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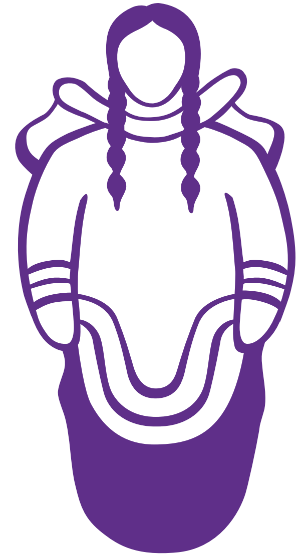
PAUKTUUTIT
INUIT WOMEN OF CANADA

Inuit Sexual and Reproductive Health: Supporting Inuit Families and Communities

Distinction-based Indigenous Health Legislation — Engagement Report



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Executive Summary

From September 2021 to March 2022, Pauktuutit spoke to Inuit in Inuit Nunangat and in urban centers across Canada. We heard from health care workers, administrators, nurses, researchers, elders, and Inuit mothers about their experiences in the Canadian health care system. They told powerful stories that call for dramatic change to the current approach to Inuit sexual and reproductive health care. There were five common themes that must be addressed:

1. Inadequate Infrastructure and Services;
2. The Need for Education and Training in Inuit Communities;
3. The Harm from an Ongoing Legacy of Colonialism;
4. The "Medicalization" of Reproductive Care; and,
5. Ineffective Mechanisms for Confidentiality.

These issues cannot be resolved by flying in more medical professionals from the south or sending off Inuit to be trained far from home. To build an equitable foundation for Inuit sexual and reproductive health, distinction-based Indigenous health legislation must:

a. Facilitate and fund access to culturally safe and substantively equal midwifery and sexual reproductive health care services in Inuit communities;
b. Require language plans and provide interpretation to support Inuit in navigating midwifery and sexual reproductive health care services;
c. Facilitate and fund program development to return control, certification, and service provision of sexual and reproductive health care services to Inuit communities;
d. Affirm Inuit individual and collective rights to health care, and Inuit jurisdiction over their health services;
e. Develop health education models, with online and in-person components, that will allow Inuit people to train and certify as medical professionals within their own communities; and,
f. Require a standard for medical transportation that includes transportation for Inuit patients' families.

About Pauktuutit

Pauktuutit Inuit Women of Canada is the national representative organization of Inuit women in Canada and is governed by a 15-member Board of Directors from across Canada. We advocate for the social, cultural, political, and economic betterment of Inuit women and their families.

Most Inuit in Canada live in 53 communities across the northern regions of Canada in Inuit Nunangat, which means "the place where Inuit live." Inuit Nunangat is comprised of four regions:

1. Inuvialuit (Northwest Territories and Yukon)
2. Nunavik (Northern Quebec)
3. Nunatsiavut (Labrador)
4. Nunavut

Map of the regions of Inuit Nunangat[1]

1 Indigenous Peoples Atlas of Canada, Inuit Nunangat, available at: https://indigenouspeoplesatlasofcanada.ca/article/inuit-nunangat/.

Federal Distinction-Based Indigenous Legislation

In September 2020, the Government of Canada committed to co-developing distinction-based Indigenous health legislation with the goal to "foster health systems that will respect and ensure the safety and well-being of Indigenous Peoples."[2] The Government of Canada also committed to ensuring that the new federal legislation is complementary to existing provincial, territorial, and self-government health models.[3]

Co-development is meant to be a collaborative approach to:

- Establish overarching principles as the foundation of federal health services for Indigenous peoples;
- Support the transformation of health service delivery through collaboration with Indigenous organizations in the development, provision, and improvement of services to increase Indigenous-led health service delivery; and
- Continue the advancement of reconciliation and a renewed nation-to-nation, Inuit-Crown and government-to-government relationship with Indigenous peoples based on the recognition of rights, respect, co-operation, and partnership.[4]

In recognition of the right to self-determination, engagement is being led primarily by First Nations, Inuit and Métis Nation partners and organizations at national, regional, and sub-regional levels.[5]

2 Government of Canada, "Co-developing distinction-based Indigenous Legislation", available at: https://sac-isc.gc.ca/eng/1611843547229/1611844047055.

3 Ibid.

4 Ibid.

5 Ibid.

Engagement Sessions

From September 2021 to March 2022, Pauktuutit sought to engage directly and collect input from community members, as well as staff and health practitioners serving Inuit throughout Inuit Nunangat. Our objective was to provide a report based on feedback from stakeholders to inform the co-development of distinction-based Indigenous health legislation.

To meet this goal, Pauktuutit held sessions with individuals, health care workers and administrators that live and work in Nunatsiavut, Nunavik, Nunavut, and Inuvialuit. Sessions included a brief presentation and discussion questions (*Appendix A*). Pauktuutit also circulated questionnaires (*Appendix B*) to allow for written contributions. In addition, Pauktuutit worked with Inuit Tapiriit Kanatami (ITK) to engage with urban Inuit organizations to determine their respective needs.

The focus of this engagement was:

1. Barriers to sexual and reproductive health care in Inuit communities;
2. Sexual and reproductive health care needs in Inuit communities; and,
3. Midwifery services and education.

In total, there were 24 participants in the four engagement sessions, and four responses to the written questionnaires.

Below is a summary of input from the engagement sessions, followed by recommendations by Pauktuutit in relation to distinction-based Indigenous health legislation.

Urban Inuit Organizations – September 2021

Inuit who migrate to southern Canada often experience further marginalization in the health care system then in their home communities. Participants identified that they felt barriers to accessing care based on language, lack of information, inhumane treatment when dealing with government systems, and a lack of access to culturally safe and responsive health care.

Participants observed that there was a need for specialized interpreters who can communicate the nuances of medical terms. In addition, there is an acute need for education and training opportunities for Inuit to provide their own health care. Participants highlighted the challenge of medical travel and the trauma of limited options for escorts to travel with Inuit women and families for labour and delivery and other health care needs.

Participants also stressed how difficult it is for Inuit women and families to navigate through the hospital system, suitable accommodation, and meals during pregnancy and labour and delivery. They focused on the need for a holistic approach to pregnancy where there is support throughout the childbirth process. Participants sought options for home births and midwifery care, along with access to Inuit healers, traditional foods, and a place where they can have their babies without fear of discrimination or judgment.

Nunavut – November 30, 2021

There were nine participants in this engagement session. The participants included Inuit mothers and health care workers that assisted with midwifery, physiotherapy, and health care administration. Below are the main themes that emerged from this session.

Insufficient infrastructure for childbirth in Nunavut is a serious concern. Nunavut women give birth primarily at the emergency departments at hospitals or clinic settings with limited space. Some communities have no facilities at all. As a result, Inuit women often must leave their communities for extended periods of time to access medical services for labour and delivery.

This infrastructure shortfall means Inuit families endure the trauma of being separated from one another at an extremely critical time in their lives. The issue is compounded by the fact that medical transportation is difficult to access in Nunavut. Family and/or support people for expectant mothers travel separately and must wait, at times, for several days before taking a commercial flight to be present at their loved one's birth.

Lack of in-community professional training opportunities. Nunavut's communities are inaccessible by road, which makes access to local opportunities especially important. There are two major shortfalls here. First, there is the absence of any program for Inuit to train as medical professionals in the field of sexual and reproductive health. Inuit must leave their communities to seek out this training and education, which strains their connections to community and can interfere with the availability of housing upon their return.

Retaining staff and keeping local clinics open. Participants observed that birth centres or midwifery clinics have closed because they did not have enough funding or staff to stay open. The midwives who worked in these clinics where quickly burnt out or stayed for short durations before returning south.

Greater community awareness and prevention programs is an important pillar missing from Inuit sexual and reproductive health care services. The participants identified a lack of education on sexual and reproductive health in many communities. This education gap comes hand-in-hand with misconceptions about sexual health, sexually transmitted infections, cancer screening, contraception, family planning and access to health services for youth and young mothers. There is a lack of coordinated, on-the-ground support strategy for mothers-to-be and there is an absence of information about the options available to parents for labour and delivery. To be effective, support and education needs to be brought "into the house" instead of taking the mother and baby "out of the house".

Decolonizing Inuit medical care must be addressed. A major hurdle that stands in the way of Inuit sexual and reproductive health care is the deep seeded mistrust of the health care system. There is a sense among Inuit that the health care system, as an extension of the colonial system, does not value or trust Inuit knowledge nor the capacity of Inuit to understand what is appropriate for their own health care. This reality is intensified by the fact that Inuit are often forced into a medicalized model for pre-natal, birth, and post-natal care. The connection between Inuit health care and the legacy of colonialism cannot be ignored. Inuit mothers often avoidtheir appointments with health care professionals for fear of being judged and labelled unfit, which in turn could lead to their being flagged to family services.

As one participant remarked:

> *Inuit can deliver their own babies with traditional midwives. The federal government should be more 'accountable' to Inuit, and Inuit should be telling the federal government how their laws need to work, and not the other way around.*

The participants were clear they wish to see a normalization of the cultural and traditional Inuit practices for childbirth. As one participant succinctly noted: "you can deliver a baby in hospital, but at home is just as well if there are no risks."

Nunatsiavut – December 1, 2021

There were five participants in this engagement session. The participants included a registered nurse, a women's health worker, a violence prevention project coordinator, and a regional dietician.

Insufficient resources for sexual and reproductive health programs were a concern flagged by all participants. The major barrier here is the limited birthing facilities in Nunatsiavut communities and a shortage of clinicians to address sexual and reproductive health. The health services available locally to Inuit women are limited to those offered by registered nurses. There are no permanent doctors or medical residents. In general, doctors come to Inuit communities once a month and stay for a week at a time. There is also limited access to sites to obtain prescription medication. In most communities there is no pharmacy and no pharmacist. Inuit are forced to obtain their prescriptions from Happy Valley-Goose Bay or, at times, from a local clinic.

The consequence of these limited resources is that for more than 30 years most Inuit women in Nunatsiavut have had to travel to Happy Valley-Goose Bay and other southern hospitals to give birth. The necessity of travel for sexual, reproductive and obstetrical health care has a significant impact on Inuit women and families. Expectant mothers who already have children are faced with the challenge of leaving them at home to give birth. They may be away for weeks, which splits families and creates significant stress. The other result is there are circumstances where Inuit women are forced to give birth in a strange city and unfamiliar labour and delivery suite without anyone there to support them. Participants observed that the isolation and stress triggered by these traumatic birthing experiences has led or contributed to increases in suicides and mental health challenges among Inuit women before and after labour and delivery.

The stress of travel and being away from home to give birth also places pressure on Inuit women to have Cesarean deliveries (C-Sections). They are afraid that a standard vaginal delivery could lead to being away from their community for longer as they recover. Compounding this, medivac transportation is not a 24-hour-7-day-a-week service. As a result, women and families will not seek medical treatment for themselves or young children unless they are "sick enough" to be taken.

The necessity of back-and-forth medical evacuation for health care creates significant barriers to preventative care as well. There are few opportunities for check-ins to monitor progress. Inuit women must travel to Happy Valley-Goose Bay for their 20-week ultrasound and wait another 16 weeks for their next ultrasound scan. As a result, health complications that would otherwise be detected, diagnosed and treated on routine prenatal checkups are not discovered until many weeks later, which can amplify the risk to the mother and child.

Beyond infrastructure and travel limitations, there is also a significant economic barrier to recruiting qualified medical professionals to Nunatsiavut. There is a significant salary gap between what is offered in Nunatsiavut and other parts of the province and country. As a result, there is little to no incentive for medical professionals to sign on and stay in the region.

Limited post partum support for infant feeding is a fundamental challenge for Inuit women in Nunatsiavut. Participants observed the Happy Valley-Goose Bay Hospital "is not a baby friendly hospital." After delivery, doctors often provide women with birth control contraceptives. Rarely will there be a discussion at that time on the effect the medication has on breast milk production and supply. Before and after pregnancy, there is limited or no support for maternal or infant nutrition. The regional lactation consultant is based in Labrador City and only attends in Happy Valley-Goose Bay 3-4 times a year. The result is breast feeding is effectively unsupported and many Inuit women having difficulty with breast feeding end up relying on formula to feed their newborns even if they would have preferred to continue breast feeding. In communities were food security and lack of access to nutrition is of critical concern, impediments to breastfeeding and infant nutrition call for investigation and mitigation.

It is widely acknowledged in Canada that breast milk is the best food for newborn babies.[6] Yet, Inuit women are treated differently. They are not offered the same information or given the opportunity to decide how to best feed their children. This is inequality based on race.

"Emergency Medicalization" of labour and delivery. Most people in Inuit communities do not have family doctors. The absence of regular medical care means Inuit women seek maternal care at emergency departments throughout their pregnancies and often for delivery. The pre-natal, labour and delivery, and post-natal care they receive is from interns, first year resident doctors, or a general physician who sends medical images to specialist in southern hospitals, then they wait for results and medical orders

This approach to sexual and reproductive health means that Inuit women face tremendous challenges when attending at a hospital to give birth.

For example, one participant relayed how there were no labour and delivery staff available when she arrived at the hospital to give birth. After waiting some time, she was seen by a nurse who saw her walking the hospital floors. The nurse would not admit her because she thought the participant was not sufficiently dilated. Within 10 minutes, the participant was fully dilated but the nurse would still not admit her because her water had not broken. As a result, the participant went into labour and delivered her baby without being admitted to an appropriate delivery room. She had to deliver in full view of the maintenance workers present. This kind of experience and the subsequent turmoil of follow up care erodes the trust Inuit women have in the health care system.

As one participant put it, *"the emergency room does not feel like a safe place for a pregnant woman to be."*

Discrimination, poor communication, and consent problems during medical care was reported by all participants. As noted above, many medical practitioners that serve Inuit communities are recent graduates. Most have little or no cultural sensitivity training or knowledge of Inuit language and culture.

6 Public Health Agency of Canada, "Breastfeeding your baby", available at: https://www.canada.ca/en/public-health/services/health-promotion/childhood-adolescence/stages-childhood/infancy-birth-two-years/breastfeeding-infant-nutrition.html.

Medical care for Inuit women is delivered in a colonial way where women are expected to not question authority, which in this context means the medical decisions or actions of doctors. There is no practice of asking for consent when assessing pregnant women during labour and delivery or when initiating medical procedures to advance the delivery of the child. For example, a participant reported enduring a cervical stretch during her delivery (a painful and invasive medical technique) without being asked for her consent. In her view, there was no choice, and she could not speak up because there are no alternatives to the care she received.

The challenge of confidentiality in small communities. Many Inuit communities in Nunatsiavut are small. This creates significant challenges around the right to privacy and confidentiality. For example, Inuit women may face a situation where seeking a pregnancy test or abortion information means going to a clinic where they may be recognized. This leads to fear and reluctance to seek services they may not want their community to know about. The fear is that judgment will be passed on them and becomes a significant barrier to preventative care. Participants identified their desire for a way of sharing the message about family planning and sexually transmitted infection testing without having the recipients being targeted or stigmatized.

Limited education on sexual health. Many Inuit do not know their rights to request a doctor or a second opinion. This is compounded by the limited information around childbirth and pre-natal and post-natal care. The result is Inuit women do not feel supported in sexual and reproductive health care or in raising their concerns with the government.

Inuvialuit – December 2, 2021

There were four participants in this engagement session. The participants included early childhood intervention staff and Inuit Elders.

Lack of resources and local services. In Inuvialuit there is a lack of specialized medical professionals available to provide care in sexual and reproductive health. We heard from participants that medical professionals they do receive are often underqualified or not trained to work in remote communities. This is a barrier to accessing services because there is a lack of confidence in the competency of the medical professional providing care to Inuit patients.

The participants emphasized that it is important for sexual health programs to be available in Inuit communities, especially programs that seek to educate and destigmatize sexual health and terminology.

The need for youth education and training. It is difficult for Inuit to pursue careers in midwifery in Inuvialuit due to the lack of local programs. Inuit who are interested in participating in these programs must leave their community for extended periods of time. Not only are Inuit reluctant to leave their homes because of their connection to family and community, but they also face the possibility they may lose their housing accommodations, which is in short supply and may not be available upon their return.

In general, education about pregnancy and substance abuse during pregnancy among Inuit youth is still limited. Inuit youth also need to be supported to rethink sexual health stigma (e.g., embarrassment about discussing pregnancy or shame about sexually transmitted infections). The participants emphasized *"youth need to be empowered and they need to feel good about sexual health".*

There was consensus that midwifery in Inuit communities is viewed positively — and it could help foster healthier relationships among youth, and pre-natal and post-natal care by Inuit parents. Further, youth and Elders need to be involved in the process of education to remove barriers surrounding sexual and reproductive health.

Loss of culture. In the early 20th century, doctors were not required for labour and delivery in Inuit communities. Inuit families would see Inuit medical specialists. Now, labour and delivery for Inuit women is a "top-down" and "medicalized" process where childbirth is managed through a physician-centered emergency room medicalized and emergent care approach.

The participants emphasized the importance of returning to traditional ways and supporting the return of Inuit culture in Inuvialuit. This is how the needs of the new generation can be learned and supported. Midwives are seen as vital in returning tradition to Inuit communities as community births align with Inuit culture. Participants thought Elders may provide the necessary guidance and knowledge to reinvigorate traditional birthing.

The need for consistency and collaboration. Healthcare workers come into Inuit communities on short shifts — typically 3-6 months. This constant turnover and change erodes trust and prevents young women from receiving consistent care. Trust in pre-natal, labour and delivery, and post-natal care is vitally important. Currently, Inuit women face frustration and discouragement in constantly having to re-explain their medical history and story to every new doctor and medical professional they see. The participants saw midwives in Inuit communities as a way of offering support throughout pregnancy and childbirth. The participants found that better care comes from building relationships and trust with the community. Service providers would have better relationships with their patients if they were from the community or understood Inuit language and culture. "It's about comfort and understanding… somebody to talk to — it can create a really good feeling".

Nunavik – February 10, 2022

There were six participants in this engagement session. The participants included a sexual health representative from the Nunavik health board, nurses, a public health officer and medical advisor working closely with midwives. In addition, the engagement included an interview with Hilah Silver, a Registered Nurse, BScN, and PhD Candidate from the Department of Family Medicine at McGill University, about research she has completed on Inuit birthing experiences in Nunavik. Through this study, Ms. Silver engaged with 5 Nunavimmiut women, 3 Nunavimmiut men, and 2 female Inuit patient attendants working at Ullivik, which is a boarding home in the Montreal suburb of Dorval that houses medical patients from Nunavik travelling to Montreal for treatment.

Limited availability of local midwifery care. The communities in Nunavik are fly-in and fly-out. Only four of 14 Inuit communities in Nunavik have midwifery services. Most sexual and reproductive health services are provided by small clinics with limited capacity. Inuit women who wish to seek out midwifery care need to travel to the coasts. Complex cases need to be evacuated south to Montreal.

There is a significant difference in the type and quality of care received by Inuit women with access to midwifery services versus those who do not. In communities with midwifery care, the door of entry for carefor pregnant women is through a maternity clinic. Once they suspect that they are pregnant, Inuit women may go to a midwife for a pregnancy test and their care starts there. The next visit will be with a physician who will assess if there are pre-existing conditions of concern. After that, blood work and gynecology follow up care are provided by the midwives. A third trimester evaluation by a multidisciplinary team is then arranged to evaluate if the pregnant women is safely able to give birth in the community or need to be medically evacuated to a hospital in the south. Post-natal care is provided by midwives.

In communities without midwives, care is provided by a general nurse. The quality of the care varies based on the experience of the nurse. The nurse will call a doctor if there is a complex issue or complexity arises they cannot deal with. Doctors fly into these communities once a month. They see pregnant women once per trimester. After those three visits, an Inuit woman must travel to the place where she is going to give birth. This is incredibly stressful for pregnant women and their families. Often, they are away for four weeks and face giving birth without the comfort and support of their community.

A need for local training opportunities. If an Inuk wants to train as a midwife, then they must travel to attend school. This is a barrier to training Inuit midwives. It is no small thing to get up and leave your family and community. The participants observed that studying in the south leads to challenges for Inuit family relations, mental health, and housing as previously noted

The opportunity to train locally, either through remote schooling or other programs, is essential to increasing the number of individuals qualified to deliver children in Nunavik. One significant barrier to local training is the limited availability of internet access. Many communities have inadequate and very slow connectivity, which impairs their ability to participate in virtual training or distance care.

Establishing training opportunities in Nunavik will need to be accompanied by a broader education program. For decades, Inuit in Nunavik have been told that when they graduate high school, they need to go to the south for college or university. This imperative comes from the reality that there are no clear alternative options available to them if they choose to stay.

Disempowerment and an ongoing colonial legacy. Historically and today, Inuit communities are disempowered in health care. In the past, local community members provided many medical services, including x-rays. Overtime, those roles have been replaced by provincial professional services. This exclusion is ongoing colonialism whereby Inuit are told they cannot provide services to themselves. The participants relayed they would like to see local certification programs that allow community members to resume their past roles in providing medical services, including Inuit women in assisting and delivering babies in community.

The legacy of colonialism also continues with a model of care built on southerners flying into Inuit communities to provide medical services. The absence of culturally competent, informed, and safe care is a common complaint amongst Inuit women and families. The current requirement for medical professionals to provide primary care for sexual and reproductive health in Nunavik is to complete a short one-month training. In that brief time, they are expected to learn about and be competent in emergency situations, sexually transmitted infections, and assessing pregnant women. There is no space devoted to culturally safe care.

When southern medical professionals travel into Inuit communities to provide services in Nunavik, they speak mainly English to their Inuit patients. However, there were reports of gossip among non-Inuit medical professionals about their Inuit patients taking place in French, on the assumption that Inuit will not understand. Some Inuit do understand French and hearing gossip about themselves or other patients undermines any trust Inuit may have in the system. Currently, there is a lack of culturally competent and safe care.

Infrastructure. As one participant remarked: *"you would never have hospitals in the south like we have here."* The medical infrastructure in Nunavik is crumbling. There is an inferno of staff turnover. There is limited internet access, sewage management, and access to clean water. The only community with running water and pipelines is Kuujjiuraapik. Often, there are four generations of people living under one roof. These social issues and lack of adequate and basic infrastructure compound the dire medical services situation.

Gender and health care. There is work taking place to ensure the sex education program in Nunavik is culturally appropriate and be reflective of northern life. However, little is happening to educate youth about 2SLGBTQIA+ issues. Currently, there are no designated services for 2SLGBTQIA+ people. An investment is required to build educational programs that focus on diversity, gender equality, and education about 2SLGBTQIA+ issues.

Confidentiality is a problem in medical care throughout Nunavik. The issue of confidentiality surfaces almost immediately upon receiving medical care. It is consistently raised as a concern among youth and adults in Inuit communities where the first person a patient meets is an interpreter (who may be a family member). This lack of privacy and confidentiality places fear and shame in the minds of Inuit who may be, for example, going to get a test for sexually transmitted infections, sexual assault, or intimate partner violence. Reporting sexual assault and any related sexual health issues can be a safety concern with inadequate mechanisms for maintaining confidentiality. For some survivors, knowing that they are not able to maintain privacy can result in them not seeking services or requesting help.

Ms. Silver's research focused on birthing experiences. Participants in Ms. Silver's research acknowledged the numerous stressors associated with the quality of the accommodation facilities and made several recommendations about how their stays could be improved. The participants in her study felt that rooms at Ullivik were not set up for housing families for the long periods of time they often spend in Montreal. Small rooms, uncomfortable beds, lack of access to Wi-Fi/internet and bathtubs, as well as centralized temperature control were often cited. Several participants highlighted safety and security issues at the centre, including housekeeping staff entering rooms without consent or notice while residents were showering, and incidents of theft by staff from residents' rooms and the shared country food freezer.

Participants said that the experiences of Inuit families could be improved by making the following changes to services at Ullivik and the McGill University Health Centre (MUHC), their accommodations in Montreal, and their time in Montreal in general:

1. Bring more family members and children to Montreal.
2. Offer culturally adapted and Inuit-led health services and programs at Ullivik and the MUHC (including Inuit midwifery, cultural activities, prenatal classes, and interpretation/navigation services).
3. Establish a family transit house in Montreal and improve safety, comfort, and food quality at Ullivik and the MUHC.
4. Provide more financial support to families.
5. Increase staff training on cultural safety and Inuit health and culture.

Analysis of Feedback

There are five dominant themes that emerged through the engagement sessions across Nunatsiavut, Nunavik, Nunavut, and Inuvialuit:

1. **Inadequate Infrastructure and Services.** The theme across all Inuit regions is a woeful lack of infrastructure and services. This shortfall includes inadequate physical infrastructure, such as hospitals, clinics, internet access, water, and sanitation in many regions. There is also a shortage in medical professionals that can provide comparable services to what is available in the rest of Canada.

   The services that are available to Inuit women and families are most often available outside of their communities. Transportation options are limited and at times unavailable — even in emergencies. As a result, Inuit women have no choice in their sexual and reproductive health care. They are forced to travel long distances and spend extended periods isolated and alone or they must accept inadequate care. Both situations are fundamentally unjust and must be addressed.

2. **The Need for Education and Training in Inuit Communities.** The call for education and training to come to Inuit communities is clear. The needs here include general sexual and reproductive health education programs and training programs for Inuit to become certified as midwives and other medical professionals that can service their own communities. Those medical professionals must also be adequately compensated. Adequate compensation means paying salaries that are competitive with those offered elsewhere in Canada.

   There is a strong call for the return of midwifery services to all Inuit communities. This does not mean flying in more midwives from the south or sending Inuit to be trained far from home. Instead, there must be funding and recognition for culturally appropriate and relevant ways of providing sexual reproductive care. Inuit have a long history of midwifery. A return to and recognition of traditional practices must be part of health care in Inuit communities.

3. **The Harm from an Ongoing Legacy of Colonialism.** The undercurrent that flows through the feedback we received is that Inuit women and families do not feel safe in the health care system. Instead, they feel judged, degraded, and ignored. This is compounded by the management and control of certification as well as medical practice by federal and provincial authorities. In this current system, Inuit women and families endure racism, neglect and poor care, regardless of conscious intent of medical professionals. As a result, there is a deep mistrust of the health care system.

   It is an unsustainable solution to continue to have the bulk of medical care for Inuit women and families provided by doctors and nurses who lack appropriate cultural training and awareness. That is not to say that cultural sensitivity training itself will solve the problem. There must be a concerted effort to decolonize the health care system and return management and control to Inuit communities.

4. **The "Medicalization" of Reproductive Care.** A common issue we heard is that pre-natal, labour and delivery, and post-natal care for Inuit women is defined and treated in the context of emergency medical care. The health care system available to Inuit women pushes expectant mothers into a foreign hospital setting for labour and delivery regardless of the risks associated with the birth. Home birth is unsupported and midwifery (i.e. non-hospital care) is only available in limited areas. The result is Inuit women are giving birth out of their communities in hospitals most often when not medically necessary.

5. **Ineffective Mechanisms for Confidentiality.** Confidentiality is an essential element to health care. If a patient cannot trust their personal health information will remain private, then they will be less likely to seek care or share necessary information. This is a common element in health care across Canada. In many ways, the challenges that Inuit face here are like that in other small communities in the country. However, the situation is exacerbated for Inuit by the constant cycling and high turnover of health professionals from the south that do not always respect the privacy of their Inuit patients.

Recommendations

The federal government has committed to co-developing distinction-based Indigenous health legislation that:

- Establishes overarching principles for federal health services to Indigenous peoples;
- Transforms health service delivery by collaborating with Indigenous organizations; and,
- Increases Indigenous-led health service delivery.[7]

We submit that to meet these goals with respect to Inuit sexual and reproductive health, distinction-based Indigenous health legislation must:

a. Facilitate and fund access to culturally safe and substantively equal midwifery and sexual reproductive health care services in Inuit communities;
b. Require language plans and provide interpretation to support Inuit in navigating midwifery and sexual reproductive health care services;
c. Facilitate and fund program development to return control, certification, and service provision of sexual and reproductive health care services, including midwifery to Inuit communities;
d. Affirm Inuit individual and collective rights to health care, and Inuit jurisdiction over their health services;
e. Develop health education models, with online and in-person components, that will allow Inuit people to train and certify as medical professionals within their own communities;
and
f. Require a standard for medical transportation that includes transportation for Inuit patients' families.

7 Government of Canada, "Co-developing distinction-based Indigenous Legislation", available at: https://sac-isc.gc.ca/eng/1611843547229/1611844047055.

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