers and their babies (Klein, Johnston, Christilaw, & Carty, 2002). Metis women receive no additional health benefits from the Federal government (Bent, Havelock, & Haworth-Brockman, 2007). This—coupled with jurisdictional ambiguities and resource limitations—means that rural Metis might be unable to access locally available federal health services, resulting in the need to travel long distances to access provincial services during their prenatal and antenatal periods. In the Northern Health Region Metis women travel to regional centres such as The Pas, Flin Flon or Thompson for prenatal and maternity care.
4.3.1. Cost of Transportation

For women who are economically vulnerable, expenses such as travelling far distances to receive maternal care (transportation, lodging, time lost at work) can be enormous (Klein et al., 2002). Indeed, Manitoba has the largest rural–urban income disparity in the country, with higher unemployment and lower incomes in rural regions compared to urban regions (Laurent, 2002). Those who cannot afford to travel to other communities for antenatal or intrapartum care could potentially be medically compromised (Kornelson, Moola, & Grzybowski, 2009).

The cost of transportation has been recognized by the provincial government. The Northern Patient Transportation Program [NPTP] is a program available to all people living in the north to subsidize the cost of transportation (Government of Manitoba, 2013b). Eligibility for NPTP is limited to Manitoba residents north of the 53rd parallel on the west of Lake Winnipeg; on the east of Lake Winnipeg to the Ontario boundary coverage is extended south to the 51st parallel. In addition to geographical location, travel must be approved by a physician, and the patient must not have additional coverage from an insurer or funder (Government of Manitoba, 2013b).

Transportation for Metis families in the Northern Health Region is a fundamental need. This need has been documented in other studies by the Manitoba Metis Federation. In these studies access to reliable and affordable transportation is a significant issue for most participants (Bartlett et al., 2012; Sanguins et al., 2013b).

4.3.2 Other Complications Related to Travel

The centralization of health services and the medicalization of childbirth have numerous consequences for women, babies, families, and communities (Klein, Johnston, Christilaw, & Carty, 2002). Increased stress from having to travel to receive maternity care can result in negative pregnancy outcomes (Dooley, Kelly, St. Pierre-Hansen, Antone, Guilfoyle, & Driscoll, 2009). For example, in one British Columbia study rural intrapartum women were 1.3 times more likely to undergo induction in labour compared to women who did not have to travel (Kornelsen, Moola, & Grzybowski, 2009).

In remote communities’ expectant women, even those at low-risk, are required to leave home at 36 weeks gestation (Payne, 2010) because they cannot fly after that point—a policy that was implemented by the federal government to decrease maternal mortality and complications associated with rural and remote childbirth.

4.3.3 Support for Healthy Pregnancies

In the province of Manitoba there are currently several programs available for all pregnant and parutrient women. The most widespread program is the Healthy Baby program funded by Manitoba Health. This program offers prenatal benefits and community supports to pregnant and new mothers across the province (Government of Manitoba, n.d.a).

There are two components to the Healthy Baby program. The first component is the Healthy Baby Prenatal Benefit. This is a cash payment of up to $81.41 monthly available to all pregnant women with incomes under $32,000 a year in their second and third trimesters. Unlike benefits provided in other jurisdictions, the Manitoba Healthy Baby Prenatal Benefit is provided without any condition–women may spend the benefit on whatever they wish (Government
of Manitoba, n.d.a). This program is currently undergoing evaluation but initial results suggest positive outcomes. Early results indicate that the Healthy Baby Prenatal Benefit is associated with a reduction in low birth weight births, reduction in small for gestational age births, fewer preterm births, and an increase in breastfeeding initiation rates. There has been a decrease in length of stay for women with vaginal births and there has been an increase in one and two year immunization rates in the cohort who received the Healthy Baby Prenatal Benefit (Brownell, 2014).

The second component of the Healthy Baby program is comprised of a variety of community support programs available to women during pregnancy and following birth. Healthy Child Manitoba funds Parent-Child Coalitions, the provincial Fetal Alcohol Spectrum Disorder Strategy, and the ‘Healthy Babies’ community support programs offering resources, social support, and informal learning opportunities, prenatally and postpartum in rural and northern communities. All the Healthy Baby support programs offer the same provincial programming based on a standardized curriculum for women during pregnancy and postpartum. All Healthy Baby programs provide support before and after the baby is born, parenting tips, nutrition activities, bonding with baby, and milk coupons (Government of Manitoba, n.d.a). In some areas of Manitoba the Healthy Baby community support programs are co-run by PHAC’s Canadian Prenatal Nutritional Program (CPNP).

Following birth, Public Health Nurses assess families for social and economic risk factors streaming ‘at risk families’ into the Families First program. The Families First home visiting program provides services to families with children (from prenatal to five years old) who are living in what are considered at-risk conditions. These can include “children with congenital health problems, teenage parents, parents in financial difficulties, or parents with mental health problems (Government of Manitoba, 2010, p.1). The Home Visiting Program is offered to any family that is found to be in need. All families are able to maintain contact with their public health nurse following initial assessment, regardless of transitioning into the program. The Families First program offers home visiting supports to families with children at no cost while providing informational supports on accessing available community resources (Government of Manitoba, 2010). In the 2010 program evaluation there were several areas of improvement noted for parents who were involved in the program including increased positive parenting, increased social supports, and increased connection with their neighbourhood (Government of Manitoba, 2010).

The ‘Healthy Beginnings, Supportive Communities: A Strong Future Metis Maternal Child Health’ DVD was developed at the Metis Centre at the National Aboriginal Health Organization when it was identified that existing mainstream and First Nations specific maternal and child health programs were not resonating with Metis women. The DVD provides Metis women and families with information that incorporates Metis values and cultural teachings into their pregnancy and birth experience.

Another support for healthier pregnancies is the InSight Mentoring program (Government of Manitoba, n.d.b). This program is an outreach program in which pregnant women with substance abuse issues are offered intensive support. Typically the mentees are not well connected to community support services. Using a strength-based approach mentors work with the women and their families over a three year period to “build and maintain healthier lifestyle in a supportive, non judgmental way using trauma-informed and harm-reduction practices” (Government of Manitoba, n.d,b, n.p). Results of an evaluation of the program will be available in 2015.
4.4 Metis Women’s Experience in Pregnancy and Childbirth

4.4.1 Metis-Specific Information Gap

There is no Metis-specific information on pregnancy and birth in northern Manitoba. Other research with Metis midwives, health professionals, and elders, identified themes specific to Metis women’s pregnancy and birth experiences including infant care, Metis identity, Metis language, and Metis pride (Infinity Consulting, & National Aboriginal Health Organization, 2010). Specifically, they found that Metis knowledge, traditions, and ceremonies regarding the use of the umbilical cord and placenta, and community support and involvement of elders in labour and delivery were deeply embedded in Metis communities.

Metis women expressed how midwifery and homebirth strengthened family bonds and the impact of hospital birth:

“It was so wonderful, everybody was right there with the baby. While you were in the hospital, there was none of that. That closeness after the baby was born, the closeness of the family—all of that wasn’t there, anymore. By the time the baby came back [from the hospital], and it came home wrapped up, you were scared to even go near it. It was like it was sick or something, because it came from the hospital. It had a big effect on—mostly I would think—the bonding of that baby to the family” (Infinity Consulting & National Aboriginal Health Organization, 2010, p.18)

The National Aboriginal Health Organization identified priorities in their study on Metis maternal and child health in Canada (Infinity Consulting, & National Aboriginal Health Organization, 2010). Metis midwives spoke of the importance of emotional and physical support for the woman and her family. There was also a need for increased cultural competence in the development of maternal and child health programs. Programs needed to be tailored specifically for Metis women, with a focused Metis birthing strategy, and a plan to disseminate and share Metis knowledge within their communities (Infinity Consulting, & National Aboriginal Health Organization, 2010). Metis women saw pregnancy as a time to reclaim their Metis identity while Metis Elders spoke about the importance of traditions, ceremonies, and language (Infinity Consulting, & National Aboriginal Health Organization, 2010). The issue of accessing Aboriginal health care providers was seen as important. Many Metis women expressed their gratitude in having Aboriginal health care providers (Infinity Consulting, & National Aboriginal Health Organization, 2010). Language was another factor impacting Metis women’s pregnancy and birth experience. Metis women identified the need to learn and pass on their languages to their children as a way of bringing about cultural pride (Infinity Consulting, & National Aboriginal Health Organization, 2010).

4.4.2 Impact of Pan-Aboriginal Approaches to Prenatal and Postpartum Programs

Funding for maternal and child health programs in First Nations, Inuit, and Metis communities remains a major challenge for the Canadian health care system as it often embraces a Pan-Aboriginal approach (Health Council of Canada, 2012). Manitoba has established and maintained a distinctions-based approach to program and care development and delivery in other aspects of health care. Society of Obstetricians and Gynaecologists of Canada guidelines state that “Health professionals should recognize that First Nations, Inuit, and Métis may have different perspectives about what culturally safe care is and should seek guidance on community-specific values” (Wilson et al., 2013, p.S3). There is a lack of
awareness about Metis knowledge and traditions that are culturally relevant and accessible to Metis women (Dyck, 2010). The needs of Metis women may not be adequately addressed by current Aboriginal services, with the focus being on First Nations’ needs and priorities instead (Infinity Consulting, & National Aboriginal Health Organization, 2010). Bartlett (2005) identified that the health and well-being of Metis women in Manitoba includes a holistic vision not only physical but also spiritual, emotional, and mental components.

Changing programs will be challenging. Considering Metis women within the family, community, and Nation in which they are situated provides a starting point to refining existing services to offer culturally appropriate maternity care.

4.5 Summary

Pregnancy and delivery are natural processes that for many women occur with little intervention. For those who do need assistance it is important that they have early and ongoing interactions with their health care provider(s). In Canada, there are substantial health disparities between urban and rural communities, and in Manitoba it is no different. The province’s centralized health system and geography create immense challenges for providing quality maternal health care. While much research has been done regarding the state of maternal health care in Canada, little is known about maternal health care for northern Metis women in Manitoba or Canada. Studies have identified many barriers to adequate maternal health care including lack of health care providers such as physicians, aboriginal midwives, registered midwives, and primary care nurses. Broader issues of transportation and centralization of health services are also barriers to care for Metis women in Manitoba. While there are several provincial and local supports for maternal health services in northern Manitoba, programs and services that consider/incorporate Metis values and traditions are quite limited.
References


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saine/pregnancy-mental-health-grossesse-sante-mentale/index-eng.php


Section 5: Research Design

5.1 Methodology

A community-based participatory research (CBPR) approach was used in this study. CBPR is a collaborative approach to research that equitably involves all partners in the research and process, and recognizes the unique strengths that each brings (Israel, Schulz, & Parker, 1998). CBPR is used to engage with community partners—in this case Metis women in northern Manitoba—in the research process, and to benefit the community by translating the knowledge gained in the research into intervention and policy change (Cargo & Mercer, 2008). This process in turn is used to create social change, build relationships based on trust, improve the quality of life for community partners, and give them a voice (Israel et al., 1998).

A guiding principle of CBPR is that the community is seen as a unit of identity. CBPR has a co-operative focus—to engage community members and researchers in a joint process in which they contribute equally. Other guiding principles ensure that CBPR is:

- Conducive to co-learning and a capacity building process;
- Empowering to community partners (builds on strengths and resources of community);
- Mutually beneficial with a balance between research and action; and
- Recognizant of the long-term, cyclical, and iterative nature of the CBPR process.

In keeping with the principles of CBPR, this research was conducted in collaboration with members of the MMF community, who assisted in every phase of the project—from selecting the study sites, through recruiting participants, to analyzing the data, and to interpreting the data. Community members on the research team also reviewed the preliminary report and assisted in dissemination of report results in the community.

5.2 Methods

5.2.1 Protocol for Entry into Communities

In recognition of, and in commitment to, CBPR principles and to strengthen bonds of trust with the Metis community, researchers in this study followed a specific process to obtain permission and gain access to Metis communities for relationship building and data collection. This process engaged community collaborators at each step. A letter of support was secured from the Vice-Presidents of MMF The Pas and MMF Thompson Regions. The Region’s Vice-Presidents assisted in recruiting participants by contacting the chairs of the Metis Locals in regional communities and informing them of the research to garner interest among local Metis citizens. They arranged meeting space, provided refreshments for the focus groups, and attended all focus groups and interviews to introduce the researcher and assist with note taking as well as data analysis.

A letter of support was also obtained from the Northern Health Region for the project and to gain permission to approach health care staff employed by them.

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3 Locals are Metis communities in which one or more members of the community have a membership affiliation with the Manitoba Metis Federation. Locals provide a contact for Metis affairs throughout Manitoba.
5.2.2 Data Collection

This study focuses on four northern communities in the MMF The Pas Region and MMF Thompson Region, regions located north of the 53rd parallel (see Figure 2.3.1) and within the Northern Health Region. There is much discrepancy in the ways that the terms “northern”, “rural”, “remote”, and “isolated” are defined in the literature. For the purposes of this study, northern areas—sometimes referred to as “the north”—are all the areas in Manitoba located north of the 53rd parallel (see Figure 2.3.1). This definition of northern areas is used by other organizations in the province, including Manitoba Health. For example, to be considered a northern resident eligible to receive the benefits of the Northern Patient Transportation Program, the resident must live north of the 53rd parallel (Government of Manitoba, 2013). In this study, we examined four northern communities in which Metis lived—all of which were located north of the 53rd parallel.

Figure 5.2.1 Map of Manitoba Indicating MMF The Pas and Thompson Regions (53rd parallel indicated in red)


Rural areas can further be classified as being remote or isolated. The Rural Committee of the Canadian Association of Emergency Physicians (1997) defined rural remote as “those rural
communities about 80–400 km (or 1–4 hours of transport in good weather) away from a major regional hospital” and rural isolated as “rural communities greater than 400 km away from a major regional hospital (4 hours or more of transport in good weather)” (p.12). As per these definitions, only one of the northern Metis communities involved in this study was rural remote (by population size and density, as well as distance to an urban center). The community did not have reliable road access as it was gravel-topped, often in poor condition, difficult to traverse in the springtime, and isolated during the winter months. The other three communities had access to a hospital however none of the hospitals could be classified as a “major regional hospital”. It is important to note here that several rural/remote communities were approached to participate in the study but were unable to take part. As a result the women in our sample had access to more services than we would typically expect in more rural or remote communities.

In keeping with the principles of community-based participatory research, MMF The Pas Region and MMF Thompson Region research team members were influential in choosing the study communities. Three communities chosen for focus groups with Metis women were small towns with regional hospitals. The other community identified by the team was two hours by car in good weather away from a regional hospital. A description of the study region follows—however in order to maintain the anonymity of the study participants no description of the specific study communities is given. The results from the four communities were pooled together to reflect the collective voices of Metis and our analysis does not provide the results for each community separately.

Participants were chosen through snowball sampling (Miles & Huberman, 1994), with key people providing the community collaborators with the contact information of those who had indicated an interest in participating in the project. In order to inform community members about the study, posters were also displayed in the local post offices, Friendship Centres, and MMF Regional Offices. The poster was also printed in the MMF regional newsletter and radio advertisements were broadcasted on local community radio stations.

Once participants were recruited, the Project Coordinator, with guidance from the Principal Investigator, obtained informed consent from each participant. Individuals who were interested in participating had the study explained to them, were provided with an opportunity to ask questions of the researcher, and were asked to read and sign the consent forms. The consent form was explained in detail as required.
Focus groups and key informant interviews were carried out in four communities. Throughout the data collection period, one visit was made to each of the communities. Each focus group involved three to six individuals with a total of 16 women participating in the focus groups. Basic demographic information was collected from the participants—this information was anonymized, aggregated, and will be used for descriptive purposes only. Each of the four focus groups lasted approximately 1.5 hours.

Thirteen key informant interviews were undertaken with health care providers using a semi-structured interview tool in order to create a holistic picture of the prenatal and maternal health care systems, including their strengths and challenges. The key informants were individuals who provided health services in one, or more, of the study communities. They were health providers employed as staff with the Northern Health Region, or as physicians practicing in the region. Each person who volunteered to participate was interviewed. The key informant interviews lasted approximately 1.5 hours. Respondents were asked questions pertaining to prenatal and maternal health services, community strengths and weaknesses, existing health-related services and programs in the community, barriers to care, and their own personal experiences.

Based on the previous work done in the community, the overarching research question guiding this inquiry was “What are the experiences of Metis women with accessing maternity care in their own communities?”

Specific objectives of the study were to articulate resources that currently exist for pregnant and parturient Metis women in Manitoba, and include:

- To identify and describe existing supports (programs and services) for pregnant and parturient Metis women within the provincial health care system
- To identify and describe existing supports (programs and services) for pregnant and parturient Metis women in the Northern Health Region
- To identify and describe supports required for wellness for pregnant and parturient Metis women in the Northern Health Region
- To identify and describe existing governance structures that support wellness for pregnant and parturient Metis women in the Northern Health Region.

5.2.3 Data Analysis

Data analysis was conducted by all members of the research team using the Collective Consensual Data Analytic Process (CCDAP) (Bartlett, Iwasaki, Gottlieb, Hall, & Mannell, 2007). Key informant interviews and focus group discussions were transcribed by the Project Coordinator. Each transcript was reviewed and coded separately by two people—the Project Coordinator and the Principal Investigator. In this coding process, each narrative was broken down into ideas, and key phrases were identified. These phrases were then printed onto cards. The two coders then compared their coding to ensure consistency in coding or inter-rater reliability. After all of the transcripts were coded, the entire research team met in a facilitated analysis session. The team worked collectively to cluster the cards under random symbols. Once all the cards were placed on the wall, the clusters were themed according to the information they contained. Two groups of analysis occurred: one for Metis women and the other for care providers. Results of the analysis are presented and discussed in Section 6. To protect the anonymity of participants, names are not attached to quotes used in the analysis and results.
5.3 Ethics

The fundamental tenet of the project was that it was founded within an ‘ethical space’ whereby representatives of the Manitoba Metis community could meet together with researchers through all stages of the research project in order to engage in a constructive dialogue about the intentions, values, and assumptions of each project partner. Constant engagement in this ‘ethical space’ allowed for a deeper understanding of the unique perspectives of Metis community representatives and researchers, the development of common interests for both partners, and the promotion of mutual respect and trust which has continued even after the completion of the research project (Castellano & Reading, 2010; Ermine, 2007). Indeed, the Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada & Social Sciences and Humanities Research Council of Canada (2010) advise “taking time to establish a relationship can promote mutual trust and communication, identify mutually beneficial research goals, define appropriate research collaborations or partnerships, and ensure that the conduct of research adheres to the core principles of Respect for Persons, Concern for Welfare—which in this context includes welfare of the collective, as understood by all parties involved—and Justice” (p. 110). Principles of Metis-focused research (ownership, control, access, and stewardship) were negotiated and respected throughout the research process.

Ethical approval for the project was secured through the University of Manitoba Human Research Ethics Board (Bannatyne Campus).

5.4 Rigour and Trustworthiness of Data

In any qualitative study it is essential to discuss the topic of trustworthiness as it relates to the study findings. There are a variety of methods by which a qualitative study can be evaluated to establish its trustworthiness. One of these methods is to apply Guba & Lincoln’s (1989) set of four evaluative criteria to the study. These four criteria include credibility, transferability, dependability, and confirmability. To achieve the first criterion, Shenton (2004) listed a number of measures that can be taken by researchers, some of which include adopting well established research methods; developing an early familiarity with the subjects’ culture; triangulating (the use of different methods such as focus groups and personal interviews); using tactics to encourage honesty in informants; peer scrutinizing of the project; and examining past research findings to assess congruence with the current research. We believe these steps have been taken in this study—a testament to the credibility of this research. Shenton discussed the difficulty in applying the research findings to other situations and populations but indicated that to allow transferability, the second criterion; researchers must provide enough detail on their study to allow others to replicate the study. In order to meet the second criterion, we have carefully documented the methods used in this study. In order to establish confirmability we have taken steps to ensure the findings accurately represent the data, by ensuring that the original coding was completed independently by two individuals and that our analysis process was done collectively. We believe that we created knowledge in a systematic manner that builds on previous literature and extends understanding access to maternity services and supports for Metis women in Manitoba. Understanding of these experiences may ultimately lead to better support for those seeking services.
5.5 Knowledge Translation

Knowledge Translation (KT) is an important aspect of successful community-based research (Masching, 2006) used to focus on the interactions or partnerships between the research team and end users to facilitate the use of research findings in decision making (Shea et al., 2005). KT is accomplished by generating and mobilizing research findings into a structured knowledge-sharing platform, ensuring appropriate engagement amongst researchers, policy developers, program deliverers, and communities of interest.

The results of the study are being used to produce this report for the Manitoba Metis Federation. Data are reported in an aggregated form, and no participant-identifiable data are presented. All publications are subject to prior review by the Manitoba Metis Federation. Community members on the research team reviewed the draft report and data synthesis, and will participate in the dissemination of report results in the community. Additionally, information will be disseminated to the communities in more established mechanisms of newsletters, face-to-face sessions, and at their annual general meeting. Participants have also been offered the option of having the report mailed directly to their homes. Abstracts will be submitted to relevant academic conferences.

5.6 Limitations

There are always limitations inherent in carrying out a qualitative study. In the ‘Reclaiming Birth: Understanding Access to Maternity Services and Supports for Metis Women in Manitoba’ several communities were approached to participate in the study but were unable to take part. As a result the women in our sample had more access to services than we would typically expect in more remote communities. A related limitation was seasonality. In this study, focus groups and key informant interviews were collected during the winter and spring seasons. As a result, during the winter it was difficult to travel to smaller rural and remote Metis communities. During the spring some communities that would have provided a better picture of rural/remote experience were excluded due to spring flooding, which made it impossible for us to reach them. In one study site, physical access to the community was slow and bumpy due to heavy construction on the unpaved road.

Pregnant teens were not included in this study. Metis teen pregnancy rates are higher compared to that of all other Manitoba teens (70.2 vs. 46.4 per 1000) (Martens, Barlett et al., 2010). Metis teen pregnancy was identified as a sub-theme in this study and as an area that needs further exploration.

As with any qualitative study, data is comprised of the experiences of a few individuals and are not generalizable to the larger population. As the responses were not ranked by participants in order of their importance, further research is needed to provide policy makers with substantive evidence for program direction. Nonetheless, given the lack of Metis-specific information regarding access to maternity services and supports in the Northern Health Region the present study will offer an important and useful starting point for discussion within the region. Findings will also be of interest to other MMF Regions in the province as well as to Metis in other provinces.
References


Section 6: Findings

In this section, the results of the study will be presented and discussed. As described in Section 5, focus group discussions (Metis women) and key informant interviews (health care providers) were recorded, transcribed, and then underwent a process of data display and theming using the previously described CCDAP method (Bartlett, Iwasaki, Gottlieb, Hall, & Mannell, 2007). In section 6.1 we provide a description of our sample. In Section 6.2 the voices of Metis women are presented and discussed. Then, in Section 6.3 the experiences of prenatal and maternity health care providers are presented. It is important to note that there is an overlap between some sections, as many of the issues were identified by both Metis women and care providers. Accordingly, issues may be presented more than once if they were discussed in focus groups and in key informant interviews.

6.1 Description of Sample

Focus groups were held in four communities. A total of sixteen Metis women took part in the focus groups and thirteen care providers, predominantly women, engaged in key informant interviews. All participants completed demographic information surveys.

In the focus groups, participants ranged in age as follows: under 20 years (6%); 20-29 years (56%); 30-39 years (31%); and 40-49 years (6%). The age at first pregnancy was under 20 years for 50% of participants and 20-25 years for the other 50% of participants. Almost one third (30%) of the women had one child; 38% had two children; 13% had three children; 13% had four children; and 6% had five children or more. The majority of participants (75%) travelled less than 5 kilometers for prenatal care; 13% of the women travelled 5-25 kilometers for prenatal care and 12% travelled 25-100 km for prenatal care. Access to transportation was always available for 50% of participants, occasionally available for 44% of participants and unreliable for 6% of participants. The majority of participants had a high school education (81%) with the remainder of women holding a university degree. The majority of participants reported an annual income of less than $20,000 per year: 38% were under $10,000 and 25% were between $10,000-$20,000 annually. While 13% of participants reported an income of $20,000-$40,000 annually, 12% claimed $40,000-$60,000 and 12% reported an income of $60,000 a year or more.

The majority of key informant care providers were between the ages of 30-39 years (39%), while 15% were under 20 years, 20% were 20-29 years, 20% were 50-59 years, and 6% were 60-69 years. All of the key informants provided care in the community in which they were interviewed, and 15% also provided itinerant care in another community. For those providing itinerant services (n=4), 2 people travelled under 5 km, 1 person travelled 5-25 kms, and 1 person travelled over 400km to the site where they provide prenatal care. The frequency in which key informant travelled for services was daily (1), a few times per week (1), and ‘as needed’ (2).

6.2 Metis Women’s Voices

The following ideas were gathered from the experiences and opinions of Metis women living in northern communities in the MMF The Pas and MMF Thompson Regions who participated in this study. While each of the four communities in this study is unique, their
residents share many of the same challenges and barriers to health services. In order to gain an understanding of Metis women’s prenatal and maternal health care experiences, participants were asked to respond to a series of open-ended questions based on the Wellness Areas® during focus groups. The following topics emerged as important themes related to Reclaiming Birth: Understanding Access to Maternity Services and Supports for Metis Women in Northern Manitoba: Impact of Pregnancy; Metis Women’s Birthing Experiences; Health and Social Services; Being Metis; and Looking to the Future. Each theme will be explored in the following pages.

6.2.1 Impact of Pregnancy

Pregnancy experiences varied among the women. Pregnancy impacted their nature – or how they saw themselves physically, emotionally, psychologically and spiritually.

**Emotional and Physical Impact of Pregnancy**

Emotional and physical changes impact all women during pregnancy. In this study, Metis women had a wide range of positive and negative feelings and concerns regarding their pregnancy. Overall, Metis women experienced strong emotionally positive reactions.

“My family was excited. I was excited. My boyfriend was excited.”

“I was happy I was pregnant and I still am. I loved it. I am happier than I was before I had a baby, and I loved being pregnant and I enjoyed the nine months of being pregnant.”

“I loved being pregnant, and I have like 7 kids and my oldest one is having his own family now and my baby is just 17 months old and it’s just a big gap. So I did that ‘been there and here’ kinda mom.”

“I just loved it and with all my pregnancies I loved it. I loved having kids and it just seemed that’s what I am here for. To just make the best things.”

Not all women experienced a positive emotional response to pregnancy.

“I didn’t want to be pregnant. It was too fast ‘cause I just had the other one and I didn’t want the kids so fast. My other son just turned two. I’m excited now…”

“Well my first pregnancy I was young, naïve, and alone. I lived with my mom and the father was nowhere to be found or unheard of so I felt that I was not doing right by my baby and I should not have been pregnant and I felt stressed - and I felt stressed and hurt.”

“It’s hard to be pregnant especially when you are not where you want to be in your life”.

Women spoke freely about the range of emotions they experienced while they were pregnant. We were told:

“Cry for nothing. Your emotions when you’re pregnant (everyone laughs). Oh my sisters’ ‘Oh it’s your birthday coming up’ and I start bawling… ‘I’m gonna be this age’. You know?”

“I was irritable and sometimes I didn’t want to be cuddled or anything like that.”

“It was a hard struggle being a first [time] parent ‘cause it’s like something new and all these emotions you would go through and always angry and sad.”
One participant reflected on the effect of her emotional rollercoaster while she was pregnant. She recounted:

“…my spouse, it was more distant because it seemed to me that he didn’t understand what I was going through and I noticed that once in awhile I would have these emotional bursts and he wouldn’t understand my hormones, what my hormones are going through, so it was up and down and good and bad.”

There were concerns over physical changes during pregnancy. Some women were concerned about weight gain during pregnancy.

“The only thing I am scared of is that supposedly every woman in my family that’s ever been pregnant gets huge! So nobody gains less than 30-40 pounds in my family. So that’s what I’m expecting and watching what I eat.”

“Losing the weight (laughs). It’s hard for me!”

Pregnancy was expressed by some as draining and tiring. Women reflected on the physical toll pregnancy took on their bodies.

“My pregnancy was kind of hard. I kept getting admitted to the hospital because I had high blood pressure and I quit my job because I was like two months pregnant and how bad my morning sickness was ‘cause it was a little bit of financial stress. But all is good now.”

Pregnancy was described as a time of abstinence from previously established habits.

“I think some people don’t realize that when you are pregnant the things you have to give up too. They take it for granted. Like I know with me, everyone was, like I was heavy into drinking and everything and I like stopped…”

“I stopped smoking just because I see my dad and my different family members who had asthma and sometimes so bad they just turn blue like they my dad…and some people are like ‘That shouldn’t affect you smoking and you should still smoke and blah blah blah’ and I tried tell [them] how ‘You shouldn’t be when you are pregnant and you are suppose[d] to do this’. [They would tell me] ‘You can still do that’, and I’m like ‘No’.”

“I love Greek salad and I couldn’t eat it when I was pregnant because they say not to eat it because of the feta cheese and not eat Caesar salad because of the dressing and everything and all these things that I love and I was like ‘Oh no you shouldn’t be eating them’ ‘cause of the different risk involved even though it’s just tiny and I was like ‘Tell me what I was supposed to eat then!’ ”

**Financial Impact**

Finances are an important support for all families. Most of the participants experienced financial stress during pregnancy and postpartum. For some women the decrease in employment income to maternity leave benefits was a big adjustment. For many women, the wait time for Employment Insurance [EI] maternity benefits was stressful and lengthy.

“I had my baby…and that was 6 years ago but I had to wait like ‘til the end of February before I got anything and they were like ‘Sorry it’s coming. It’s coming’. Every time you phone and I was like ‘No, it’s not coming’. ”

“I think for me it was after I had my baby, like going on maternity leave, to go on such a drop in pay”

“I am still waiting for it [EI] and my kid is four months old.”
"I took it [maternity leave] a month early and I’ve been waiting for 5 months now [for EI]."

Costs of medications and prenatal vitamins were problematic for some women.

“For me it was hard ‘cause I had to pay for my medicines. It’s normal but I got lots of yeast infections when I was pregnant with my daughter and it was hard to pay for my medications all the time and I didn’t know at the time being a first [time] pregnant Metis mother. I didn’t know Public Health gave out medications. Like now I know with him [her son], they have medications and stuff like that. Before I didn’t know and it was hard.”

“…with my second baby I never went for any prenatal care for him. I didn't even give him vitamins… at the time I was living in the city with him and I never really had money and I never really had bus fare to get to my appointments so I missed my ultrasounds and I was never able to get out…”

The lack of meaningful and sustainable employment opportunities in their community was an issue for some participants. Many women spoke about the struggles they experienced due to reliance on social assistance.

“Like my older ones when they were growing up, again it was financial stress because we are on social assistance, like there are no jobs [in Community x] whatsoever.”

**Impact on Social Networks**

At a time in their lives when personal supports are really important, many women spoke of how pregnancy had impacted and changed their social networks. The change in social networks for Metis women was identified as a transformation in which women came to understand themselves and their friendships better.

Many women spoke about how pregnancy and becoming a mother ended previous friendships.

“…Like nobody, wanted to, well you find out who your true friends were, like who stayed with you.”

“…and then I found out who my real friends were because they just completely left and I have never spoken to them again.”

“When I didn’t have kids I always had friends ‘cause I drank, and I stopped drinking and I stopped having friends.”

**Ageism**

Ageism, or stereotypes attributed to individuals based on their age, during pregnancy and birth can be experienced by both older mothers and younger mothers. Some of the women in this study described experiences of ageism - judgment or discrimination - during pregnancy and labour by family, friends, and health professionals. An older mother described the reaction she got from people during her most recent pregnancy.

“[For] me the reaction I got from my last baby I had was ‘What? How old are you?’ ”
Another woman spoke about people’s judgments towards women during pregnancy.

“I have never experienced that myself but other people have said things like ‘She is too young to be pregnant’ or ‘She is too old to be pregnant’. I have never experienced it myself but being around people who do talk about others.”

**Impact on Intimate Partner Relationships**

From the participants in this study we learned that there existed a spectrum of intimate partner relationships. Most of the participants in this study described positive, supportive relationships with their partners. These relationships nurtured them and enabled them to feel supported and cared for during their pregnancies and into parenthood.

“My boyfriend was very supportive; like always there for me”.

“I rely on my husband for my support”.

“I have my husband here. Anytime he’s not really busy and I asked him ahead of time, he [helps out]. He doesn’t force me to ask him to do something”.

Regrettably this was not always the case. For some the relationship was characterized by simply a lack of support during pregnancy and postpartum periods. For example, one woman realized that her partner was working out of town to support her, yet she missed his physical presence.

“When I found out I was pregnant, he left right away because he had to go out to work because he works out of province and that was his way of supporting me, like going away to make money for the family and then we moved into our own place after and I felt good about it but there was a lot of times when I felt alone and I just wanted him to be with me.”

Some women reflected on lack of support of the partner and how it affected them.

“Well I was in a relationship for a long time, and then we got pregnant and that put a lot of strain on it. And he couldn’t accept it for a little while.”

“I have six others [children] with this guy I’m with now. During the years, he hasn’t been supportive I felt and hasn’t been there for me during my pregnancies. Sure he says ‘I love my kids’ and hold my stomach and say, like ‘You are holding my baby I love you for doing this’, whatever but he didn’t comfort me. It’s just that I needed someone to be there for me but I didn’t get that…It made me a stronger person I believe.”

“…after I had [daughter’s name] he was gone for a month. He was gone with his friends and the important month of [daughter’s name] life but he says if he could be would try and change it, be there for her and be there for her in the first month of her life…”

“How did it make you feel when he left and went drinking?”

“I was sad. I was like ‘How can he do that?’ you know, ‘How can he miss the important month of her life like to watch all her emotions and her cooings and cuddles and the first time noticing she had hands!’ Like the important stuff, it hurt me.”

Other women in the focus groups spoke frankly of their experiences with intimate partner violence that often escalated during pregnancy. Violence against women during pregnancy included physical and emotional abuse. One participant initiated the discussion by identifying anger in her son and blaming herself for it.
“My oldest son now I feel that he has a lot of anger issues and I am blaming myself for that ‘cause of how I felt when I was pregnant with him. Like I believe that these younger women should have emotional support.”

Another woman accepted blame for the presence of violence in her home.

“I know that’s not the healthy lifestyle for my children but it just seems that I have to live it because it’s the life that I chose but I don’t want it for my kids. I feel like I birthed to live it because of my home”.

A young mother spoke of physical violence at the hands of her partner during her first pregnancy.

“When I was pregnant with my daughter, I got in an argument and I was trying to stop him from leaving and he pulled me down and started dragging me around by my hair and I was worried about my daughter...be kneed me in the stomach and then strangled me and then I blacked out for a couple of minutes.”

Women spoke of being wounded or nearly killed during pregnancy by intimate partners.

“I lost my hearing because of my ex. He shot me in my ear and he tipped my forehead and shot me.”

“...he was choking me out and I blacked out and thank goodness my mom was there, I don’t know what the hell would have happened. Like it was scary. When I started to see the black I thought ‘Oh my God’, I’m like dying’. And I was like ‘I don’t even know who’s gonna take care of my son.’ ”

Consistent with stories of other women in similar circumstances, many women believed their partner would change.

“Christmas day, me and my oldest son’s father, broke up on Christmas day, because he, like throughout my pregnancy he started to get a little bit better, but then he was way worse at the end, and then worse than he was before and I was like ‘Okay’, I kept telling myself like, ‘He’s gonna change, once he sees that baby, he’s gonna change’. I was wrong. (laughing). It was the hardest decision I ever made ‘cause on that day when I told him I was gonna leave him.”

“...like you know that [pregnancy] probably contributed to part of it like getting abused and stuff. Like whenever I was pregnant he would just start going like that and I kept saying ‘He’s gonna change, he’s gonna change because of...for my son...for my kids. Like things are gonna get better’. I would try to fool myself.”

“...he tells me ‘I am sorry, I’m sorry’. I say ‘Why are you sorry?’ and he says ‘Because I could have killed your baby or I could have killed you’. I say ‘It’s okay and she’s here and she’s alive and I’m alive too as long as you don’t hit me again’. He says ‘I’m better now’.”

Women described temporary changes in their lives they had made to protect themselves.

“Right to my last pregnancy that’s exactly what you just explained: the violence, the arguing, the emotional stress on me, it was just all there. There was a time when I knew he was out drinking so I locked all the doors and closed all the windows and this was in the summertime and he come home and he was banging on the door and the kids started getting up and he kept banging on the door, banging on the door and then he left and it scared me. That’s when I was thinking ‘What’s going to happen? What’s going to happen?’, if he gets through that door. But then something just told me don’t open that door because I knew he was really intoxicated and he was mad and I don’t know
why, I just didn’t open the door for him and I believe that I did a good thing by not opening the door because I felt that it would have turned into physical abuse."

“They have a shelter for women in [town], and I been there a couple of times, like during the past 24-25 years. I take my kids with me there, either sleeping or would hope they are sleeping…and it just seems like if there was a house, like a place for me and my kids to go, like I would, like a drop of a hat. I would leave this community. It’s just travelling with the kids and not knowing where to go.”

Other women did not have a place to go.

“Through my other pregnancies I just didn’t think of it as much until this last pregnancy and I think he drank more during this last pregnancy and he just did more damage, then emotionally so he wasn’t there for me. I felt like I wanted to leave him but then I thought my kids had a home and I didn’t know where to go.”

One woman recounted the story of her former partner’s use of physical violence. Her experience has empowered her to share her story with Metis women to help prevent future violence.

“I was living with this guy who abused me for 3 years. I helped women get out of abusive relationships because of the scars that I had ‘cause I got stabbed, I got beaten, I got raped and stuff. I shared my stories with other women around here because they don’t know how to share their stories with other women to get out of domestic violence because it keeps going in a cycle and it don’t stop…I thank God for giving me another chance on life. Being with a guy who never loved me but abused me. I don’t [know] why I fell for that; it’s crazy. He’s still in jail; he got 15 years-to-life after what he did. I love being Metis and I wish more Metis women would come forward and share their stories…That’s why I like to share my story with my Metis friends, but a lot of other women too”.

**Pregnancy as a Life Altering Experience**

Many women spoke of pregnancy as a period of transformation or as a life altering experience. Some of the changes reported by participants included recovering from substance abuse, reducing alcohol consumption, and the transition into motherhood. In this context the life altering experience was always for the betterment of the woman as she transitioned into motherhood changing her life ‘for the better’.

One woman’s life altering experience during pregnancy was stopping the use of crack. When she became pregnant she was able to overcome addiction.

“I was too deep in my lifestyle of drinking and getting high. Like I was crack user and me I was walking the streets of [city], trying to find ways to support my habits and then I came out here and I got pregnant with my daughter and I stopped everything. Even now I had those feelings of withdrawal and I was okay and I always wanted my pipe but no, I never touched it since I found out I was pregnant.”

Other participants also reflected on the metamorphosis in their lives.

“…now I am happy to have kids and happy to be alive. It was stupid what I did and I didn’t know that then but now I’m happy that I am not dead ‘cause today I have two kids and a man who loves me. I really do think if I didn’t have kids I wouldn’t be here.”

“I was wild and everybody thought ‘She’s gonna be a bad mom’, and I thought ‘Oh yeah, right’ but I am probably one of the best ones out of all my brothers and sisters [laughing]!”
“I was an alcoholic, I partied, I did everything and I was suicidal and I got pregnant with [daughter’s name] and everything changed. I stopped drinking, I quit everything right when I found out I was pregnant.”

“I thought I wouldn’t be able to do it but I’m actually a good mom and it’s changed my whole life around.”

6.2.2 Metis Women’s Birthing Experiences

Metis women’s birthing experiences in northern Manitoba reflect a broad spectrum. These ranged from women trusting in their own bodies to feelings of disengagement due to negative experiences within the health care system. Overall, while northern Metis women had similar labouring and birth challenges to other women, the limited knowledge of Metis culture and identity among health care providers led to dissatisfaction with their care for some participants. Many women spoke of the influence of having a care provider they were familiar with, either a physician or a midwife, to their sense of having a ‘good’ delivery.

Labour Experiences

Labour experiences differed between Metis women; they also differed with each pregnancy. Participants spoke at length about these experiences. The amount of governance or ability to influence their destiny and future affected their perspective of the experience.

One Metis woman spoke of how she planned ahead in preparation for labour to improve her experiences.

“This was just like one of the earlier pregnancies; it wasn’t my last previous pregnancies. I learned from that, when I start having the pains is familiar pains and I just act. I didn’t hold anything back. I just told them I’m having pain and now I know I am supposed to wait five minutes then minutes before the contractions are apart, they are something. I let everyone know ahead of time, like the taxis are going to be available and the nurses are going to be available. I just planned that all out.”

“My last baby they sent me home and I said ‘I don’t want to go home’…They were sending me home, and I went from three centimeters to nine and they were sending me home, and I knew that something was wrong. And so I called my sister and they said they are sending me home as I was having a contraction. And it wouldn’t show up on the monitor my contractions at all…And I told her ‘Feel my belly’ and she started feeling and she believed me and she’s like timing and she’s like ‘You are like three minutes apart’. Gradually going faster and faster and you are one minute apart and ‘Don’t push’ and ‘[the nurses] are going crazy.’

“With my daughter the nurses couldn’t make up their mind about what they wanted me to do as soon as I went in they were like ‘Okay, you are four centimeters you have to say here’ and they made me try walking up and down the hallway and then try to do the ball and different things. As soon as I started doing it they said ‘What are you doing? You are supposed to be on the bed’.”

Another Metis woman had her birth plans changed during her labour.

“Yeah I got it an epidural. I felt pressured to do it.”
**Delivery Experiences**

A range of delivery experiences were reported by participants. Some had very good experiences with their infant’s birth while others had less favourable memories.

“My experiences were pretty good, I only had to stay in the hospital for one night and everyone was good, hands on and they all helped me.”

“And because it’s my seventh pregnancy, ‘okay if I am going push it out, you better catch him’ and if the doctor wasn’t there I just listen to whatever my body told me to do.”

“…when I had my baby she was like the first baby she [the doctor] ever delivered, and it was just like a total gong show, and I was like ‘Never again!’ I was like ‘Oh my God! I can just do this myself - just get out of the way!’ (laughing).”

“For myself I had nine people in there. I had three student nurses and two doctors; it was an awesome delivery but then after I had her, no one came to check on me. They put me in the back room and I thought ‘What you are not going to check on me ’cause I got three kids?’”

One woman recounted how her plans for a scheduled caesarean section got changed.

“For me I was supposed to be induced on January 1st, so I got there at like 8:00 in the morning. They are like ‘Get the gown on and get all ready. Here’s your room’, and all of a sudden they come and an hour later I was getting all excited ‘cause I thought, you know, this was gonna be the day. They were like ‘Oh no, you are gonna have to go home’ and I was like ‘Why?’ Well, the doctor went out to the New Years’ Eve party last night so she’s not feeling too good today. Can you come back tomorrow?’…I was like ‘Are you serious?’ So I came back the next day and the same thing happened to me. I don’t live like five minutes away. I have to drive like 40 minutes to get there. And just the excitement of this is the day and then it’s like ‘No. Go home’. You know? I was just so pissed off. I didn’t even want to see her face.”

The need for emotional support during delivery was articulated by participants. If they were able to be supported by family or friends they appreciated it; if there was no one present with them labour and delivery became more challenging.

“My room was full, all family, when I had my daughter”.

“That was negative again because I didn’t have nobody with me.”

The importance of continuity of care, either by physicians or a midwife, was articulated by the women in this study. For some this meant having the same health care provider for the delivery of multiple generations in their families.

“Dr. Y delivered me and all my kids. He’s pretty old and he is still working but not delivering babies.”

“Dr. X. is a good doctor; he’s the one who delivered me! And he delivered my kids.”

“He delivered you and he delivered my kids.”

“My family doctor, he helped me through a lot. Like he always gave me advice like being so close to labour, he told me to ‘walk lots, be active, you won’t have such a hard labour’.”

Having a baby delivered by a care provider with whom you are unfamiliar can be uncomfortable and distressing. This woman remembered:
“Some doctor at the hospital gave birth to my baby but it was weird ‘cause I never had a guy look down there before besides my boyfriend and he had put his fingers down there and was looking backward and he could tell I felt awkward.”

Another woman spoke of her baby being delivered by a provider with whom she was not familiar.

“For me I was four centimeters dilated so they couldn’t take me to [City] so I had my baby in [Community Z] and some guy gave birth to me ‘cause I thought the midwife would be back but I had [my baby] ten days early.”

It was clear in the focus groups that given the option many women would prefer to have a midwife as their care provider. Many women spoke of midwifery offering them a different more holistic birth experience as they felt they learned more about what to expect. Women spoke of the positive support and strength they received from the midwife in their community. One woman stated her midwife was ‘really there’ for her:

“Actually, three times a month I walked to the midwife or she would come and see me, even after the baby is born for home visits, and she will bring a training midwife who comes with her and does whatever she needs to learn, the midwives experiences. I want to be a midwife too. That’s pretty cool and I don’t have to wait to see one doctor. You just go see the midwife and she would be ready to come and talk with you.”

Women spoke of how different the prenatal and birth experiences were when they had a midwife.

“My other pregnancy I found out at 13 weeks and I went to see the midwife here and she was so nice and made me feel welcome and made the second pregnancy feel different, learning more what to expect and it’s just different.”

“I had a midwife. It was good hands on; and she massaged you and really hands on. She wants you to be in most comfortable environment you want to be in. Unless you say ‘it’s okay’ she won’t let any other nurses help you”.

6.2.3 Health and Social Services

The theme ‘Health and Social Services’ encompasses a wide range of prenatal and maternity factors. These include the provision of a wide array of health services, monitoring and improvement of the quality of maternity services, the provision of social service and support in the community, and the promotion of ‘breast is best’ policy.

Prenatal Programming

Prenatal services that were discussed by the women in the focus groups included programs that assisted women during their pregnancy and in preparation for labour and birth of their children. One participant had learned a lot experientially throughout her pregnancies but identified that with her first pregnancy she lacked information that she wanted and needed.

“My last pregnancy it just seemed like everything was there I guess but my previous pregnancies, it seems liked there was stuff missing that I didn’t have like answers to my questions. Like my first pregnancy my mom was there but sometimes like there were old wives tales like I was talking about like the babies heads being too big and I didn’t want to rely on just my mom and I wasn’t going to school and I didn’t have prenatal care and I didn’t know a lot of stuff of being pregnant.”
This same participant had learned a lot from her mother but sensed that the information was neither current nor accurate.

“My prenatal class was my mom. My mom’s words, ‘Don’t sleep too much - your baby will have a big head’. Just stuff like that, that’s just one of the things people used to say. Now they are saying ‘Get your rest, get your rest, sleep while you can’, that’s what I try to tell them now, like things change over the years and that I know has changed lots.”

‘Like my mom, she was there for me through my first two pregnancies. She didn't get any helpful like prenatally to me, she would be there if I had questions but I didn't want to ask her 'cause it seemed like I wasn't getting the right answers from her and I felt like her answers were old-fashioned and I wanted up-to-date answers at the time and I didn't have that.”

Many women spoke of the importance of formal prenatal classes in their pregnancy experiences. For most Metis women, prenatal services were accessible and important during this early period of their pregnancy.

“I took prenatal in [Community X] and I had to pay for my own ride and that was every Wednesday.”

One participant said:

“There was this lady – they do all these prenatal classes like does cooking, baby education and stuff like that. Because of her I breastfed all my girls.”

Another woman recounted:

“When I heard there was [a prenatal program] I actually phoned them in [Community X] and asked if it was too late, 'cause I was like 8 months pregnant. I found out about it but again the transportation was an issue. Whenever I needed something I just stopped in there and the lady there was very nice and friendly and welcome. I was telling her about the issues that I was having with the healthy foods and the fresh fruit and vegetables that were not to my access, and she just opened her cupboards and started emptying her cupboards and put freshest fruits in a bag for me, and milk, and those milk coupons.”

Another Metis woman spoke of a different experience with prenatal classes during her first pregnancy.

“I know we went to the Health Complex…this was like 13 years ago… I took my best friend and we were at the trap line. And me and her were just laughing in Lamaze class and I didn't know what to do. It was my first baby and we said we were just laughing and here we were just me and her two girls. And at this time she was my best friend so we just laughed. And they never have that anymore, especially the younger ones. That was my first child and I had no idea what I was doing.”

Other women also found the classes less than helpful.

“I went to the one for Primary Health and I kind of just thought it was a joke.”

“It wasn’t really informative so I just stopped going.”

**Maternal-Child Health Programs**

Women spoke of the benefits of maternal-child health programs that provided them with support during their pregnancy and birth. However, women spoke of variations in care
quality, suggesting the need for program improvements throughout the Northern Health Region.

Women noted that the programs were well advertised.

“Posters for ‘Baby and Me’ are all over the hospital and everywhere in the community.”

While the women were all aware of the programs, at least for one participant it was unclear if the programs continued postpartum or were solely to be accessed prenatally.

“I just wanted to add something about the money. Like sometimes when you are pregnant you get money to buy healthy food and I don't know if that's only for pregnant people, I wasn't sure. I am not sure about that”.

Métis women spoke about the benefits of participating in maternal-child health programs. For women who are facing financial constraints these programs are especially beneficial. We heard that the women learned to cook and make baby quilts, baby pillows, and breast pads at the classes. As one woman who had a positive experience with her maternal-child health program declared:

“I go to prenatal classes once in awhile. I even take all my girls and husband too, cooking session too. Before I moved out here [to Community K] I didn’t even know how to boil an egg. Ever since I have been going to cooking classes, I have been cooking better than my husband.”

We were told that:

“They have a whole section of clothes and stuff. So if you need things you can basically pick whatever you want.”

“Now they [Best Beginnings] pay for your cab fair, they didn’t before. It was so much trouble to get there all the time, once a week every Wednesday but it’s worth going ‘cause [of] the stuff. Those [maternal child health] materials they give you are good.”

“I like when they give you the recipes and you try something new or whatever and they encourage you to come back all the time.”

“…and I talked to ‘Baby and Me’, that program for healthy women. That’s a good program, eh? I used to go to that all the time, ‘cause a lot of stuff you don’t know they actually help you, they tell you and I'm on my fourth and I'm still learning!”

“I started one called ‘Baby’s Best Start’. That’s a program for after you had a baby or before you have a baby. They give you a meal bag, coupons for milk and proteins you should be eating.”

One woman commented on the failure of maternal-child health programs to assist her during her pregnancy and postpartum.

“‘Baby and Me’ [in Community L] too but they don’t do nothing they just say ‘Oh you are here. Here are your milk coupons. See ya next week’ and that’s it and they won’t give you nothing and then they are like ‘Here’s a survey’. . . . fill it out. It’s like ‘How am I doing my job?’ Well if handing out MILK coupons is your job you’re doing a great job [everyone laughs]. You know?”

**Food Security**

During pregnancy it is important that mothers strive to eat a balanced diet. Food insecurity in northern Manitoba is a well-established concern. This is especially true in rural and remote communities where there are no stores with fresh produce. Women spoke about the lack of
access to healthy food choices in these communities. For many Metis women the importance of healthy food was a critical issue for them during pregnancy and for their babies. As one Metis mother said:

“Well, for me it was financially stressful because in our community we don't have the stores to get the fresh fruit, vegetables, and even milk that we are supposed to have when we are pregnant. We don't have that.”

Another woman agreed with this assertion and added:

“We have no stores here, and the stores we have are house stores4 and it's straight junk food.”

One mother spoke of her desire to see more healthy food choices for the younger generation of pregnant women in her community.

“Well, you want my opinion, my oldest son is 24 years old and from that day so many things have changed from one pregnancy to another. Like with him, the taxi business was always the way it was now but the thing that need[s] to change are for the younger women nowadays with the pregnancies is the supply of healthy food for them, and the supply and resources for them in our community and maybe a different transportation plan for them just something for them to grab on to if they need to have it.”

**Access to Transportation**

Many of the women identified transportation as an important issue in their community. There were difficulties accessing transportation as well as the cost of transportation. Metis women do not have non-insured health benefits for medical transportation, and in their communities there are no designated medical vans for transporting Metis to and from appointments. This posed a challenge. As one Metis woman explained:

“Pregnancy affected me financially. I don’t make a lot of money and it was hard to get to the city and they wouldn’t help ’cause I was not Treaty and I had to get to the city somehow and I was already getting high blood pressure and I didn’t know how to get to the city because I didn’t have help. So my dad borrowed a vehicle off a friend and he drives us all the way to [City] and I stayed with my sister.”

Another woman told us:

“It was hard with [daughter’s name] ’cause it was like a 2 hour walk for me ’cause I used to have to walk from my house to the clinic when I didn’t have a ride…”

Many women spoke of the cost associated with transportation in their communities.

“So again we are just travelling to [Community X], paying people to take us grocery shopping and we can’t afford $60-$80 every week. Like me myself I am on social assistance as of now and I can’t afford that.”

“Plus we have pay people ourselves. We don’t have vehicless or whatever so we hire people like $60-$80 to travel and transport us to [town] to buy our needs so that’s our issue right now.”

“My pregnancy would have been better if I had more help in transportation to get to [Community X] and to [City] ’cause it’s hard to try to pay your own way, especially when you have to pay your own way and you don’t get that much income.”

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4 House stores are located throughout small remote communities which generally sell non-perishable food items.
Consider this woman’s story:

“Yes, I was like 30 weeks pregnant and I had to walk to the hospital in the snow storm. The snow was really deep and it was hard to walk.”

[What was your concern why you had to go?]

“Oh [a] doctor’s appointment or no NST [non-stress-test].

[How come you didn’t take a taxi?]

“Probably because I didn’t have much money.”

Metis women in rural and remote communities encountered financial stress associated with ambulance expenses.

“That’s how much mine was too when I had to pay for an ambulance for false labour. During my false labour we met them halfway and it was still $378.00.”

The Northern Patient Transportation Program [NPTP] is in place to offset the cost of transportation and related costs. The NPTP is a beginning for women however it was suggested that it was inadequate to meet some people’s needs.

“…you have to pay up front for everything. There is like a certain amount they pay like $65.00 dollars for hotel.”

One unique story we heard from one participant was related to her experience with the local taxi. She informed the group that she did not have to pay for taxis when they were needed for medical care. Rather her concern with the taxi care was different. She told us:

“…there is only one taxi driver in [my community] and if she’s on a run and you are in labour there is no telling what could happen… There were a few times when the taxi driver kind of panics, there was one driver I am not saying the taxi driver now at the time, but in one of my pregnancies…He figured he had to stop and give birth and deliver my baby. I was like ‘Just get me to the hospital’. It’s a story I will never forget, it scared me. Within half an hour I gave birth.”

**Breastfeeding Support**

Breastfeeding is an important public health prevention initiative that is consistent with traditional Metis practices. Breast-feeding is considered best Public Health practice. Many women spoke of the support they received in the hospital for breastfeeding. As one woman stated:

“Yes, I breastfeed. They were really good in the hospital. ‘Cause I was just learning and they always came in and checked on me.”

One woman in a rural/remote community with a strong breastfeeding support system proudly reported:

“I have four girls now. The oldest is 6 and I breastfed all of them…I just breastfeed them. I never once used bottles on them.”

She felt empowered through her breastfeeding experience.

“I think breastfeeding was easy for me. The [others] last like three months and then they start partying and they go out and stop breastfeeding. But I think about my girls’ future and I don’t have to pay for milk and heat up the bottle or pay for milk, I just have to breastfeed them and I have a three year old who always comes and lifts up my shirt even in public sometimes. She will embarrass me. Yeah it was easy for me.”
To breastfeed or not should be a woman’s decision as not all women choose to breastfeed. One woman spoke of the pressure that was exerted on her to breastfeed in the hospital.

“The girl at the hospital said she did not want to breastfeed. I think they tried to push it on her and made her feel very uncomfortable and said the doctors were very pushy.”

**Limitations of Health Services**

There were limitations observed by Metis citizens when accessing care during pregnancy and child birth. Challenges including accessing doctors, and receiving adequate and competent care, were health care limitations for Metis women in the Northern Health Region.

Women reflected on difficulties accessing consistent physician care prenatally.

“To get a family doctor here is hard ‘cause they are non-stop rotating.”

“I used to just go into a walk-in when I was pregnant to go get a follow-up ‘cause I couldn’t get hold of Dr. X. either. I hardly seen him throughout my pregnancy - say only three times in nine months.”

“I tried to get in with Dr. Q but I couldn’t get in…”

“[I did not see a doctor] until I was like 6 months. So then I went to [Community Y] ‘cause that’s closer to where I’m from and they didn’t have a doctor there to deliver babies...Because they had one there and then he quit. And then they sent one of their other doctors to go learn this stuff. So pretty much my whole pregnancy there was like no doctor there…”

Participants linked the lack of continuity of care to physician shortages in the north.

“I think it’s just a shortage of doctors up here. Nobody really wants to come up here to work, you know, you are in the middle of nowhere...So I talked to a lot of them and they say they just come and do these spurts to pay off their schooling and stuff, they are not here to stay.”

“Especially up north. I think a lot of it too is because we live up north, and a lot of people are having kids, and like these doctors that are obstetricians and stuff are just overwhelmed ‘cause there are so many people like cancer patients and family doctors. And like, yeah. We can just don’t have enough doctors up here. Period”.

Lack of continuity of prenatal care led to a problematic information gap for one of the participants. She told us:

“...for this last pregnancy I had gestational diabetes. I finally had to take insulin. Like I wasn't told, like I was told how to but I wasn't told how to rotate them so I was giving myself that one spot so the doctors were looking at me and he said ‘You didn't rotate your needles' and I said 'I wasn't told to'. I didn't know.”

**Dissatisfaction with the Health System**

Metis women were dissatisfied with the current health care system during their pregnancies and birth. There were concerns regarding accommodation at the hospital. Many Metis women spoke of challenges when seeking information regarding their own or their babies’ health care concerns. Travel and related financial barriers created further difficulties in attending prenatal and specialist appointments.

As one woman observed:
“My friend, she used to have to travel for one hour-and-a-half just to come for ultrasound.”

Another woman reported:

“My girl friend got stuck in the hallways when she was dilating slowing. She was very uncomfortable. But it’s very common to get stuck in the hallways in our hospital.”

Transfers between community hospitals were reported due to lack of beds, or lack of physicians who are able to deliver babies. We heard:

“My sister she was in labour here in [Community X]. We had no doctors here; no beds actually and she was in labour eh? And um I think she was like 4 centimeters dilated. They sent her to [Community Y] by ambulance!”

Some women expressed concerns over lack of follow-up by the healthcare system.

“My son had an extra beat in his heart that wasn’t supposed to be there and I never got any information back from the hospital about that but he is healthy and happy.”

Another Metis woman spoke of her rollercoaster through the healthcare system to determine what was wrong with her baby.

“My little guy’s so chubby now, it’s not even funny (laughing) but I struggled and like the day I got back from [City] that time after I still have go back again this year, just to make sure...to confirm that it is the thyroid...I think they said ‘overactive’. That’s what it was. I go back to confirm...I tried to get sources and no good sources...nobody would help me...I don’t know how many doctors I have seen down there. Finally I got a referral from Dr. Q. here, in between here and there and I told him what was going on. He’s the one who rushed me. That’s how I got Dr. G. to call [Dr.] F. cause of Dr. Q. He squeezed me in, he was going away; he squeezed me in right then and there, like quarter to five, ‘get here now’. I brought my baby, checked him over and he said ‘He needs to go’.”

**Unprofessional Conduct**

Unprofessional conduct among health professionals was a barrier for Metis women receiving adequate prenatal and postpartum care. Several Metis women spoke of feeling disrespected by health care providers during their pregnancy and birth experiences. One woman stated:

“More doctors...it just seems that they get to be that nasty because they are just so rushed and they have to be here, there, and everywhere. They just seem that you’ve been there four times to see a prenatal doctor and you are coming in for the fifth time and it seems like ‘What’s your name again?’ You know? You just feel like you don’t matter.”

One woman had a distressing experience when she presented for an ultrasound.

“The only one [Physician] I had a problem with was the very first one for pregnancy test confirmation. Because we found out we were pregnant through an ultrasound. The first thing she said “Yes, you are pregnant are you considering an abortion?” and she just looked at me and my boyfriend, very serious about it. “No!” We are here because I had previous complications with pregnancy years ago and she was supposed to be helping us get pregnant...but I told them the next time I called I never wanted her to be my doctor for my prenatal. I was like I have been in here for three months trying to get pregnant and now that I am you are like “Have an abortion”.
Nurses on postpartum were identified as being impolite. This participant shared:

“The nurses I had were on the grouchy side; they weren’t just mean to me but also to the guests [visitors] and I know that when the kitchen staff brought me my food they told me that I had to eat it or force me to eat it. So I forced myself to eat it and one of the nurses came in and said to my boyfriend to ‘Get up and do something instead of just sitting there and go put the tray away into the kitchen’. She was very demanding.”

As another woman describes below:

[So this nurse that was seeing you, where was that?]
“Maternity ‘cause you know there are some cranks up there! [Everyone laughing]. The rest were pretty good.”

Women spoke of health care professionals in the hospital not listening to them during labour.

“They didn’t listen to me. Like, I was telling them that I was having contractions and they were like ‘No, no. It’s not time yet’ and then they induced me and Dr. X came in like four hours later and I was in such…like I felt like I wanted to push but my water didn’t break. Then he came in and he checked on me and I was like six centimeters…he broke my water and I went to ten just like that [snapped fingers].”

Another woman spoke of feeling rushed during her time at the hospital while she was labouring.

“And this other woman must have been having a bad day. She was a nurse, anyway, oh honestly I was so upset. She didn’t even care. She just wanted to get me the hell out of there and send me home. Oh what was I going to do? Walk to emergency downstairs? That was how much pain I was in - I couldn’t even walk.”

Another participant described her experiences with staff during delivery and immediately postpartum.

“…and then the nurses were there trying to get their little coat things on and I was about to deliver this baby and she’s like ‘this’ big and she’s like I NEED A STOOL and I am just like ‘Oh my God!’ This is just a joke and my baby was already out before she even stood there…and I didn’t even have my placenta out and one of the nurses was like ‘You have got to get out of this room now. You have got to move to another room. There is another lady coming to have her baby in here’ and she didn’t come until eight hours later and of course it was one of her friends and they didn’t even wheel me to the next room, they just grabbed me by the arm and dragged me to the next room and I’m like…Just take me home’."

**Child and Family Services (CFS)**

Aboriginal children occupy a unique position in the Canadian child welfare system. From a social perspective, Aboriginal families experience many disadvantages related to myriad socio-political factors. Many Metis women spoke about the culture of fear and distrust of child and family services as an organization with ill-intentions for their children’s health and well-being.

“That’s one of our concerns because like my family’s concerns is that ‘Oh well, you’re pregnant again. Are CFS gonna take your kids away now?’"
“I just feel sorry for the kids who end up in the system… I just cry for their parents.”

“It’s sad because my mom has CFS children too [that she cares for] and I don’t like it. Some parents are in the same community and they don’t even see their children.”

As one woman stated:

“Like that’s like a lot of the reason, like even schools and teachers and that…Yeah. Like even Child and Family Cares they have like stronghold with people of influence…like you know Primary Health…like they can phone child and family services and you know when your kid is not showing up to school and they don’t understand kids illnesses and stuff so right away they will phone Child and Family Services … ‘They are not in school’.”

Some women felt that Child and Family Services did not understand their child’s health problems and acted improperly due to lack of medical knowledge. One Metis woman recounted:

“Like Child and Family Services has come to see me at different times because different people have called because they don’t understand my son’s bleeding disorder… It’s like yeah he does get bleeds and sometime he misses school… like ever since the beginning of the school year he’s only been there for like maybe 15 days and people don’t understand. I’m not purposely keeping him out of school… like I’m doing this because of his bleeds… because he has to go to the hospital every day.”

6.2.4 ‘Being Metis’

‘Being Metis’ encompassed a unique identity experienced by women during pregnancy and birth. It included Metis identity, family, individual, and negative community supports, along with positive parenting. Below is a description of each category that was identified as part of ‘being Metis’

**Metis Identity**

Metis identity was an important experience for Metis women during pregnancy and birth. Women recognized their identity as being distinct from others within the Northern Health Region. One Metis woman stated:

“Like even that President Chartrand, I met him in [City] and even when I go to school I don’t have a Band ‘cause I am not a band member of anywhere ‘cause I am not Treaty and I just go to the MMF in [City] and they will help me get my schooling and textbooks.”

Another woman spoke of her Metis identity in relationship with financial costs associated with living in the Northern Health Region. She commented:

“I like the way I am living now. I don’t mind. I am already used to it. My husband thinks the way I live is the white man’s way. Like I pay for everything.”

Another woman spoke of her strong Metis identity after overcoming trauma. She stated:

“I can honestly say we are strong women. Like people like us they often hang themselves, they juice, they die, or these scars that I have from being shot from being on life support still affect me too when I talk about it. I like to share my story and inside we are strong, like we are still standing and we keep our babies strong.”
Many Metis women spoke of wanting to share their life stories with other Metis women. They spoke positively about participating in research studies like this one in which they had the opportunity to share their pregnancy and birth experiences.

“People like you [researchers] too you should come more often!! You know when people come together and share their stories.”

Participants questioned the inequity between First Nations Peoples and Metis.

“We should have the same rights as the Treaty. We are all family I think. We are the same and we should all be treated fairly.”

One participant had been able to resolve the identity dissonance for herself.

“Actually for me I am not worried about my girls or my husband, but my husband is worried about me. He thinks I can't afford things and we argue about that he just wants me to get my prescriptions paid for from the government, like they promised the Treaty people and I didn't understand it for awhile. Like the way I am I have experienced a lot where the Metis people came from and what they are going through. I like being Metis and I like reading the history of it and it’s pretty awesome, it is!”

Positive Parenting

Many Metis women spoke of positive parenting, using role models from their past, to help guide them throughout motherhood. With regard to raising her children, one woman stated:

“I want to teach them good ‘cause I never had a mother in my life, she left us when we were four at the park with my auntie. She just said she ‘was going to get something’ and she never came back and all I had growing up was my dad and I want to teach them good like my dad teaches me.”

We heard:

“Like I want to be the mom that I never had growing up and I want to teach them right and wrong and I don’t want them to be like me. I don’t want them to do bad stuff. Like you have got to have taught love too, especially when they don’t want to listen.”

“…well the way my parents were growing up and stuff…I’m not going to treat my kids like that…”

One participant stated that she wanted to educate her children about what’s right and wrong. She said:

“I think we learn from our mistakes and what we went through. Well okay we don’t want our kids to be like that so in order for that to happen, we got to switch our lives around, which people are like you are not really going to do it ‘cause you are in it so bad. You know what? That’s the reason I am doing it ‘cause I need to prove to my kids that life doesn’t have to be the way that people make it out to be.”

Significant Individual Supports

Many women spoke of an important individual(s) who supported them during their pregnancy, birth, and postpartum periods, without judgement. Typically the women in this study found support from other women - sisters, mothers, grandmothers - in the community. As one woman explained:
My mom was helpful and I listened to her ‘cause she has 5 kids and one of them is 8-9 months older than my baby and it wasn't that long ago that she was pregnant. My grandma told me all these tales that I didn’t want to believe. Like I wanted to find out the sex of my baby and she told me to find a ring on a necklace thing and if it swings this way it’s a girl and if it swings the other way it’s a boy but I wanted to go to the doctor and find out the sex of my baby.”

Others identified a variety of female supports:

“...I found myself communicating more with mothers.”

“...Yeah I talked mostly to my grandmas, my friends. I wasn’t really in any groups or anything.”

“I have my sister; she is a reliable confidante for the last couple of years and pregnancies.”

Some participants were able to find support and depend on male members of their family. Participants told us:

“I told my dad [I was pregnant] and he said ‘Congratulations my girl!’ And then I was like ‘Dad can I come and stay with you? I can’t stay here anymore.’ My dad was all like ‘Sure my girl, you can live here. This house is always open to you.’”

“My dad was there, he always helped me and to put my head on a shoulder, he’d be there”.

**Family and Community Supports**

Some women spoke of positive community supports. Another participant reflected on the support she had received when she was pregnant and in school.

“The school was a resource for me because they have counsellors there and you can talk to them about anything, it was a pretty good support system and even now I [am] still close to the counsellors there.”

One woman explained the positive experience of moving to a rural and remote community away from an urban centre within the Northern Health Region.

“I got married and we’ve been moving place to place, house to house. That’s what was bothering us for awhile. Like even living with other people we have to follow the rules and we wish we had a house for our family...we decided to come out here and it’s safe and we wanted to have a new life and live on the reserve.”

For some Metis women it was not as easy to have familial support. One participant spoke about missing her family who lived far away from [her community].

“My family is not from here. They are from [Community A], [Community B], [Community C]. I got married out here at the United Church. My dad didn’t show up on my wedding day cause he didn’t have no transportation to come over here. So my own family rarely comes to see me.”

A few Metis women spoke of negative family or community reactions to their pregnancy. One woman told us about how her father set up an appointment for a therapeutic abortion without her knowledge or consent. Other women expressed feeling a lack of family support from their own families during pregnancy.

“I couldn’t talk to my mom about these feelings and it seemed like I didn’t know who to talk to at the time. I was just living at my mom’s and being pregnant and there was a bunch of emotional stress and my mom was not supporting me 100%. She was more or less against what I was doing… I got pregnant and it was hard and I didn’t have the resources to help me.”
“Like for me I had a strain with my mom and my dad. I have a 14 year old, and 8 year old, and 11 month old baby. For me I have an 8 year old with Type 1 diabetes, and my mom was like ‘What you gonna do?’ and ‘It’s gonna be too hard on you’ and ‘What if both of them have it?’ It was like she was jinxing it. You know, so I didn’t want to be around her. Just that negative vibe. Just like the whole time I was pregnant I didn’t want to go visit her, or phone her, or nothing, because she would just always bring it up.”

“And even with everybody else, like even within my own family and all those relationships just stopped. Like nobody, like wanted to… Like not even my own family, they didn’t even want anything to do with me anymore; they just totally cut themselves off”.

“Me and my husband, our families don’t come around and see us and they don’t come and see the kids that we have.”

One woman spoke of a negative family response regarding her having additional children.

“And here she struggles more than me with her children and yet I have her kids every other weekend kind of deal and I’m like and I’m her older sister and she’s telling me not to have any children.”

Women reflected on the negative response they received from their partner’s families and how relationships had changed:

“When my boyfriend’s mom found out that I was pregnant and she got so mad, so mad and kicked us out of the house and we had to go live with my dad. She was like ‘you should have kept your legs closed. You should have used protection. You guys never think of anyone. You never think of anything.’ ”

“When I was pregnant with [my daughter], [my boyfriend’s] side of the family didn’t believe that was [my boyfriend’s] baby, so they didn’t want anything to do with me but then when [my daughter] was born, they looked at her, they knew it was [my boyfriend’s] and they were sorry and they regretted treating me that way when I was pregnant and they help me a lot now and they are always wanting her to come sleep over at their house and give me a break and all that, cause they always thought that [my daughter] wasn’t his and now they are good.”

One woman spoke of the judgment she felt from others in her community by choosing to stay home with her daughters postpartum rather than going out to socialize.

“Most people will say ‘Why stay home so much?’ Why don’t I go anywhere and I don’t drink. I [say] ‘I like staying with my girls ‘cause they are all under six’.”

**Systemic Racism**

Systemic racism affected the lived experiences of Metis women. When the issue was mentioned and then we asked more directly about it, the women consistently responded that they had encountered racism during pregnancy and delivery by health care professionals.

Women helped us to understand the experience of having a white-skinned dad was another ‘face’ of racism. We heard:

“They are like ‘How can you be Metis when your dad is so white?’…Who cares if he’s white? My family members could be any colour. [If] doesn’t mean that you are this, or that, or even… it’s just stupid.”
“I get that too ‘cause my mom is native and my dad is white. When they see me with my mom they don’t think that’s my mom. They will say ‘Oh, is this your daughter?’ And they say ‘Oh this is your daughter?’ They are always shocked [laughs].’

“I believe that as well. It’s like who you are or kinda what you look like. I see that where I work all the time.”

[When you say, ‘It’s what you look like’ what do you mean by that?]

“Like racist.”

Another woman spoke of overhearing racist conversation in the hospital. She recounted:

“When I was in the hospital with my daughter I was getting ready to leave and I heard the nurses talking. They thought I was asleep. They were talking about this lady; she did have nine kids. They were like ‘I wonder why CFS hasn’t got on her ‘cause she’s like sleeping around?’ And they are like talking about her like this. They said ‘Oh, she has too many kids to take care of any of them’. I was like ‘little do you realize that her family is like watching her kids?’ It’s not like it’s bad to take a cab to the airport to go fly home, it’s not like it’s a bad thing, but it was just the way that they were talking about her…”

“I think it’s different nurses ‘cause I know your situation. ‘Cause like when I was in labour before the same thing happened to me. I think it’s also who you are.”

“I don’t even think people realize that they are like that. It just comes so naturally to them. You know like in the ER they will see a native person with all her kids and then see a little old white lady, ‘Well, we’ll take her first’. You know? I see it at work all the time.”

“Some of them, they are just kinda like ‘You are native, you probably have lots of kids. You know what you are doing?’ I was like ‘Are you frickin’ kidding me?’ ”

The women also spoke about lateral racism that existed in their communities:

“I have a brother that lives here but my sister-in-law doesn’t like me. I don’t know why. Ever since we’ve been growing up she has never liked me or my mom because we’re not Treaty”.

6.2.5 Looking to the Future

Metis are resilient. As a culture they have survived attempts at cultural assimilation, forced dispersal from their land, and the 60’s scoop. Protecting the health and safety of future generations is a responsibility with which each person is tasked. “The Metis family and community is the cornerstone of our Nation and is built upon love, respect, honour, strength and heritage” (Metis Child, Family & Community Services, 2015, 3). In order to strengthen strong families and communities, a system of well-supported prenatal and postpartum supports and services need to be available. In order to improve labour and delivery experiences for all women, participants had several suggestions for the consideration of the Northern Health Region. These ranged from staffing, to a clinic dedicated to prenatal and postpartum care, increased resources for pregnant women including healthy food, transportation, emotional support and a safe place for women when home is no longer safe for them and their children.

When considering staffing, women observed that there were too few doctors and this impacted their prenatal visits. To remediate this situation it was suggested that they have one doctor with a specialty in obstetrics rather than each doctor being a generalist.
There should be one doctor for prenatal; there’s enough of us when you consider the surrounding areas.”

Given the overwhelmingly positive response there was to working with a midwife it is not surprising that a number of participants identified that there need to be more midwives.

Hospital staffing was also identified as an area that required improvement. We heard about the need to have more staff in the labour & delivery as well as postpartum units.

“I think there should be more nurses on the maternity ward ’cause you have to wait a really long time when the maternity ward is really packed up.”

In addition to staffing logistics, participants commented on the setting in which they had prenatal care.

“I still think it’s gross going to the hospital when you are pregnant. Just walking through the ER and that.”

“You have to go through the ER and everyone is like coughing.”

As a solution to this, women articulated the desire to have a clinic that was solely for prenatal and postpartum care similar to the Women’s Health Clinic in Winnipeg. Participants were very clear that they wanted this clinic for the use of all women in the region – not only Metis.

Participant 1: “No just for women in general…”

Participant 2: “For anyone…”

In the more isolated community it was observed that women lack a number of resources that would support them to have healthy pregnancies.

“I would like to see these younger ladies pregnant to have more resources not only mentally, emotionally physically or financial. I would like them to have the ability to have healthy eating habits. That was a struggle for me, and I would like to see more resources for that, for young women, their pregnancies.”

“Like some women who are having children, it’s not easy to travel and even financially, when it’s the middle of the month, when we are on social assistance…”

The need to have a safe place to go when women feel threatened was identified.

“To this day, I think that it should be there for the younger woman, so they should have a place to go.”

Ensuring consistent staffing such as mental health counsellors in isolated communities and supporting food security initiatives within the region would ensure that some of these resources are available for women and families.

Another area that was identified by the participants as a significant factor that impacted on their ability to support their family post partum is the lack of daycare spaces. This is a province-wide issue that affects many women. We heard:

“A lot of people have opened up home daycare because there is no enough childcare in this town.”

“You have to apply very early to get daycare.”

Daycare is not an area that is considered within the umbrella of formal health care delivery,
however; it is important that sufficient, safe, and supportive, daycare spaces be available for all children.

One final thought the participants left us with was their appreciation for the opportunity to gather and share stories – to ‘yarn’. This may represent an opportunity for ongoing formal support groups prenatally and postpartum.

6.3 Key Informant Interviews with Health Professionals

The existing infrastructure of prenatal and maternity programs and services includes care at hospitals, community health clinics, and nursing stations. A health professional is an individual who provides services in a systematic way to people, families or communities. By providing direct care to women and their children before, during, and after pregnancy, childbirth, maternal and newborn health care practitioners play an important role in child-bearing experiences.

We did not conduct an exhaustive series of key informant interviews with health care professionals in the Northern Health Region; rather we attempted to speak to a few key health care professionals in an attempt to gain a sense of their roles in providing prenatal and maternity care to Metis women. These healthcare practitioners included obstetricians, midwives, and public and community health practitioners.

The following themes emerged from these key informant interviews: View through the Practice Window and Prenatal and Maternity Experiences for Metis Families and Communities. These themes will be explored in subsequent paragraphs.

6.3.1 View through the Practice Window

Reflecting on My Practice

Each of the interviews began with a question about their role. Those we spoke with included obstetricians, midwives, family physicians, nurses, and other allied health professionals. There was a vast difference in the experiences captured. These differences reflect the varied training and authority these individuals have in providing prenatal and maternity care.

As one health professional working as an interpreter with Metis and First Nations clients receiving maternity care stated:

“When someone is admitted some of us become clamped up when trying to speak English, especially where there is an emergency. That’s when I come in as an interpreter. I don’t go into the patient’s room and tell them what to do. I go in a room and say ‘What can I do?’”

One very commonly mentioned program was the ‘Families First’ umbrella of programs including Best Beginnings, Baby & Me, Babies Best Start. One health care professional identified the strength of the ‘Families First’ program was connecting women to resources within their community during pregnancy and birth:

“[Families First] is a provincial program. It is set up and funded by Healthy Child Manitoba. We have ‘Families First’ in [Community X] and that is a home visiting program and there are three home visitors. It is set up through Public Health and the Public Health Nurse will coordinate the program and is the one who introduced the program and gets them enrolled, so I am the coordinator...
Another care provider described the role of the ‘Families First’ Home Visitor and the system in place for assessing and triaging clients using a ‘decision tree’:

“We have a decision tree in which we tell our supervisors who contacts the RCMP. If it’s just something just mentioned I provide them with resources, if it’s not an immediate issue. We set goals for our families.”

Another home-visitation worker explained about their experience of working with families enrolled in the ‘Families First’ program in one community:

“Well I've seen the bad and I've seen the good. It all really depends on their day. Like when they are having a good day and it’s warm and inviting, and you know they [offer] you tea or coffee, and it’s the home setting. Sometimes you come in and it’s not such a good day and there is fighting and alcohol use and it’s not very fun....Right, well I've had the door slammed in my face.”

Another prenatal and maternity service we heard about was midwifery. One health care provider spoke of the relationship between midwifery and women's health services in one community.

“We have a midwife service that has been going ten to twelve years, maybe a bit more. We sort of actively encouraged that here. We have a lack of female doctors here and I would say 10% of women are polarized to want female practitioners. No problem with that. So we have had female doctors and the midwife service.”

One midwife described her approach to women coming into her care during pregnancy:

“One thing I tell ladies when they come into my care is that we talk a lot about issues and stuff that comes along in pregnancy.”

One health care provider explained how they tried to reach women in all regions of the Northern Health Region for midwifery but were unable to.

“…we did try very hard to reach women in all regions and now there are quite a lot of areas in Manitoba where there is no midwifery service....”

A midwife reflected on how the system in place to accommodate all the prenatal care in her community was not efficient and was insufficient to meet the needs of the community.

“…not everyone can come on that day and if everyone was coming on that day you would not be able to accommodate them. The way it was set up was to work in a system that wasn't really working, wasn't efficient. People were not getting the care they needed...”

Another health care provider explained that having only one physician who offered prenatal care in the community made it difficult for women to access adequate prenatal care:

**Health Provider Pride in Programs and Services**

A sense of pride was identified amongst all the prenatal and maternity health care providers we spoke with. For those working in smaller communities, care providers voiced satisfaction in working in a community where everyone knows each other.
“It’s a small community here and it’s easy to get to know other families here. Even if you just come in here and talk to the nurse, they get to know us and we get to know them. If you have multiple children we really get to know them. That’s a benefit to being pregnant here, in that sense!”

One health care provider described the benefits of community women being pregnant and delivering in their own community.

“I’ve always been told that this is a wonderful cottage hospital with wonderful people. Most of the nursing staff has had babies here and they know people and they know everyone you know what I mean.”

**Change Over Time**

Health care providers were dedicated to serve their communities within the Northern Health Region. Many of them had given many years of service and as a result had witnessed a number of changes in maternal health and health systems overtime. As one health care provider explained:

“Yes because it’s thirty-some years; I started in 1982 and now it’s 2014, it would be really hard to go through all the changes. When I first started there were few midwives, there were a couple of traditional midwives who went to northern births and I did meet them but it was illegal and no hospital privileges…most of the births were homebirths. I have done 600 homebirths and then it [was] legislated.”

Another care provider eloquently explained the tremendous changes they had witnessed overtime in maternal health care for women in the Northern Health Region.

“Lots of changes. When I first came in 1991 we had an itinerant ultrasound service. We now have ultrasound here. I’m not quite sure how long that’s been here I would suspect about 25 plus years but 30 years ago it wasn’t. The other thing was that when I first came here there were lots of mums who never came in…I remember I had one family, the A’s, they had 11, 12, and 13 kids from 3 sisters. You ask them ‘Are you retiring now?’ and there is just a little glint in their eye like ‘See yeah next year!’ you know what I mean (laughs). In some communities like in [X] we still see amazing numbers of children, like ten in one family but not like we used to. Also back then you could see that the mums didn’t actually care for themselves very well so they often because they were diabetic and they didn’t come in and their diabetic care was poor. You know they were doing other things because they were busy with their families and that was trouble to get those women get to come and be seen. Yeah those are the major things.”

There was also a change in midwifery care in the Region.

“Midwifery is another thing that has come up and has been very positive. I was very supportive of that and I think that it’s good for the community.”

“I would say that coming here was something that was invited by the elder midwife in the north. When we started here 15 years ago they wanted to see nothing more than midwifery practices in their communities. The program didn’t remain here and there is still a divide between midwifery in the north and the midwifery in the south and people need to know the difference.”

**Intra/Inter-Professional Communication**

Inter-professional linkages can foster collaboration and build capacity among maternity care providers. This may be either electronically or person-to-person. One health care provider explained that the Northern Health Region was moving to implementing electronic charting.
That participant saw this as a very positive move that would strengthen their practice and interprofessional linkages.

Interprofessional linkages also occurred amongst public health nurses and their managers. Weekly meetings ensure that consistency within the program across the region was achieved. Another health care provider explained that strong inter-professional linkages are created through the ‘Families First’ program with the Northern Health Region because home visitors and public health nurses are in continual contact.

Despite this improved communication there were still situations in which lack of communication was evident. One health care provider spoke about not having any understanding of the prenatal care received by their patients before they came to deliver in their hospital.

“Then well, to tell you the truth I have never worked with the outlying communities and I don't know the details but all the pregnant patients eventually come and deliver in [City]. They receive prenatal care at the nursing station; they must have access to prenatal care in their community.”

Another health care provider spoke about prenatal care for Metis women within the Northern Health Region. She stated:

“Getting them [Metis women] in for care and you know in the nursing stations they know who is pregnant; they know who needs to stop in for care. They need to encourage women to get prenatal care.”

Another health care provider spoke of the difficulty of not knowing what happens to women after they leave the hospital and travel back to their communities after having their baby. When asked “What happens if she lives in a community where she can't access a nursing station?” she responded:

“I don't know. I couldn’t tell you. Public Health would be responsible for the follow-up. We do full write up here, we try to be concise and note everything. We can put them as priority follow-up so she can be seen within a few days or within a week or two. Then we fax away and that’s it for us. Unfortunately when we do fax off we don’t know how all the follow-up goes. Sometimes it would be nice to know how things went for her once she got home. ‘Did she keep up her breastfeeding? ’ ‘How were her supports?’ We don’t get that (sigh).”

Communication during the transfer prenatally and postpartum may be an area that would benefit from clearer practice policies.

**Influence of Personal Cultural Ties on My Practice**

A few of the health care providers were Metis and expressed their pride in identifying as Metis. In addition to being Metis, these key informants also took great pride in being Metis health care providers. One participant offered:

“I like to visit elders. I go have tea with them. There is [a] Metis woman in [Community Z] and she is an example of the struggles of a Metis woman. Her culture is so strong she does beadwork, moccasins, mukluks to keep the Metis way and she tries to be an advocate of all Metis, especially Metis women because of the struggles.”

Another Metis health care provider explained their personal attachment to the land as part of the pride in being Metis.
“...it’s beautiful in the summertime, green grass and lake. So it made me feel traditional; when I was there I would go fishing with the kids that lived by the lake and by the rivers and had the opportunity to go fishing with my kids.”

One health care provider explained about her experience being an Aboriginal woman working in health services within the Northern Health Region.

“Being a northern Aboriginal woman from the community means I have a connection to the community.”

One provider observed that being from the area was helpful when caring for some Metis women.

“When you grow up here you know why people are shy, why they don’t speak when the physician arrives, and you understand why there is sometimes poor eye contact and why somebody is having a child but really the granny is going to be taking care of the child or the aunties, so you understand the [way of] living.”

**Identifying Client Base**

The majority of health care providers identified a lack of ability to identify who is Metis. As one health care provider explained there is no Metis-specific box to tick off on the form.

“There are a lot of people who have the same name like, Lavallée classically I guess. Some are Treaty and some are Metis and we have never differentiated. We know like some communities like [Community X] are traditionally Metis communities but in practice we don’t see any differences. I don’t think there are any demographics across here. We don’t tick off [like a box] if they are Caucasian, Metis, on a form in the hospital that get that information as there is no box to tick off.”

Another health care provider explained that they do not screen for Metis through the ‘Families First’ program.

“Yeah they do but they are not screened for Metis. The ‘Families First’ Home Visitor has a screening form and you can identify yourself as Aboriginal or non-Aboriginal and I think there is a section for Metis. I know there is a new 2014 [form] but I don’t think that’s changed.”

It was not clear from the interviews if care providers felt that they would be able to give better care to the women if this was information they had.

**6.3.2 Prenatal and Maternity Experiences for Metis Families and Communities**

The prenatal and maternity service providers we spoke with were committed to providing quality care. They reflected on the impact of pregnancy and birth experiences on Metis families and communities. Barriers to care were identified by many health care providers. They also spoke of family violence, teen pregnancy, and the importance of family support.

**Barriers to Care – Awareness of Prenatal and Maternity Services**

There are several reasons why women might not access prenatal or maternity services. Health care providers were able to identify many of these. These include awareness of services, cost, and feeling marginalized. Some health care providers didn’t recognize that there might be difficulties for Metis women to access health programs and services.
There were a variety of thoughts on how aware Metis women were of services, or from where they got that knowledge. Some health care providers indicated that awareness of prenatal and maternity care came from nursing stations.

“…knowledge of services comes from friends and family. Or it has to come from the nursing stations or wherever they go for their prenatal.”

Other health care professionals offered that Metis women may not be aware of what is available to them in the Northern Health Region.

“I think there are some women who don't know how to gain resources. I want to service everyone. For me we have a lot of resources for women but other groups might beg to differ but the challenge is that women don’t know what is available.”

We were told that for many who do hear about prenatal and maternity services, information comes from either friends or family. One key informant observed:

“Most of the women hear about the clinic through the family members and friends, even though it is a population of 7,000 people. The roots of the communities are built on families and their historical roots of names of families so a lot of people know a lot of people. There is a lot of close communication. That’s the way most people access midwifery services here.”

Another reason health care providers gave for women for not attending prenatal services was not awareness but rather was that they already had many pregnancies and didn’t feel the need to attend prenatal care.

“But there are also ladies who are on their 6th and 7th that do not go to prenatal. Period. But then there are the new moms who don’t know what to do”.

Increasing the profile of services is another opportunity for the Northern Health Region to strengthen its maternity services.

Barriers to Care – Impact of Finances

Cost can be considered a barrier to accessing program and services. When asked about cost of their service, health professionals all commented that there were no costs associated with their services. One provider stated that “they all” have medical cards and should not have any barriers in accessing programs regardless of where they live.

“Whether it is accessible to them or not you know I have never come across any woman that has trouble accessing prenatal care whether they are Metis or Treaty or non-status patients; they all have medical health cards and they can access the services like any prenatal patients, especially in the outlying communities.”

Although there are no direct costs for using prenatal or maternity services, other health care providers acknowledged other economic factors might affect how Metis women access care. One care provider stated:

“You will find that if you are working with a mom and she needs a prescription and if they are Treaty most need a prescription they have coverage. Here we use the term working poor. They are caught really where their income is really low but they don’t have extra services going in.”

Some health care providers identified that Metis women have a greater financial burden due to personal cost of transportation and accommodation during medical transportation for childbirth within the Northern Health Region. One health care provider described the
experience of a Metis woman whose family had to pay out-of-pocket for her travel and accommodation during pregnancy and labour in [City].

“I understand why they want them to go to the closest place where they can access services but as an example you will probably meet this woman, it was an upsetting situation, her first pregnancy was hard. Her family goes back a long way in this community but being that she is Metis and I get so few women who are Metis that I wasn’t expecting this so I thought “well okay she would have a choice of going either to [City] or [Town] to have her baby” that’s the way I talk about it to women and her mother lived in [City] and this was her first baby and she was 16 and she could go be with her mother and her sisters that live in [City] and she would not have to worry about accommodation. They would be there for labour support for her and she could have her baby in [City] and they would not authorize the transportation and I told them “she doesn’t know anyone in [Town] and she is 16 and she doesn’t have money for a hotel and she would only be out there for a couple of weeks, for confinement”. Most women would go out at 37 weeks in case you are early if you don’t have a history. How is she going to pay for a hotel for 6 weeks? She ended up going to [City] but her family had to absorb quite a lot of costs…. .”

Another health care provider explained the different life circumstances a Metis woman experienced as a single working mother supporting her daughter who doesn’t work, is in school and about to have a baby.

“…like you know a Metis women I helped came in with her mother late in her pregnancy and the first thing she said was how “I am a single working mother and my daughter doesn’t work and she’s in school and how am I going to manage? Where are we going to stay when she has the baby?” It was a big issue.”

**Barrier to Access – Continuity of Care**

Health care providers spoke of the importance of continuity of care and choice of health care provider for Metis women and their impact on access to health care. Many health care providers spoke of the impact of having different physicians come into the community on a week-to-week basis. This routine practice of fly-in and fly-out doctors negatively impacts the lived experiences of Metis women and mothers.

“…[the mothers] want to have continuity too because in the community clinic it really depends on who is here working at the time and there are a rotation of the physicians, very often a women will see different physicians throughout her care and they are just really tired of telling their story and someone not knowing them, and what their situation is and they often don’t disclose a lot of problems.”

Not all women are able to access the provider of their choice.

“…there is not a lot of options but I don’t know if that’s all that different from other communities. Even in the city maybe you don’t really get a choice of your healthcare provider. So a lot of women are turned away as well [from midwives]. So it’s not appropriate but I don’t know if that’s out of the norm.”

**Barrier to Access – Transportation and Accommodation**

Other barriers to access for maternity services for Metis were identified and described by health care providers. These included travel during pregnancy and labour, and accommodation.

“Transportation and childcare are the two biggest ones. I have a lot of people who don’t attend
because their babysitter didn’t show up or their kid is sick or they don’t have a ride and especially in winter, attendance goes way down.”

A key informant identified:

“…it makes a difference for Metis women [if the services are] 4 hours away. If you don’t have your own vehicle that’s a long way and if they don’t know you and you don’t know them it makes it difficult.”

Another health care provider identified that there were transportation services for First Nations although she was unfamiliar with transportation services for Metis women.

“But on the reserve for Treaty patients they send the van to the homes to bring them in for prenatal care but I don’t know how it works exactly but somehow these women get to the nursing station and they get care.”

“The services in the community are largely provided by the First Nations governance. [X First Nations] provides the medical transportation vans.”

One health care provider described that they were not clear about the barriers to access for transportation and accommodation for Metis women receiving maternity care. She stated:

“For example like Treaty patients they have their travel and accommodations covered and if they need to go to [City] for prenatal fetal assessment the Treaty women and Metis women are covered through NPTP but the only difference is that their travel cost is covered but not accommodation. You know I don't know any of the details but I fill out the travel warrant and usually there is not a problem with that.”

Health care providers spoke of the Northern Patient Transportation Program [NPTP] as not being flexible for Metis women.

“The Northern Patient Transportation System [NPTP] will pay for women to travel to the closest area for the service so it doesn’t matter if their family lives there or not. There is no accommodation; they would have to stay in hotel. So they pay for transportation there and back and I think they pay for meals but as far as accommodation, but as far as I know none of the Metis women have had help with accommodation.”

**Barrier to Access - Feeling Marginalized**

Marginalization is an internalized process in which an individual feels ‘less than’ within the dominant group of society. Metis health care providers explained that Metis citizens’ feel marginalized within the Northern Health Region.

“Like I come from a community where there is Treaty and non-Treaty and if you are Metis you are seen as not having. Like they will give your services but it’s like they are extending the services to you - it’s not a right. They can access it but you are not Treaty and they know that and they say those things. It’s like a gift.”

As one Metis health care provider stated about feeling different:

“Maybe most feel a bit of a difference, [but] we treat everyone the same. I can see this because I am Metis myself. There are no services for them.”

Other key informants spoke about the equality of treatment among patients.
“I think they give the same services as any other women when it comes to prenatal care because there is a standard of care.”

Another health care provider reflected on Metis women’s participation throughout pregnancy and labour. She stated:

“...with her second baby she was postponing leaving and she was going to go to [Town] and then she ended up going into labour here and then having her baby here. I would say this is a failure to the system - I mean they didn’t try to accommodate her. This is typical of a lot of things in the Metis community right? You don’t clearly fall into a government type of well-thought out, planned approach to things, even though the roots of the Metis families here go back hundreds of years into the community.”

Bill C-31 and Bill C-3 have contributed to a decrease in the Metis population in communities throughout the Northern Health Region. The long term impact of Bill C-31 and Bill C-3 is yet to be determined but in the short term service providers have reported that many people are giving up their Metis identity in order to get the benefits of the status card.

“My elderly neighbor who just passed away did not get his status card until a few months before he died, yeah and he was always like ‘no I haven’t needed it up ‘til now’ but on another level he saw that the Metis community was atrophying.”

Metis have their own unique history and context. For some maternity care providers there was a clear lack of understanding and knowledge about Metis people within the Northern Health Region. A first step in providing a culturally safe environment for Metis women’s prenatal and maternity experiences is ensuring there is an understanding of the differences that exist between Metis and First Nations clients, and the support services, such as non-Insured Health Benefits – including transportation - to which they are entitled.

**Supportive Families**

Service providers identified the support of family as an important component in Metis women’s pregnancy and birthing experience. As one health care provider observed, women often visited the health clinic along with an important female family member. The family members had expectations that their pregnant daughters, granddaughters, or sister should be provided with excellent prenatal and maternity care.

“The women often come with their families and in fact some of the younger women always come with the family member, like a grandmother, a sister, a mother and that is more common than coming with the father of the baby. There are few women who come with the father of the baby all the time but many actually come with women members of their family and a lot of them are quite young women. They are often brought in by their grandmothers or mothers because they want them to have the education that comes along with the care and the time.”

“Well I know we’ve had some of them [Metis] show up whether it’s with their mother or their bigger sister, and it’s their mother that is holding the admission paper and you will ask ‘What are you here for?’ and it’s the [labouring woman’s] mother giving the answer and the mother is [in labour] around the corner. So far as accessibility I thank goodness that person was there for her and could help her and communicates with us to help her out.”

Health care providers explained that some women don’t get escorts sent along with them when they arrive to the hospital in labour.
"From what we notice in the clinical setting is that their supports are their families and here there are no escorts allowed to be sent with them. For what we see is that childbirth is an addition to family and the communities they don’t allow escorts to come out to be part [of labour and delivery]. It seems like they only get escorts if they have a C-section."

Some health care providers commented that Metis women don’t have costs covered for a companion to be with them during labour and birth, which can impact birth outcomes.

"The one big difference is that Metis don’t get their accommodations covered. Like for example there are people in [Community T] who are Metis they will not stay in the town because they have to pay, I believe and that’s a huge concern. This is a concern because it’s been shown for many years that if you have a caring person with the pregnant person it makes a difference in terms of the medications, their performance in labour is better."

Another health care provider in a remote Metis community had a different experience and explained that no women in the community are alone during pregnancy.

"…they have their family supports. Like no woman is pregnant alone here. It’s just not like that."

Unless they are able to pay for their own transportation and accommodation it is not always possible for family members to attend prenatal care or deliveries. This lack of support may affect how Metis women access prenatal and maternity care.

**Communication Barriers in Prenatal Care**

There were two main areas identified by key informants regarding communication with Metis clients: use of cell phones and the lack of Metis-ized resources. Many health care providers commented on communication barriers due to client’s use of texting or social media during medical appointments and labour. This was frustrating for the providers.

We were told that resource packages provided to all women in communities do not include any Metis specific maternal health information; nor do they allow for differing levels of English literacy.

"… [our resource] package includes a breastfeeding moms group and public health immunization record and it’s lots of information and it can be overwhelming. When we do our teaching with the moms we give the package; we just [assume] that they are taking the responsibility for themselves. We just hope they take the initiative."

One health care provider had taken steps to mitigate this and had attempted to include any brochures she could find that had “Aboriginal” content. A second step the region could take in providing a culturally safe environment Metis families could be ensuring a variety of education materials are available that are user-friendly and understandable for all clients.

Among some health care providers there was an awareness of the need to increase Metis women’s participation during pregnancy and birth with the Northern Health Region. One health care provider claimed that Metis women are provided with information to access services during pregnancy and birth, if they self-identify. We heard:

"We don’t screen them [Metis] out but the best way is when they tell the nurse that they are Metis or they access some of the Metis services."

It was unclear what services the provider was referring to as in its umbrella of services the MMF does not have prenatal or maternity programming.
Teen Pregnancy

There is a high rate of teenage pregnancy in Metis in Manitoba, including in the Pas and Thompson MMF Regions compared to other Manitobans. While in many circumstances pregnancy is viewed as a positive event for any woman, maternity care providers do not always believe this to be the case. As one health care provider explained:

“I think moms are pretty young, a lot of adolescent pregnancies, and this past year some 13 and 14 year olds with concealed pregnancies.”

Concealing a pregnancy can lead to poor prenatal care and poor birth outcomes for the infant.

Another health care provider suggested that the lack of role models for young males in communities was related to teen pregnancy.

“…the lack of role models for young males and how that affected the relationships, therefore there was infidelity and they didn’t stay together. I listen to all of that, and I know that, but I never saw it to the degree I see it here.”

Intimate Partner Relationships

Similar to focus group participants’ description of violence before and during their pregnancies, health care providers recounted their experiences of violence against their clients. As explained below:

“There is one woman - I helped her four times now, her first pregnancy at 15. He ended up being incarcerated for violence, and third pregnancy and fourth pregnancy again violence, and then she had her finger severed off by him and her children actually witnessed it, and she still thinks he is the father of the children and should be respected.”

Another health care provider described the scope of the issue of family violence in the community in which she worked.

“It’s incredible and epidemic here. I could have one day when I have two women come in and they are bruised and there is not much I can do. If there are children involved then I have a legal obligation to report it and it’s systemic and it’s not just physical but is very controlled living situations where the women don’t go out and it’s not uncommon that the father of the baby is accusing her of that – he is not the father of the baby. It kind of starts from scratch and often [ends in] physical violence and women are hurt very seriously.”

The recognition of domestic violence as an issue by both Metis women and healthcare providers offers common ground for Northern Health Region to work with MMF to identify approaches to begin working on this problem.

Gaps in Programs and Services

Prenatal and maternity services assisted women in many ways. For example, one health care provider observed that providing Metis women with supportive and encouraging environments increased breastfeeding rates, a practice that is valuable for the health of moms and their infants.

“Since I’ve been practicing in this community I think our breastfeeding rates have gone up. There is no private place for breastfeeding in the mall or there is no change table in the bathroom. Even in the houses women don’t have private places to breastfeed. There is some sexism behind not breastfeeding
and also there is strong culture of formula feeding in this community. Also certain things happen such as social assistance gives you extra money for formula feeding so a lot of women do that for that reason. It would be nice if they gave women more money for breastfeeding. A lot of people don’t see breastfeeding as a main issue and that’s unfortunate.”

Another healthcare provider spoke of sexist attitudes towards breastfeeding as a barrier. They stated:

“…and the breastfeeding is another area where we see the sexisms and attitudes about breastfeeding as a barrier to well-woman care.”

6.4 Summary

The voices of Metis women in the north are unique and powerful. Metis women recounted their experiences in pregnancy, birth, and postpartum. Additionally, their insights into Metis culture and their identification of the importance of having a voice, both personally and politically, contributed another dimension to our understanding of the pregnancy and birth experiences of Metis women in the Northern Health Region. Themes extracted from our formal health care providers identified issues that reflect the larger literature surrounding pregnancy and birth in rural and remote communities in Manitoba and Canada and in many cases validated the experiences of the Metis women.

In the next section key findings arising from this study will be reviewed.
References


Section 7: Final Thoughts

7.1 Revisiting the Objectives

The overall goal of this research was to better understand access to prenatal and maternity services and supports for Metis women in northern Manitoba. The specific objectives were: 1) To identify and describe existing supports (programs and services) for pregnancy and maternity care for Metis women within the provincial health care system; 2) To identify and describe existing supports (programs and services) for wellness in pregnancy and maternity care for Metis women in the Northern Health Region; and 3) To identify and describe existing governance structures that support wellness for pregnancy and maternity care for Metis women in the Northern Health Region. Each of these objectives will be discussed with specific examples provided.

We learned a great deal about the experiences of northern Metis women in Manitoba through focus groups with pregnant and new Metis mothers. Within the Northern Health Region, Metis women have experienced pregnancy and childbirth as one of life’s most momentous events. The research was successful at articulating supports that currently exist for northern Metis women—at least for those in the study communities—within the health care system. We learned about the existing programs and services available to pregnant and postpartum Metis women within their local communities, regionally (the nearest town), and provincially. We also learned about the struggles that northern Metis women face in accessing these programs and services, whether financially, logistically (long distances and child care), or as a consequence of jurisdictional ambiguity in access to programs and services. We also learned about programs and services that northern Metis believed are required to further meet their health care needs. Importantly, we became aware of some of the perceptions that northern Metis have about available programs and services, their access to them, and the inequities between themselves and their First Nations neighbours. We learned about the supports for wellness such as Metis culture and pride, and about existing governance structures such as strong MMF Locals in The Pas and Thompson Regions, that support Metis women.

As a woman transitions into motherhood her need to feel supported and safe during pregnancy, labour and birth becomes paramount. The research did identify formal networks for Metis and all other Manitobans within the health care system. These formal networks included physicians, midwives, primary care nurses, public health nurses and ‘Families First’ home visitors. However, we heard from the women that these services were sometimes difficult to access. For example, we were told the ‘Families First’ program requires individuals to be screened in through a survey tool administered by the Public Health nurse. The ‘Families First’ screening process may limit women’s access to this program; in some northern communities this program is non-existent. The research identified informal networks (i.e. family, friends, and the community) for Metis maternal health and wellness. For example, many Metis women identified their main source of information during pregnancy was their mothers or other significant women in their lives.

While not a direct support for health and wellness, the MMF Locals indirectly acted to improve the well-being of Metis in these northern communities by giving voice to the Metis residents and through fostering coherence and community spirit. In identifying the governance structures that exist to support health and wellness for Metis in the north,
jurisdictional ambiguities and different funding models for First Nations and Metis are seen as issues that need to be addressed. Actual and perceived inequities of programs and services between Metis and their First Nations neighbors have led to confusion as to what is and is not available or accessible for Metis.

The Provincial and Federal governments administer health care programs and services to Metis women such as the Canadian Prenatal Nutrition Program, Families First and Northern Patient Transportation programs as well as a variety of other services. The Manitoba Metis Federation supports the Northern Health Region in the services they provide but we heard that a pan-Aboriginal approach is adopted in care delivery, ensuring that services that are provided are not inclusive of our beliefs, values and traditions.

Some health care provider’s personal knowledge about Metis women’s birth experiences included an understanding of cultural beliefs, norms and practices, and the value of culturally–based prenatal and postpartum care. Accessing health care providers who understand and support pregnancy and birth within this context is also important to Metis women.

7.2 Summary of Key Findings

The following list of the research findings from this study is not exhaustive, but rather the key findings are stated as they related to understanding access to prenatal and maternity services for Metis women residing in the Northern Health Region.

- Metis women have similar emotional and physical experiences during pregnancy compared to other women.
- While individual, family, and community supports are important during pregnancy and birth, some Metis women reported experiencing positive and negative impacts due to changes in social networks during pregnancy and as new mothers.
- Some Metis women experience pregnancy as a life altering experience in which they ceased behaviours such as substance abuse (e.g. drinking and/or smoking) and transition into a new role as a mother.
- Some Metis women experience physical and emotional violence at the hands of partners and other family members during pregnancy and as new mothers.
- Participants advocated for safe houses located closer to rural communities.
- All of the participants wanted to be good mothers. Some women spoke of not wanting to repeat mistakes and re-live negative experiences they had with their own parents.
- Metis Locals improve community life by giving Metis a voice and contributing to cultural coherence and community spirit.
- Ongoing tensions between Metis and First Nations Peoples are due to perceived and actual inequity in the availability of health programs and services. Inequity in access to care between First Nations and Metis was reported in some communities.
- Medical transportation was a major concern reported by participants related to distance of the study communities to health care providers and cost of transportation. Local public transportation is lacking in these Metis communities and
residents may not have access to motor vehicles. Although the Northern Patient Transportation Program assists with travel to medical appointments, the program does not provide sufficient funds to cover the costs that are incurred.

- Pregnant Metis women identified issues in health care delivery including too few care providers, particularly physicians and midwives.
- Aboriginal midwifery has the power to transform Metis women’s pregnancy and birth experiences within the Northern Health Region.
- Communities that had midwives had a strong, supportive, culture of breastfeeding.
- Breastfeeding was strongly encouraged in hospitals.
- Women identified the need for a supportive well woman’s center to provide a ‘built environment’ for prenatal care and to give birth.
- Metis women spoke of fear and deep distrust of Child and Family Services impacting their experiences and interactions with the welfare system.
- Many women spoke of systemic racism because they were Metis. They especially spoke of being “too white” and “unprofessional” behaviours that were experienced during labour and birth.
- Women also experienced ageism (discrimination due to their age) because they were considered either too young or too old to be pregnant.
- Some spoke of judgemental attitudes they encountered regarding the number of children they had.
- Health care providers told us that there have been tremendous changes over time in pregnancy and birth within the Northern Health Region, including decreases in the size of families, changes in midwifery due to legislation, and availability of technology such as ultrasound and electronic patient records.
- Communication between care providers in the community and in the hospital was identified as problematic by some. It was suggested that electronic charting will strengthen inter-professional linkages in the Northern Health Region.
- Health care providers had a wide range of understanding of Metis culture; some knew a great deal while others lacked knowledge of the culture.
- There are challenges in communication between care providers and younger women due to electronic technology such as Smartphone™ usage during appointments.
- There are many services for Metis pregnant women available through public health that are provided free of charge and these should be supported.
- Programs on-reserve may not be well suited for Metis.
- Most health care providers in regional hospitals are unaware of any prenatal education mothers may have had and are unaware of what happens post-discharge.
• The Northern Patient Transportation Program has barriers for women when travelling to appointments as there is no provision for support people to go with expectant women.

• Health care providers also recognized that family violence for pregnant and parenting women is a community concern.

7.3 Thinking Upstream

Intimate partner violence is experienced world-wide and across all cultural and socio-economic groups (Van Parys et al., 2014). Key informant health care providers in the Reclaiming Birth study expressed concerns about rates of intimate partner violence amongst their pregnant patients. Most importantly, the Metis women themselves recounted many instances of physical and emotional violence during their pregnancies not only from intimate partners but also from family members. In order to mitigate future intimate partner violence, it is anticipated that working intensively with children exposed to domestic violence may equip these youth with the skills, attitudes and behaviors that are respectful towards women and each other. Designing programs specific for this population is one method for accomplishing this objective.

Roots of Empathy is empathy-based programming for children that was developed in Canada. There are two streams: a program for children in elementary grades, and one for younger children. The program consists of a parent and 2-4 month old baby, along with a trained instructor, visiting classrooms nine times over a school year (Gordon & Green, 2008). The baby provides the fulcrum for learning as children see the relationship between the parent and child evolve, and “learn to understand the perspective of the baby and label the baby’s feelings, and then are guided in extending this learning outwards” to themselves (Roots of Empathy). The programs “have shown dramatic effect in reducing levels of aggression among children while raising their social and emotional competence and increasing empathy”. Evaluative research has shown that compared to comparison groups, Roots of Empathy children exhibited an:

• Increase in social and emotional knowledge
• Decrease in aggression
• Increase in prosocial behaviour (e.g. sharing, helping and including)
• Increase in perceptions among ROE students of the classroom as a caring environment
• Increased understanding of infants and parenting
• Lasting results

According to Gordon & Green (2008) what the children learn “has universal and far-reaching implications: it shapes how they deal with each other and it lays a foundation for their future as parents and citizens” (p.35). In Manitoba sustained results have been shown up to three years after program (Santos et al., 2011). This program was adopted by Frontier School Division - the school division in which our study was located - in 2002/2003. It can be hoped that participation in this program may result in reduced rates of intimate partner violence in the future.
Families First Home Visiting Program
The Families First home visiting program was viewed positively by participants and offered opportunities for learning, friendship, and support for many of the women we spoke to. This program is a provincially administered program and was evaluated in 2010. Changes that were seen after participation in the program included an increase in positive parenting, and less “hostile” parenting. It was also found that after taking part in the program mothers reported improved purpose in life, environmental mastery and self acceptance, as well as increased social support and connection with their neighbourhood (Healthy Child Manitoba, 2010). “The Families First home visiting program was strongly associated with improved well-being in Manitoba families who participated in this program evaluation…these evaluation findings suggest that Families First home visiting program contributed to creating more secure, nurturing, stimulating environments for children where they can develop physically, emotionally and socially” (Healthy Child Manitoba, 2010, 2). Participants of the Reclaiming Birth study strongly supported sustained funding of this initiative.

7.4 Directions for Future Research
While the four communities involved in this research are thought to be representative of Manitoba's northern Metis communities, only one could be considered rural/isolated as women there had to travel quite a distance for labour and delivery. Future research could be conducted in other locations in the north to further capture the experiences of northern Metis health care consumers. Some communities have access to programs and services that are not available in other northern communities, and accurate information is needed for planning purposes. These findings will help to inform policy and guide action for those communities and the health regions in which they are located. Specifically, future directions for research from our findings include impact of teen pregnancy, breastfeeding, family violence, relationships with Child & Family Services (CFS) and ‘birthing as re-birth’ for the mother.

7.5 Conclusions
The MMF and the researchers sought to better understand access to maternity services and supports for Metis women in Manitoba and women living in the Northern Health Region. The Manitoba Metis Federation The Pas and Thompson Regions identified a need to know more about the programs, services, supports, and networks that exist or are needed for northern Metis women to have healthy pregnancies and deliveries. In a Metis-specific holistic manner, the experiences of Metis women from four rural and northern communities were documented, supplemented by information from their formal health care providers. Metis women and their health care providers were able to describe what is available, and share their experiences with accessing these programs/services. Metis women need more information about programs to ensure that they are making full use of the programs and services available to them.

The key findings were presented in this section and were discussed relative to their implications for policy and action. Program and service needs were discussed, with some important services being identified beyond the need for more local physicians and nurses. The issue of inequity of services or, in some cases, the perception of inequality between First Nations and Metis residents of northern communities, was articulated. Other important areas identified included systemic and lateral racism, and a distrust of Metis Child & Family
Services. Given that over 10,000 children in the province of Manitoba are currently in the care of a CFS authority (Government of Manitoba, 2016), and that in 2014-2015, 1351 Metis children were in care, many of them as permanent wards (Metis Child, Family & Community Services, 2015), it is understandable that women may have concerns about their parenting skills and how they are being evaluated. We feel this research has been a first step to fill the gap in understanding the programs, services, supports, and networks available at this time. It is believed that introducing culturally competent birthing services for Metis women would be useful in improving their birth experiences and is the essence of eliminating social, cultural, and financial stresses faced by Metis mothers who are referred to hospitals and urban centres.

Partnerships with Metis physicians, nurses, midwives, and their representative organizations; conducting community-based research to determine labour and delivery needs; identifying and describing Metis values and beliefs related to childbirth and its place in the family and community; and following-up with Metis women’s birth experiences in the referral communities will be effective in improving birth experiences of the Metis women and reduce birth-related stresses and obstacles.

The information we gained from this study will be shared with MMF Knowledge Networks and the communities involved in the research, and will assist Manitoba Health and the MMF to adapt health programs, services, and policies to better meet the needs of Metis people living in northern and rural Manitoba. This collaborative effort will help to improve the health and well-being of Metis families in Manitoba.
References


Glossary of Terms

Canadian Prenatal and Nutrition Program

The Canadian Prenatal and Nutrition Program is a federally funded program for pregnant women. The Canada Prenatal Nutrition Program (CPNP) was announced in 1994 by the Government of Canada. It provides long-term funding to community groups to develop or enhance programs for vulnerable pregnant women (CPNP) (Public Health Agency of Canada, n.d.).

Canadian Association of Midwives

The Canadian Association of Midwives is the national organization representing midwives and the profession of midwifery in Canada. The mission of CAM is to provide leadership and advocacy for midwifery as a regulated, publicly funded and vital part of the primary maternity care system in all provinces and territories. CAM promotes the development of the profession in the public interest and contributes the midwifery perspective to the national health policy agenda (Canadian Association of Midwives, n.d.).

Family Physician with Obstetrical Privileges

A family physician with obstetrical privileges provides family medical care along with having access to obstetrical privileges in hospitals and has maintained their skills to practice obstetrics.

Metis Locals

The seven MMF Regions throughout the province are each divided into community Locals, with their own MMF offices and memberships (MMF, n.d.).

Manitoba Metis Federation (MMF) Membership

At the MMF, Metis identity is verified by self-identification, Metis ancestry, and community acceptance through a membership application and confirmation process. By providing a genealogy with supporting evidentiary documents, an individual and his or her family are able to determine whether or not a Metis ancestral connection can be established. Supporting evidentiary documents may include Federal Census records, sacramental records, Manitoba and Northwest scrip affidavits, post records, and journals. All individuals seeking membership in the MMF are required to have a genealogy completed by a recognized institution in order to objectively verify the applicant's historic Metis nation ancestry. Application for membership begins at the receiving Local in the area in which an individual resides (MMF, 2010).

Midwifery Services

Midwifery Services are available in urban centres through regional health authorities and provide well-women care through pre-pregnancy, pregnancy, birth, and up to 6 weeks postpartum (Provincial Program) (Government of Manitoba, n.d.).
National Aboriginal Council of Midwives
The National Aboriginal Council of Midwives (NACM) promotes excellence in reproductive health care for Inuit, First Nations, and Metis women (National Aboriginal Council of Midwives [NACM], n.d).

Northern Patient Transportation Program
Subsidizes “the cost of transportation required for residents of Manitoba located in the north to obtain medical or hospital service at the nearest location available for health conditions either on an elective or emergency basis. Subsidy may include costs for an essential escort (as required for an infant or disabled person). Eligibility for the program is limited to Manitoba residents north of the 53rd parallel on the west of Lake Winnipeg, and on the east of that lake to the Ontario boundary coverage is extended south to the 51st parallel, where travel is approved by a physician, AND where the patient does not have coverage from an insurer or funder (the employer, WCB, MPIC, FNIHB, etc.)” (Government of Manitoba, 2013).

Nursing Station
Provincial Nursing Stations “provide cost-effective and quality healthcare, develop relationships with community leadership for joint decision-making on innovation and service delivery issues within the community” (Government of Manitoba_c, n.d.). Two of the study sites had Provincial Nursing Stations as their primary source of health care; the other had a Federally-funded Nursing Station.
References


