

**TOWARD THE DEVELOPMENT OF CULTURALLY SAFE BIRTH  
MODELS AMONG NORTHERN FIRST NATIONS: THE SIOUX  
LOOKOUT MENO YA WIN HEALTH CENTRE EXPERIENCE**

by

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## ***Abstract***

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This paper presents the approach taken by the Sioux Lookout Meno Ya Win Health Centre (SLMHC) to improve maternal and newborn care for First Nations peoples in Northwestern Ontario. I use a cultural safety lens to explore whether the SLMHC's focus on birthing meanings, beliefs, attitudes, and practices as described by elders may contribute to the development of a more culturally safe hospital birth model. Findings suggest that a transcultural approach aimed at understanding and involving birthing beliefs, practices, and meanings into the health care setting is a necessary aspect of returning control back to the community and is thus an important preliminary step in achieving cultural safety in the clinical realm. In areas in which health and social challenges prevent women from giving birth in their home communities, efforts such as the SLMHC initiative should be made to ensure that existing health care settings are more culturally safe.

Keywords: First Nations, maternity care, birth, cultural safety, transcultural theory

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## ***1. Introduction***

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### **Research context**

The notion of cultural safety as it applies to Canadian Aboriginal peoples is a relatively new concept, emerging in this country within the last decade. The discourse first began in the late 1980s in the postcolonial context of nursing education in New Zealand and in many ways aimed to address some of the issues inherent in the field of transcultural nursing theory (Anderson et al, 2003). As the dominant approach to the role of culture in health and health care settings at the time, transcultural theory stressed the importance of learning and using “local cultural knowledge” in ways that fit with “professional outsiders’ knowledge” when providing nursing care (Coup, 1996; Leininger, 1999, 9). The discourse of cultural safety extended beyond this concept of transcultural nursing, highlighting instead the relative social, political, and economic positions of certain groups in society (Ramsden, 1993). Viewing health and health care through a cultural safety lens sought to bring attention to unequal power relations arising as a consequence of colonialism (Anderson et al, 2003).

Although researchers have begun to apply the notion of cultural safety to the Aboriginal Canadian population, acknowledging parallels between indigenous peoples in New Zealand and the colonial experiences of Aboriginal peoples, the challenge remains as to what cultural safety looks like in a clinical setting (Anderson et al, 2003; Williams, 1999). According to the Nursing Council of New Zealand, cultural safety is achieved when a provider engages in self-reflection and awareness of “the impact that his or her personal culture has on his or her professional practice” (2002). However, in practice, a clear conclusion as to how the concept of cultural safety is operationalized has yet to be

reached or thoroughly explored (Anderson et al, 2003). The paucity of literature investigating and evaluating the concept of cultural safety in practice allows room for discussion regarding the achievement of a culturally safe clinical setting.

Addressing the Canadian policy of evacuation for birth through a cultural safety lens is appropriate because it highlights the role of colonialism in shaping how maternal and newborn care is provided to Aboriginal women in the north. Emphasizing the costs of this policy and the ways in which it has disempowered the women and communities affected are also important to help advocate for change. However, what culturally safe maternity care might look like in the north remains to be seen.

The following paper details the process taken and the emerging results from one aspect of an initiative begun by the Sioux Lookout Meno Ya Win Health Centre in Northwestern Ontario in December 2007 to explore ways to improve maternal and newborn care services in the region. It will investigate what role, if any, an approach informed by transcultural theory that focuses on developing a greater understanding of meanings, beliefs, attitudes, and practices surrounding birth as described by First Nations elders may play in the development of a more culturally safe birth model at the hospital.

### **Research questions and project objectives**

This paper seeks to explore the following broader question:

*In areas in which health and social challenges present a barrier to Aboriginal women giving birth in their home community, can an exploration of First Nations birthing beliefs, meanings, attitudes, and practices contribute to the development of a more culturally safe hospital birth model which reduces the negative impacts of evacuation?*

More targeted questions include:

- I. What are the successes and challenges arising from the approach the SLMHC has taken to improve maternal and newborn care for First Nations communities in the region?
- II. What role, if any, does the investigation of meanings, beliefs, attitudes, and practices surrounding birth as described by First Nations elders play in providing culturally safe care?

These questions served as points of analysis for the original SLMHC *Odotsemag* research initiative I was involved in as a Master's student in the summer of 2009.

Specifically, the original SLMHC initiative set out to gain a better understanding of First Nations birthing meanings, beliefs, attitudes and practices in order to inform the development of a more culturally appropriate hospital birth model. The focus of the project arose out of consultations with health care providers and community members and prior to my involvement at the SLMHC. I was responsible for meeting the following objectives which were part of a broader environmental scan being conducted at the hospital:

- I. To understand and describe attitudes and meanings attributed to pregnancy and childbirth from the perspective of Northwestern Ontario First Nations elders
- II. To identify traditional birthing practices acknowledged as important by Northwestern Ontario First Nations elders
- III. To identify facilitators and barriers to effective maternal and newborn care from the perspective of Northwestern Ontario First Nations elders

## **Overview**

In order to answer the broader research question it is important to first gain a greater understanding of evacuation for birth and the realities of giving birth in Northwestern Ontario. Prior to analyzing the SLMHC approach to improving maternal and newborn health through a cultural safety lens, a discussion of the concept and its relevance to this topic is warranted. The paper then introduces a review of historical perspectives on Aboriginal childbirth in North America, as it was a preliminary step in

the development of research tools used and is reflective of past approaches to birthing in Aboriginal communities. Finally, the results of the SLMHC initiative are presented.

Given the context in which women from Northwestern Ontario give birth and the results that emerged through conversations with elders, this paper then discusses whether the SLMHC initiative might contribute to the development of a more culturally safe hospital environment in the future.

## ***2. Background***

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### **2.1 The state of birth in northern Aboriginal communities in Canada**

Evacuation for childbirth to a southern hospital is the status quo for the majority of Aboriginal women in Northern Canada. Since the 1970s, these women have travelled out of their home communities at between 36 to 38 weeks gestation to give birth in larger urban centres (Kornelsen and Gryzbowski, 2005b; Chamberlain and Barclay, 2000; Webber and Wilson, 1993). This obstetric policy is based on epidemiological and medical notions of risk and is supported by the decreasing rates of perinatal mortality in regions where the policy has been implemented (Moffitt and Vollman, 2006; Kaufert and O'Neil, 1990). The lack of obstetrical capacity in communities whose primary care is provided by nurses at outpost stations and visits by physicians every few weeks is viewed by the majority of decision makers as an overly dangerous environment in which to give birth (Jasen, 1997; Kaufert and O'Neil, 1993).

Once evacuated to southern centres, women stay in federally funded hostels until the onset of labour when they are transferred to the hospital (Chamberlain and Barclay, 2000). A woman's stay in a more southern referral centre can be up to six weeks in duration (Kornelsen and Gryzbowski, 2005b). Although an Aboriginal woman's travel is funded by the federal government, escorts such as her husband, partner, or other relatives are not covered unless the woman is a minor or has a disability that requires the help of another to travel (Health Canada, 2005). This often results in a woman travelling to a southern hospital by herself, perhaps leaving her partner and family for a significant period of time (Calm Wind and Terry, 1993).

Despite the obstetrical evacuation policy for birth, First Nations women specifically continue to suffer disproportionately from poor maternal and fetal outcomes as compared to non-First Nations populations. In fact, rates of stillbirth and infant mortality in First Nations populations, although apparently decreasing, are still estimated to be about double that of the Canadian average (Smylie and Adomako, 2009). The Royal Commission of Aboriginal Peoples (1996) attributed this disparity primarily to a lack of control over health as well as poor living conditions, citing the following specific contributors:

*“...lack of access to health care and transportation; shortages of food; the lack of appropriate and affordable housing; the absence of culture-based prenatal outreach and support programs for Aboriginal women; and the mandatory evacuation of birth mothers to distant hospitals, regardless of medical risk...Fathers, siblings, grandparents and extended family were excluded from the birthing process, and traditional rituals to name and welcome newborns were delayed or abandoned... Vital contributions of Aboriginal midwives to health promotion and family bonding [was] lost as well” (RCAP, 1996).*

Nevertheless, the policy of evacuation remains in rural and remote regions of Canada, disproportionately affecting Aboriginal communities in the North. This policy has had significant negative impacts on those communities governed by it.

## **2.2 History of evacuation for birth in Aboriginal Canadian communities**

The process of childbirth for Aboriginal women living in the North has changed dramatically over the last sixty years. Birthing has shifted from an experience governed largely by traditions of a woman’s home community and assisted by midwives or family members, to a more medicalized experience grounded in a biomedical framework (Douglas, 2006). It has only been recently that the move toward a model of integration or blending of these two often competing approaches has been widely encouraged (Douglas, 2006).

The changes we have seen in the birth process in the last century are reflective of historical conceptions of native peoples as a “weak, declining” race as compared to the dominant European and Euro-Canadian culture as “robust” and “youthful” (Jasen, 1997, 389). By the start 20<sup>th</sup> century, the prevalent view of many Canadians as well as the Canadian government was the idea that “the Indian race was too degenerate to survive” and therefore it was imperative to implement policies of cultural assimilation for the well being of these populations (Jasen, 1997, 393). Moreover, it was thought that the major barriers to assimilation were the cultural traditions associated with religion and medicine (Jasen, 1997). Documented birth complications in native populations (albeit perhaps skewed or falsified to seem more problematic than the reality to support the government’s “civilizing mission”) were attributed to the use of native customs during the process (Jasen, 1997, 383).

The medicalization of childbirth in the North gained major momentum following the Second World War. This was a period in which the Canadian federal government became increasingly involved in northern and remote regions of Canada, delivering social services and exerting control over education, health services, and hunting restrictions (Douglas, 2006). Starting in the 1950s, the federal government began to prioritize infant mortality in Aboriginal communities as a significant public health concern. This decision was based largely on statistics collected since the 1930s indicating that maternal and infant deaths among ‘status Indians’ were higher than the national average (Jasen, 1997). As a consequence, nursing outpost stations were created where nurse-midwives would provide primary care on a continuous basis and physicians would visit regularly (Douglas, 2006). British nurse-midwives were recruited to staff these stations, as the

practice of midwifery remained legally unrecognized in Canada at the time (Jasen, 1997). The nursing station model promoted the medicalization of childbirth by shifting birth to these nursing stations or to a southern hospital and discouraging more traditional home births (Douglas, 2006). Although birth more commonly took place at the nursing stations during this time period, traditional midwives remained very involved in the process until the late 1960s. It is interesting to note that part of the mandate of the British nurse-midwives was to replace the role of traditional native midwives over time (Jasen, 1997). Indeed, the role of traditional midwives seemed to have been made redundant by the 1970s.

Major support for discrediting Aboriginal birth and promoting medicalization and government intervention came in 1962 with a rather “unsophisticated statistical survey” by the Medical Services Branch (MSB) of Health and Welfare (Jasen, 1997, 395). The survey was developed with the assumption that high infant mortality would be seen in rural and remote regions where birth was not supervised by medical personnel. The results, not surprisingly, supported this hypothesis. Authors of the consequent reports highlighted a particular concern for the number of births attended by Aboriginal midwives, as they lacked ‘appropriate’ supervision (Jasen, 1997). First Nations women were blamed for high mortality rates because they were reluctant to access nursing services provided by the federal government at the nursing outposts (Jasen, 1997).

Nevertheless, Inuit and First Nations community members maintained substantial involvement in birthing processes until the 1970s, when an “integrated medical system” was completed (Douglas, 2006, 122). Although more women were evacuated to regional and southern hospitals as air transport improved in the 1960s and 1970s, the emphasis

remained on community birthing in the presence of a nurse-midwife (Douglas, 2006). The process of evacuation for all births in rural or remote regions in the North began early in the 1980s and rapidly became the dominant policy (Jasen, 1997). This decision was made based on the premise that perinatal and maternal mortality and morbidity were reduced in accordance with the level of obstetrical capabilities at the birth locations (Douglas, 2006). The policy was supported by epidemiological data, many from Inuit communities, showing a decline in mortality and morbidity rates during the mid 1980s when the policy was implemented (Douglas, 2006). Thus, for the last decade and a half, evacuation to southern hospitals has been the status quo for the majority of Aboriginal women living in the North. The policy, as we will see, has been met with opposition on community, regional, and national levels.

### **2.3 Health and social consequences of evacuation for birth**

Given the fact that “if offered an option, most women, regardless of ethnicity, prefer to give birth within their own culture and close to their family”, it seems self-evident that mandatory travel away from ones culture and family has significant costs to a pregnant woman, a newborn infant, the family, and the community (Chamberlain and Barclay, 2000, 116). Thus, it is not surprising that although evacuation of Aboriginal Canadian women to larger southern hospitals to give birth has reduced morbidity and mortality associated with high-risk pregnancies on an epidemiological level, the practice has also given rise to many negative health and social outcomes.

The health and social consequences of travel to a southern hospital for birth have been studied extensively. Medically, a growing body of evidence suggests that evacuation may contribute to postpartum depression and increased maternal and newborn

complications (Klein, Christilaw and Johnston, 2002). Moreover, high levels of stress during pregnancy, such as those experienced women who must travel for maternity care, have been closely associated with pre-term delivery (Mackey et al, 2000). Such physiological health effects for the mother and newborn are often manifestations of numerous psychosocial consequences of evacuation including: loneliness, worry, anxiety, depression, loss of appetite, or increased smoking behaviour (Stonier, 1990). The costs of evacuation for birth are felt at both the family and community levels (Couchie and Sanderson, 2007; Chamberlain and Barclay, 2000).

One study, based on interviews with Inuit women who left their communities in the central Arctic to give birth at regional centres, identified emotional, physical, and financial stressors associated with evacuation (Chamberlain and Barclay, 2000). Emotionally, “enforced separation for family, culture, and the community” was very difficult for mothers (118). Women were concerned about leaving their children and partners behind and complained of being homesick, bored, living in a strange environment with unfamiliar foods and people, and feeling disconnected from family upon return to their communities (Chamberlain and Barclay, 2000). Another qualitative study speaking with predominantly Aboriginal women in rural and remote British Columbia yielded similar results. One woman spoke of the stress of separation from her older children:

*“[I couldn’t take the older ones]cause they go to school but [the baby] was born in February so I had to leave them after the holidays. It was pretty hard. I think it’s best if they go with you cause it’s hard, cause [then] your mind is on one thing. You’re worried about the baby you’re having and the kids [you left at home]” (Kornelsen and Gryzbowski, 2005b, 77).*

As a result of high levels of stress from separation, women may make the decision to return home before they have given birth. The anxiety a woman is feeling when away from home can outweigh her perceived risks associated with giving birth outside a hospital:

*“[My doctor] got in touch with a specialist...and I just told him it can’t be healthy for my baby either for me to be depressed because that’s how I feel. I feel depressed. I don’t want to be here and...[the doctor] said, ‘well, if she’s that far along and she’s feeling depressed and she wants to go home...let her go’”*  
(Kornelsen and Gryzbowski, 2005b, 78.)

Financially, evacuation can place undue stress on a family. Calls home, the cost of baby sitters, additional costs of airfare if a woman’s partner travels with her, and the cost of absence from work are often cited as concerns for women (Chamberlain and Barclay, 2000; Kornelson and Gryzbowski, 2005). Themes relating to a lack of choice or control in the birth process, such as an ability to choose a birth location or to choose who can be present during the birth, are highlighted as problematic by many women (Chamberlain and Barclay, 2000; Kornelsen and Gryzbowski, 2005b).

Perhaps as a consequence of the problems inherent in the policy of evacuation for birth, women often resist or avoid evacuation through various strategies (Kornelsen and Gryzbowski, 2006). First Nations women in Manitoba, Ontario, and Nunavik as well as Native Americans in Alaska have evaded nurses, hidden pregnancies, misled providers about their due date, or refused evacuation altogether in order to give birth at home – decisions which at times have meant disastrous results for the health of the mother and the infant (Hiebert, 2001; Jasen, 1997; Koval, 1994). One story told at a Royal Commission of Aboriginal Peoples (RCAP) hearing by the Interim Regulatory Council on Midwifery spoke of a woman in her ninth month of pregnancy from Pikangikum,

Ontario who had travelled to Sioux Lookout to give birth (*see Figure II: SLMHC Service Area*). She felt so strongly about giving birth at home that she managed to travel halfway home on a skidoo (Jasen, 1997). This resistance seems to be a fairly common occurrence among all Canadian women in rural areas lacking maternity care services (Kornelsen and Gryzbowski, 2006). A repeated sentiment in a study conducted with women from rural British Columbia is exemplified through one woman's statement: "I kept telling [my doctor] I was going to deliver here, I just wasn't going to tell anyone when I was in labour" (Kornelsen and Gryzbowski, 2006, 260). Resisting evacuation in various ways is perhaps a strategy for a woman to regain control over her own birth experience and create an environment that is more congruent with her needs. Indeed, Kornelsen and Gryzbowski (2005a) state that an optimal birth experience requires "continuity of caregiver, [a woman's] involvement in decision making, and the presence of partners, family, and social support" (558). Unfortunately, the obstetrical policy of evacuation as it exists today creates a birth environment that meets none of these requirements.

Despite their general dislike of the evacuation process, there is also evidence suggesting that younger generations of First Nations mothers are often fearful of giving birth in their community for reasons relating to safety. For example, qualitative interviews with Mushkegowuk Cree women in the Moose Factory zone in northern Ontario indicated that while younger women were concerned about the evacuation process (due to being separated from their children for an extended period of time, lack of financial support or resources for child care, unfamiliar foods and environment, and isolation from family during childbirth), following an explanation of the individual physical risk involved with delivering in their community, approximately 80% of the

women interviewed stated they would rather be evacuated for their births than birth at home (Webber and Wilson, 1993). Indeed, it appears that some younger women view the risks to their own health or that of their baby as too great to attempt a home birth in their community. These findings indicate that perhaps bringing birth back to the community may not be responding to the needs or desires of a younger generation (Hiebert, 2001).

## **2.4 Framing risk in childbirth**

Many have criticized the policy of evacuation from rural and remote Aboriginal communities for all births because it is based on the dominant clinical and epidemiological conceptions of risk (Jasen, 1997; Kaufert and O'Neil, 1993). The definition of risk is often isolated to the physical health of the mother and newborn in the biomedical sphere. As such, risk is most often illustrated by clinicians in terms of perinatal and neonatal mortality rates as well as “cases of disaster” (Kaufert and O'Neil, 1993, 46). Historically, birth is seen by Aboriginal peoples as a community event that strengthens familial and community bonds (Moffitt, 2004). Consistent with this view, Aboriginal peoples frequently express risk in birth as community-based (Kaufert and O'Neil, 1993). Physical risks for many people seem to be an acceptable consequence in many cases to prevent the significant social, familial, and community disruptions they see as inherent in the evacuation process (Kaufert and O'Neil, 1993; Jasen, 1997; Kornelsen and Gryzbowski, 2005b; Chamberlain and Barclay, 2000).

Arguably then, for a maternal health policy to reflect the meaning of pregnancy and birth in First Nations communities, evaluations of risk cannot end with the individual, but should extend to include the risk to the family and community. Viewing birth as merely an individualized process and not allowing the possibility of a different

approach overly imposes the norms of the dominant Euro-Canadian culture on Aboriginal peoples. Thus, failing to shift definitions and discussions surrounding risk to encompass the realities of women in northern communities perhaps leads to the further entrenchment of health inequities.

## **2.5 Potential solutions**

A number of potential solutions to address the negative consequences of evacuation have been proposed by various stakeholders. These proposed solutions range from an “integration of traditional midwifery with modern obstetric practices in centres closer to home” to a complete reversal of the evacuation policy to return birth back to the community through midwifery-led birth models (Jasen, 1997, 397).

Movements to integrate or blend more culturally appropriate methods and those of western biomedicine to create an optimal system closer to home have important implications in addressing the many shortcomings of the evacuation system while meeting the needs of First Nations mothers (Dooley, 2009; NAHO, 2006; Douglas, 2006; Van Wagner et al, 2007; Couchie and Sanderson, 2007; Native Women’s Association of Canada [NWAC], 2007; Carroll and Benoit, 2001; NAHO, 2008; Long and Curry, 1998). On a national scale, a number of dominant advocacy groups have made recommendations of this type to improve the future of Aboriginal birth in Canada.

The Society of Obstetricians and Gynaecologists of Canada (SOGC) released a report in January 2008 entitled, “A National Birthing Initiative for Canada”, in which Aboriginal birthing was one of many topics discussed. It states that an Aboriginal birthing initiative is needed to “...accelerate action to improve the health of Aboriginal children, to address health inequities, and to create a framework for comprehensive,

collaborative maternity care partnerships” (23). Such an initiative must also be “informed by culturally appropriate traditional knowledge and experiences, and the need to return safe birthing closer to communities” (24). The SOGC claims the number one core element of such an initiative is to listen to Aboriginal voices, expanding beyond discussions with pregnant women to include elder, family, and community input. Ultimately, discussions with and input from the multiple stakeholders who “define the maternity experience” in an Aboriginal context should be used to guide the development of a national Aboriginal birthing initiative (24).

The National Aboriginal Health Organization (NAHO), makes a number of similar recommendations in their document, “Exploring Models for Quality Maternity Care in First Nations and Inuit Communities: A Preliminary Needs Assessment”, released two years prior to the SOGC report (2006). Prenatal classes, labour classes, more support for young women, healthy lifestyle promotion, midwife training and certification in the communities, and the gathering and teaching of traditional knowledge were identified, among other suggestions, as immediate priorities. According to this NAHO report, not only should Canadians work to document traditional teachings, but we must also seek to work with elders and traditional midwives to promote and strengthen these teachings and practices (2006). The generational disconnect evident between Aboriginal youth and their grandparents today is expected to lessen with the reintroduction of more traditional beliefs and practices (NAHO, 2006).

Aboriginal community members who advocate for a complete return of birth to the community “to the extent that it is practical and safe” are also influential in this debate (Couchie and Sanderson, 2007, 250). This group typically points to the

Inuulitsivik Health Centre maternity ward as a potential model for best practice. The Inuulitsivik midwifery service and education program in Nunavik, northern Quebec is now internationally recognized as a model of how to return birth back to a community. A direct result of community organization and “activism for Inuit cultural revival and self-government”, the first birth centre opened in Puvirnituk in 1986 and represented a reclamation of “the birth experience by using midwifery skills and traditional knowledge about birth, integrated with modern approaches to care” (Van Wagner et al, 2007, 385). Since then, the midwifery-led primary care model has expanded to allow prenatal care, ‘low risk’ births, and postpartum care to be offered to women living in the larger villages of Inukjuak, Puvirnituk, and Salluit, whose population comprise 75% of the Hudson coast population (Van Wagner et al, 2007). The remaining 25% of women who do not live in these larger villages must travel to them in order to access care. However, as a result of the birth model led by Inuit midwives and midwifery students in training, pregnant women still obtain care in their own region, language, and culture (Van Wagner et al, 2007).

According to the Inuulitsivik midwifery model, an interdisciplinary Perinatal Committee led by midwives reviews a woman’s case at 32-34 weeks gestation and creates a care plan which includes place of birth (Van Wagner et al, 2007). Support is provided by: on-call physicians located in Puvirnituk 24 hours a day, on-site nurses called into the centre when a birth is taking place, and on-call physicians available by phone. The nearest Southern hospital is Montreal, a 4 to 8 hour commute for specialist care if needed.

The success of this approach is evident. Since the centre's beginning in 1986 to March 2005, 80% of the women from the Hudson coast have given birth in Nunavik. During this time period, the region has a reported perinatal mortality rate of 9 per 1000 (21 deaths of a total of 2253 births). Although difficult to make valid comparisons, it is noteworthy that the perinatal mortality rate for Canada in 2003, according to the Health Canada Perinatal Health Report, was 8 to 10 per 1000, and the combined rates of fetal and neonatal mortality in similar populations in the Northwest Territories and Nunavut were 19 and 11 per 1000, respectively (Van Wagner et al, 2007). According to these statistics, the perinatal mortality rate in the Nunavik region seems to be lower than that of similar environments and on par with the Canadian average.

In addition to Inuulitsivik Health Centre, other initiatives have aimed to improve Aboriginal women's birth experiences in rural and remote areas of Canada. Since 1994 when Ontario became the first province to regulate and fund midwifery, a number of midwifery-based birth models have been developed and the movement itself has gained momentum nationally (NWAC, 2007). Community-based doula models have also been increasingly implemented within dominant medical paradigms in order to decrease language and cultural barriers, foster trusting and meaningful relationships, and improve continuity of care (NAHO, 2008). As one might expect, the training of Aboriginal midwives and doulas (trained lay birth coaches) has recently gained attention. For instance, one educational initiative developed in The Pas, Manitoba trains midwives in a "model of instruction rooted in Aboriginal values and traditions" but also satisfies the competencies required by the College of Midwives of Manitoba (NWAC, 2007). A similar Aboriginal Midwifery Training Program is offered at the Six Nations Birth Centre

in Southern Ontario, which graduated its first class in 2003 (NWAC, 2007). Educational models such as these seem imperative to staffing community birthing centres and developing the capacity to promote community birth and improve existing hospital models in the future.

Generally, addressing the challenges surrounding birth in Aboriginal communities has increasingly become a collaborative process. In many communities, as is the case in northern Quebec, decisions surrounding birth have been made *by* the communities rather than for them. Unfortunately, the Inuulitsivik model remains the exception. “System dependence” on the evacuation process for childbirth has created a challenging social and political environment for change (Tedford Gold, O’Neil, and Van Wagner, 2007, 5). We face challenges relating to: a lack of community and health care provider mobilization, increasing concerns surrounding safety for birth among Aboriginal populations, and faltering relationships between all levels of decision makers (Tedford Gold et al, 2007). Indeed, some suggest that the policy of evacuation has created communities that are “unfit” for childbirth and the idea that the community is unsafe is a consequence of such a policy (Tedford Gold et al, 2005, 10). Improving birth in rural and remote Aboriginal communities has been, and will continue to be, a multi-dimensional and extremely demanding task.

## **2.6 Birth at the Sioux Lookout Meno Ya Win Health Centre**

The Sioux Lookout Meno Ya Win Health Centre (SLMHC) has been commended in many respects for its model of culturally sensitive maternity care. The location of the SLMHC significantly reduces the distance First Nations women must travel to give birth. Prior to the program’s operation, women had to travel over 300 kilometers to southern

hospitals in either Thunder Bay or Winnipeg (Dooley et al, 2009). Serving 28 remote Aboriginal communities has allowed the SLMHC to maintain a small obstetrics program with cesarean capabilities delivered by family physicians with additional training (Dooley et al, 2009). Approximately three hundred and fifty women give birth at the centre each year (Dooley et al, 2009).

The SLMHC has attempted to create a hospital environment “as close to home as possible” through the creation of a Traditional Healing, Medicine, Foods, and Supports program (Dooley et al, 2009, 77). According to Dooley, a physician with a long history at the SLMHC, First Nations interpreters are available as part of this program sixteen hours a day in order to reduce the anxiety that often arises as a consequence of language barriers. Women have access to traditional foods and are visited by an elder during their stay at the hospital. Prenatal care is provided to women at home by community nurses as well as visiting family physicians. Prenatal clinics are also held twice a week in Sioux Lookout for those women who have been referred to the centre and prenatal ultrasonography is available in communities via visits to nursing stations by one federally funded ultrasonography technician. A telehealth program, which began in 2007, is also available for women in order to reduce the amount of travel required during pregnancy as well as for emergency purposes. In 2008, two babies were born during a blizzard in First Nations communities with the assistance of an on-call physician based in Sioux Lookout. The SLMHC is categorized as a level one obstetrics program, meaning that it offers care to women “who anticipate healthy nonemergent births and term newborns” (Dooley et al, 2009, 77). The program is staffed by 3 family physicians who perform surgical delivery,

4 general-practitioner-anesthetists, and six family physicians who are available on-call for both the centre's prenatal clinic and labour and delivery.

Despite the implication that the centre deals with primarily low-risk pregnancies, the reality is that the populations served by the SLMHC face significant birth challenges relating widely to biomedical as well as geographical, social, and cultural issues. In 1997, the rate of gestational diabetes in Aboriginal women delivering in Sioux Lookout was 8.4%, over double the national average of 4% (Dooley et al, 2009). Type II diabetes in pregnant and childbearing-aged women is also becoming increasingly common. Moreover, according to a report by the Perinatal Partnership Program of Eastern and Southeastern Ontario in 2005/2006, this region had the highest rate of both smoking during pregnancy (34%) and adolescent pregnancy (9%) in the province (Ontario Perinatal Programs Partnership, 2006). Similar challenges have been identified as priorities by community partners. During focus groups in 2008, community members and representative groups identified numerous challenges to maternal care relating to: increasing evidence of diabetes in pregnancy; higher incidence of teenage pregnancies; high rates of complicated pregnancies including still births; travel distances to access intrapartum care; lack of family supports at time of delivery; lack of integrated services creating disconnects in the continuum of care; and lack of information about traditional delivery practices among First Nations women giving birth in the region (O'Driscoll, 2008).

## **2.7 The Odotsemag Initiative**

The SLMHC began the Odotsemag initiative in December of 2007 following a request by the Ministry of Health and Long Term Care Midwifery Program and Health

Canada's First Nations and Inuit Health Branch to "explore ways in the SLMHC could improve maternal newborn services in [the] region" (O'Driscoll, 2008, 1). A framework and representative model was developed outlining each aspect of the Odotsemag project and provides a holistic overview of the proposed shared care model being piloted at the hospital (*see Appendices IV, V*). Overall, the goals of the Odotsemag project are to "increase the quality of health services being provided; improve access to services; increase collaboration between community partners, and increase the participation of Aboriginal people in the design, delivery and evaluation of health programs and services" (O'Driscoll, 2008, 2). Aspects of this model have thus far included the development of a culturally relevant health promotional teaching package distributed to all new mothers at the hospital and in community nursing stations, new diagnostic equipment to help to determine whether a woman is in premature labour, thus preventing unneeded transport to southern hospitals, a review of maternity care models in other rural and remote areas in Canada and on a global level, and an ongoing environmental scan which will inform the development of an improved birth model (O'Driscoll, 2008).

One aspect of the larger approach to improve birth at the SLMHC has been the First Nations component of the environmental scan, initially described as a, "historical overview, which includes examining traditional practices, knowledge translation from community elders, a historical review of Aboriginal midwifery in Ontario and an oral history collection of stories about motherhood" (O'Driscoll, 2008, 2). The premise is that a greater understanding of First Nations birthing beliefs, attitudes, practices, and meanings will improve a health care provider's ability to provide more culturally appropriate care as well as help to develop a model that is congruent with a multitude of

cultural needs and expectations. Informal discussions with hospital staff involved with the Odotsemag project indicated that they felt speaking with the elders was critical to express respect for the community and to recognize the role of elders in the birth process. Moreover, frameworks for conducting Aboriginal research often share the opinion that, “consultation with elders and advisors, as well as community leaders is essential if the research is to be meaningful and useful to the community, and also to keep the power over the lives in the community within the community” (Kenny, 2004).

Through the Odotsemag initiative, the SLMHC has sought to address the harms of travel for birth at the level of a regional hospital. The SLMHC has chosen to focus on the hospital as a venue for improvement because, in contrast to the Inuulitsivik midwifery program in Nunavik, northern Quebec, the SLMHC faces challenging circumstances in the region relating to: anecdotal evidence of a fear of birthing locally, a wide geographical distribution of small communities preventing easily centralized services such as those in Nunavik, a lack of health care capacity in the communities, and increasingly high risk pregnancies suggesting the need for nearby obstetrical capabilities. For these reasons, physicians I spoke with generally deemed a return of birth to the communities unrealistic in the near future.

Informed by the First Nations component of the Odotsemag project at the SLMHC, the creation of a birth model that shifts control over the birth process increasingly into the hands of the community could show that returning birth to the community is not an all-or-nothing concept but rather, can be divided into steps along a spectrum. As will be discussed, while the Odotsemag approach is perhaps grounded in transcultural theory, the SLMHC tends to view such an approach as an interim step toward achieving cultural

safety. Prior to such a discussion, a thorough understanding of the concept of cultural safety and its nuances is necessary.

### ***3. Applying a Theoretical Lens***

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The concept of cultural safety originated as a tool to enable the application of a postcolonial theoretical perspective to clinical midwifery and nursing practice and education (Browne, Smye and Varcoe, 2005). As such, a discussion of postcolonial theory is necessary to fully understand the concept of cultural safety and its potential application to the case of First Nations birth at the SLMHC.

#### **3.1 Postcolonialism**

Despite significant advances in recent years, Canadian Aboriginal peoples continue to suffer disproportionately from health and social challenges. Compared to the Canadian average, life expectancy for Aboriginal peoples is 5 to 10 years lower, and infant mortality as well as crude mortality rates are higher than corresponding rates in non-Aboriginals (HCC, 2005 and Macaulay, 2009). Regardless of the health indicator chosen, Aboriginal peoples bear a disproportionate burden of poor health as compared to the broader population (Adelson, 2005).

Historically, colonial policies served to both disempower and assimilate Aboriginal Canadians into white, European, ‘civilized’ society. These policies had drastically detrimental effects on the Aboriginal community that are still felt today. According to a report by the Royal Commission of Aboriginal Peoples, health and social inequities continue to exist as a result of our failure to address the underlying power imbalances in Canadian society that remain as a consequence of our colonial history (Browne, Smye and Varcoe, 2005). A postcolonial perspective serves to address this failure by explicitly focusing on these societal inequities rooted in “the history and legacy of colonialism – how it continues to shape people’s lives, well-being, and life

opportunities” (Browne et al, 2005, 19). Although termed “post” colonialism, many argue that the implication of this term (“to name colonialism as a finished business”) is problematic (Smith, 1999, 98). Indeed, the legacy of colonialism remains in society, surviving through various institutions, policies, and societal stereotypes. As such, discourses surrounding postcolonialism tend to share the following characteristics, as determined by Browne et al (2005):

*The need to revisit, remember, and “interrogate” the colonial past and its aftermath in today’s context; the need to critically analyze the experiences of colonialism and their current manifestations; the need to deliberately decentre dominant culture so that the perspectives of those who have been marginalized become starting points for knowledge construction; and the need to expand our understanding of how conceptualizations of race, racialization, and culture are constructed within particular historical and current neocolonial contexts (20).*

As it applies to health, a postcolonial framework highlights the difficulties faced by health care systems where a dominant group (a Western, biomedical approach) tends to racialize or “Other” a marginalized group (Aboriginal peoples) (Browne et al, 2005). Racialization, whether deliberate or not, takes place when social, economic, or cultural differences are attributed solely or predominantly to race. When a person stereotypes “assumed cultural characteristics” of specific groups or members of a group, one is effectively categorizing these groups as the “Other” (Browne et al, 2005). Both of these tendencies serve to further reinforce harmful colonial precedents promoting the marginalization and disempowerment of Aboriginal peoples. This can contribute to continued social, economic, and health inequities. As such, applying a postcolonial framework to health helps to ensure we avoid such harmful practices. These issues of racialization and othering will help to inform the discussion surrounding the results of the SLMHC approach.

### **3.2 Understandings of culture: transcultural nursing and cultural safety**

Culture as a concept is commonly used as an explanatory model within the health and health care discourses (Kirkham et al, 2002). Western health care professionals have been, and are often currently guided by notions such as cultural sensitivity, cultural appropriateness, or cultural congruence/competency, frequently presenting culture as a “neutral system of shared beliefs, meanings and practices” (Kirkham et al, 2002, 223). These concepts are grounded in the field of transcultural nursing, the most common theoretical approach taken in Canadian nursing education (NAHO, 2006).

The transcultural nursing approach first arose in the mid-1950s, developed by Madeleine Leininger to teach nursing students the importance of understanding cultural factors in their nursing practice (Coup, 1996). Leininger has been credited as the first nurse to understand and articulate the role of culture in influencing health status and a person’s experience in the health care system (Coup, 1996). She defines transcultural nursing as, “a formal area of study and practice which takes into account the specific values, beliefs, and ways of life of people of diverse or similar cultures with the goal of using this knowledge in creative ways to provide culturally congruent care” (Leininger, 1994, 209). Thus, “master[ing] an extensive cultural knowledge base” of different cultures as well as understanding one’s own culture in order to be more cognisant of approaches that “reflect ethnocentrism, cultural biases, prejudices and other problems that limit the quality of nursing care to people of specific cultures” are integral to practicing transcultural nursing and to providing culturally competent/congruent care (Coup, 1996, 5; Leininger, 1994, 217). Cultural sensitivity is also an important goal of transcultural nursing practice. Being sensitive and attentive to a client’s cultural and language

differences in order to “work with the client as a co-participant in identifying, planning, implementing and evaluating their own care” is central to the approach (Swendson and Windsor, 1996; Coup, 1996, 5).

The field of transcultural nursing is an incredibly dynamic one and since the 1950s has undergone significant transformation (Kanitsaki, 2003). Controversy surrounding the numerous ways in which the concept has been conceptualized around the world, according to Kanitsaki (2003), has contributed to the evolution of the field, and to “more dynamic and diverse ways of dealing with cultural complexity and the many challenges it poses to those working in nursing and health care domains” (vi). Aspects of transcultural nursing have been widely accepted and integrated into systems of health care education around the globe (Kanitsaki, 2003). In this way, the construct has been invaluable in generating worldwide recognition for culture as a determinant of health and in doing so, has contributed to the overall effort of challenging the existing dominance of a “monoculture” inherent within many health care systems (Kanitsaki, 2003, viii).

The discussion surrounding the role of culture in the health care setting is ongoing and continues to search for ways to improve some of what many define as weaknesses of transcultural theory. Discourses such as postcolonial theory criticize transcultural approaches by arguing that culture is in fact not a static, preexisting, neutral entity passed down in a linear fashion through generations (Kirkham et al, 2002). In fact, understanding culture in these terms arguably serves only to reinforce inequities and further marginalize various groups of people by promoting harmful stereotypes and “othering” (Kirkham et al, 2002; Smye and Browne, 2002). The concept of cultural safety challenges such narrow views of culture by maintaining respect not only for cultural

beliefs, practices and meanings, but also by ensuring that attention is paid to differing power relations grounded in a postcolonial history (Kirkham et al, 2002).

### **3.3 What is cultural safety? What does it look like?**

In contrast to transcultural nursing, cultural safety was developed initially by culturally non-dominant Maori nurses in New Zealand (NAHO, 2006). According to Ramsden (1993), who was involved in the initial conceptualization of the notion, cultural safety is both a process as well as an outcome in the nursing field. In terms of practice, cultural safety works to challenge cultural stereotypes. While both Leininger (founder of transcultural nursing) and Ramsden share the idea that a person's cultural beliefs and values should be respected within a health care encounter, Ramsden disagrees that a cultural knowledge base is necessary for providing culturally appropriate care. She argues that "to try and teach nurses to be experts in [a different] culture would be demeaning and disempowering" for that cultural group (Coup, 1996, 8). Instead, Ramsden requires that nurses "become experts in understanding the poverty cycle and the various histories and sociopolitical conditions which establish and maintain it" (Coup, 1996, 8). As a required competency for nurses and midwives in New Zealand, the movement seeks to create health care practitioners who challenge power imbalances in the health care environment (Kirkham et al, 2002). In this sense, cultural safety as a concept seeks to foster a shift away from the dominant health care practices which promote these power imbalances.

The notion of cultural safety has also recently been adopted into Canadian undergraduate medical education. The Indigenous Physicians Association of Canada (IPAC) in partnership with the Association of Faculties of Medicine of Canada (AFMC), for example, cites cultural safety as a guiding framework in their April 2009 curriculum

report (Lavallee et al, 2009). Rather than utilize the notions of cultural competence or cultural awareness, these groups decided to use a cultural safety lens when developing their curriculum, “as it encompasses the additional skill of self-reflection” and it promotes patient-centered care (Lavallee et al, 2009, 9). The report also states that, “cultural safety is predicated on understanding the power differentials inherent in health service delivery and redressing these inequities through educational processes” (10). This focus on reducing structural inequity within the health care system is fundamental to the concept.

Through a lens of cultural safety, patient-centered care is promoted because of an emphasis on establishing trust with a patient; empowering people by reinforcing the notion that “each person’s knowledge and reality is valid and valuable” (NAHO, 2006, 2). Trust is key to cultural safety because it allows for open communication between patient and health care provider, giving patients a strong voice to shape his or her own care (NAHO, 2006). Ultimately, cultural safety education focuses on two main tasks: 1) to teach students about colonialism and its overall impact on Indigenous peoples (rather than attempting to create experts on Indigenous customs and beliefs), and 2) to promote self reflexivity, helping students to understand what baggage they bring to health care encounters (NAHO, 2006).

### **3.4 Critiques of cultural safety**

Despite a focus on developing individual health care professionals who act in a culturally safe manner, many maintain that one cannot establish a culturally safe health care system through individual interactions (NAHO, 2006). Instead, the focus must be on the meaningful involvement of Indigenous peoples in decision making processes and a

structural shift in power dynamics (Browne, Fiske, and Thomas, 2001). The focus on reducing power inequity within the health care system through attitude and behavior change of individual providers falls short of promoting wide scale structural change. Thus, the concept of cultural safety must be acknowledged as a political discourse and should extend beyond the educational realm to help reform structural aspects of the health care system.

Although there has been widespread uptake of the concept in the New Zealand health care sphere, the definition of cultural safety continues to evolve (NAHO, 2006). As the concept evolves, the precise ways in which cultural safety differs from other concepts such as cultural sensitivity, appropriateness, competency, and awareness and how these approaches may overlap remains subject to debate and discussion (NAHO, 2006). The most accepted definitions, as mentioned in the literature, are the following: culturally safe practices are those practices which “recognize and respect the cultural identity of others and take into consideration their needs and rights” whereas unsafe practices “diminish, demean, or disempower the cultural identity and well being of an individual” (Whakarurahu, 1991,7; Anderson et al, 2003, 198). These definitions and understandings of the concept are built on and presented in numerous ways throughout the literature:

*...an environment which is safe for people; where there is no assault, challenge, or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity, and truly listening (Eckermann, Dowd and Martin, 1994).*

*Cultural safety was designed to focus attention on life chances – i.e. access to health services, education and decent housing within an environment in which it is safe to be brown – rather than lifestyles, i.e. ethnography (Ramsden, 1992)*

*Cultural safety extends beyond cultural awareness and cultural sensitivity. It empowers individuals and enables them to contribute to the achievement of positive outcomes. It encompasses a reflection on individual cultural identity and recognition of the impact of personal culture on professional practice (Bin-Sallik, 2003)*

*Cultural safety might assist nurses to examine how popularized notions of culture and cultural differences are taken up; to develop greater awareness of how individual and societal assumptions and stereotypes operate in practice; and to better recognize how organizational and structural inequities and wider social discourses – within health care and in our society – inevitably influence nurses' interpretive perspectives and practices (Browne et al, 2009, 171).*

Beyond the evolving definition of cultural safety in theory, variation also exists when attempting to interpret and implement the concept in a clinical setting (Johnstone and Kanitsaki, 2007). In a study of 145 participants in Australia by Johnstone and Kanitsaki (2007) comprising patients, health care providers, and health care managers, few people had heard of the term cultural safety. Those who had some understanding of the concept stated that it was about “doing things safely” and ensuring that patients got “safe care” through effective communication and “cultural knowledge and awareness” (251). The authors maintain that despite the fact that Australia promotes cultural safety as a basic right of Indigenous peoples, the concept as it is currently framed is problematic. They criticize the widespread uptake of the concept in health care education and practice in New Zealand, given that there is almost no research evaluating the effect of the approach on the health care system and the health of the Maori peoples. Lastly, they advocate that in order to successfully operationalize the concept, it needs to be better informed by and integrated into the more widely accepted notion of cultural competency based out of the United States. They propose that through achieving cultural competency, cultural safety can be reached. In this way, cultural safety is deemed an important concept

that simply needs reframing so that it exists as the final step along a continuum of preliminary changes.

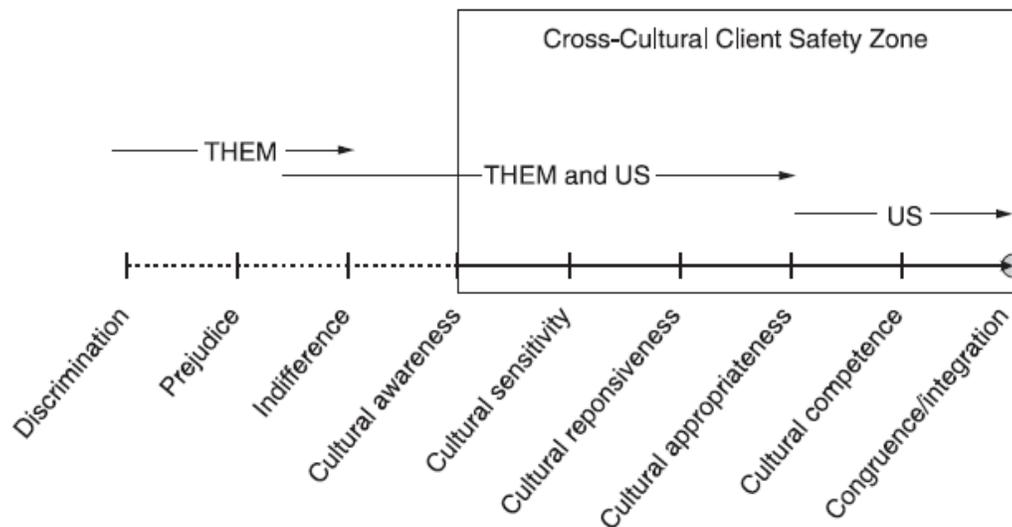
Despite controversy, implicit in the literature is the acceptance of the central tenets of cultural safety as imperative to providing safe care. Critiques are isolated to the lack of understanding of the concept among health care professionals or to debate surrounding how the concept can be implemented in a health care setting through either individual attitude change or a systemic shift in power relations. Critiques do not seem to target the concept itself. On the whole, the theoretical underpinnings of cultural safety present a promising new approach that addresses the fallacies often inherent in transcultural approaches – namely, the notion that culture is static or homogenous, the reduction of culture among health care professionals to a set of technical skills, and the idea that culture is always central to medical care (Kleinman and Benson, 2006).

### **3.5 How do these concepts fit together?**

Many proponents of cultural safety maintain that the western transcultural concepts of cultural competence or cultural sensitivity are harmful approaches which incorrectly emphasize “an ethnospecific approach to knowledge as the basis for effective therapeutic relationships with clients” (Coup, 1996, Johnstone and Kanitsaki, 2007, 248). As such, many suggest that cultural safety is its own entity, free from any influence from other approaches to culture. However, other schools of thought suggest that cultural safety is the final outcome of a thorough step-wise learning process. For example, according to Ramsden, cultural awareness is the first step in which a health care provider begins to understand differences, cultural sensitivity is the second step in which the student “recognizes the importance of respecting difference”, cultural competence

focuses on the skills, knowledge and attitudes of clinicians, and cultural safety is achieved as the final step in this series of progressions (Lavallee et al, 2009, 9; NAHO, 2006). A similar continuum model has been proposed by the Sioux Lookout Meno Ya Win Health Centre (*Figure I, below*). Steps are outlined progressing from cultural discrimination to cultural congruence, at which level cultural safety is achieved. The SLMHC approach at the hospital is broadly based on both achieving cultural competence as well as cultural safety; “namely, expanding the understanding of the colonialization processes and their impact, and expanding knowledge and awareness of cultural practices, and traditions” (Walker et al, 2009).

Figure I: The continuum of cross-cultural client safety (Walker et al, 2009)



### 3.6 Relevance of cultural safety to SLMHC maternity care

Through the previous discussion of evacuation for birth in Aboriginal communities as a colonial legacy, the applicability of the concept of cultural safety to this topic is evident. Evaluating the SLMHC maternity care model and approaches to improve it through a cultural safety lens will promote an emphasis on: 1) understanding power

dynamics within the system and how these have been shaped by colonial policies, and 2) the approach taken by the SLMHC grounded in transcultural theory and how it may be harmful or beneficial to the creation of a culturally safe environment.

Moreover, using cultural safety as a framework to guide the application of the results from qualitative interviews with elders in developing a new hospital birth model has significant implications. For example, Kruske, Kildea and Barclay (2006), reviewed maternity care studies which evaluated services for Aboriginal and Torres Strait Islanders in Australia using a cultural safety lens and concluded that women do not feel “culturally safe when experiencing a western medical model of childbirth” (75). Women identified “choice, cultural considerations around birth (e.g. being cared for by women and appropriate care of the placenta), having family members with them during birth, and having their children nearby” as missing from the current hospital birth models (75). As a consequence, women frequently respond to such culturally unsafe maternity services by not accessing them (Kruske, Kildea and Barclay, 2006). As we will see, there are important parallels between these findings and those of the SLMHC study that were originally informed by transcultural theory. Given that no consensus has yet been reached as to where transcultural approaches may lie in discussions of how one operationalizes cultural safety, the SLMHC initiative may serve as a valuable case study.

## 4. *Methods and Methodology*

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### 4.1 Research design

As previously discussed, this paper details the results from the First Nations component of the broader SLMHC Odotsemag project, which began in 2008 and was developed and designed by a team of physicians, nurses, community members, and hospital administrators. As a practicum student, I was responsible for implementing an aspect of the First Nations component of the Odotsemag project which had previously been designed by this team. A qualitative research design was employed by the SLMHC initiative in order to explore and understand practices, beliefs, attitudes and meanings attached to the birth process as described by elders from Northwestern Ontario First Nations.

Key informant interviews were conducted with local 3 First Nations elders prior to the development of a semi-structured interview guide in order to first develop a greater understanding of cultural sensitivities, historical context, and areas identified as priorities by the Hospital Elders Council at the Sioux Lookout Meno Ya Win Health Centre. Following these discussions and supplemented by a review of the literature, a preliminary interview guide was developed. The literature review identified themes surrounding indigenous childbirth in North America to establish a representation of how Aboriginal childbirth has been represented historically (*see following chapter*). A bicultural, interdisciplinary stakeholders meeting was held with First Nations elder representatives, hospital medical interpreters, and hospital researchers in order to discuss the proposed guide and make necessary changes. Following this meeting, a final interview guide was developed and approved by all parties involved.

Semi-structured interviews were chosen as a method to gather qualitative data to ensure a starting point for discussion, to help the discussion remain broadly focused on the main themes of the study, to allow individual participants the space and time to express their opinions and knowledge, and to increase reliability of the translations when interpreters were needed. Although the majority of interviews conducted were individual, group interviews were also conducted at the request of the participants and the communities for their own convenience.

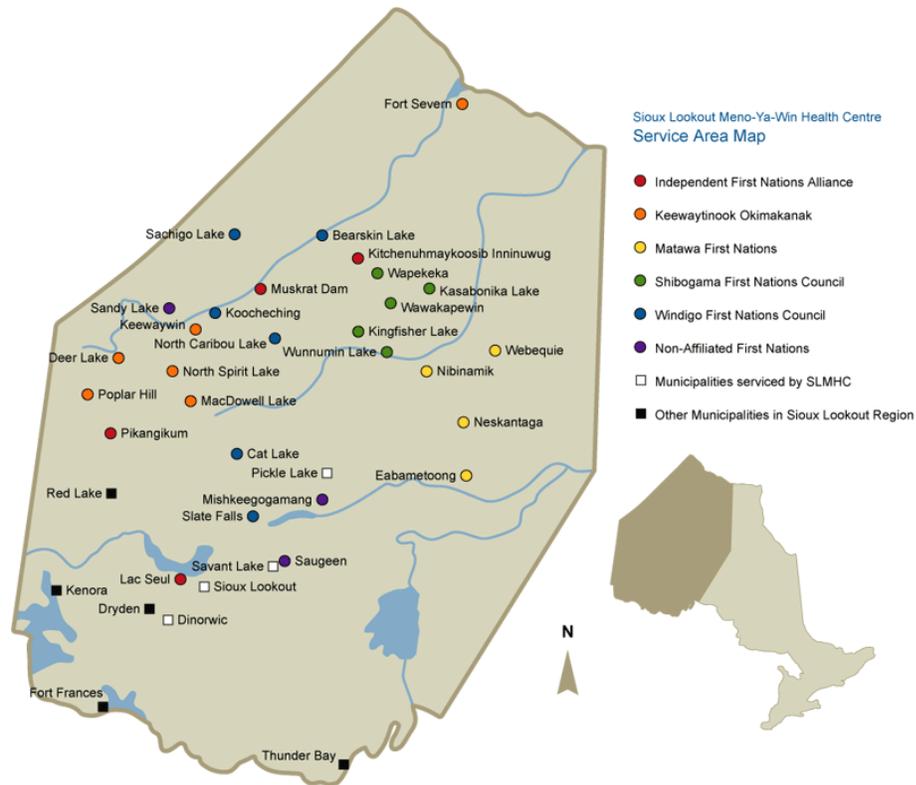
#### **4.2 Research setting**

Research preparation and analysis was based out of Sioux Lookout, Ontario at the Meno Ya Win Health Centre, Ontario's Centre for Excellence in First Nations health (SLMHC). The SLMHC has the largest service area of any community-based hospital in Ontario, serving approximately 25,000 people across 385,000 square kilometres; 85% of whom are Anishnawbe First Nations people (Walker, 2009). The hospital is fully accredited, with 36 acute care beds, 5 chronic care beds, and a 20 bed Extended Care facility, which includes the Community Counseling and Addictions Services Program (SLMHC, 2009).

Beyond Sioux Lookout, the SLMHC serves northern Nishnawbe-Aski communities, the Treaty #3 community of Lac Seul First Nations, and residents of Pickle Lake and Savant Lake (*see Figure II below*). This geographical area comprises 28 First Nations communities home to approximately 18,000 people and four municipalities (SLMHC, 2009; Walker, 2009). The majority of the 28 First Nations are accessible only by air transportation. Therefore, when these patients travel to the SLMHC they are often very far from any family or community supports (Walker et al, 2009). In addition, many

of the First Nations patients seen at the SLMHC speak either Ojibway, Oji-Cree, or Swampy-Cree (Walker et al, 2009).

Figure II: SLMHC service area (Sioux Lookout Meno Ya Win Health Centre, 2009).



The SLMHC is governed by the *minoyawin* model of care, an Anishnawbe term depicting health as a “state of wholeness in the spiritual, mental, emotional, and physical make-up of a person” (Walker et al, 2009). This holistic approach has driven the SLMHC to develop comprehensive and integrative patient supports through the introduction of a Traditional Healing, Medicines, Foods and Supports Programme (Walker et al, 2009). As a result of this approach, the centre has been applauded in many ways for bringing more culturally appropriate care closer to home (Dooley et al, 2009).

Interviews conducted for this study took place in four communities: Sioux Lookout, Sachigo Lake First Nation, Webequie First Nation, and Mishkeegogamang First

Nation (*see Figure II*). Sachigo Lake and Webequie First Nations are fly-in communities, whereas Sioux Lookout and Mishkeegogamang are accessible by car. According to Indian and Northern Affairs Canada, in 2009 Webequie, Sachigo Lake, and Mishkeegogamang First Nations had registered populations of 777, 789, and 1,619, respectively (INAC, 2010). Sioux Lookout itself has a registered population of approximately 5,600 (Municipality of Sioux Lookout, 2009). Interview locations varied by community according to what was convenient for the participants, often taking place in the community nursing station or the participant's home.

### **4.3 Study population**

This particular study involved interviews with First Nations elders with experience or knowledge surrounding birth and the birthing process. 12 elders in total were interviewed: 3 from Sioux Lookout, 3 from Sachigo Lake, 3 from Webequie and 3 from Mishkeegogamang. Women interviewed tended to have had experience delivering babies in their communities and ranged from the ages of 64 to 87. A number of younger women (under the age of 70) had experience as Community Health Representatives and therefore had also been trained in biomedical methods.

### **4.4 Recruitment**

Participants were selected using a combination of purposive and snowball sampling. Women were identified by First Nations representatives at the hospital who fit the criteria of being both a First Nations elder as well as having had some experience or knowledge with regard to birth. It is important to note that female sex was not a necessary inclusion criterion; however, 100% of the participants in this study were female.

Participant observation data highlighted that there were a few men who knew how to deliver babies in some communities in the region.

Prior to contacting women in the communities, the Chief of the community as well as the Health Director were contacted by either the Traditional Programs Manager or the Special Advisor on First Nations Health at the SLMHC to explain the study and ask for approval to enter the community. We obtained permission to enter six communities where women were identified as having experience or knowledge regarding birth. Due largely to the introduction of the H1N1 virus into two communities, in the end six women from four communities were identified and contacted by hospital First Nations representatives. If the woman was interested in participating in the study, she was then contacted by one of the researchers by phone and a date and time was confirmed to conduct the interview. Once in the communities, the researchers often asked local women as well as the participants themselves if they were aware of other women who fit the inclusion criteria for the study. Six more women were identified and interviewed according to this method of sampling.

#### **4.5 Consent and withdrawal**

Prior to beginning each interview, a participant information sheet was reviewed, translated if necessary by an interpreter, and signed by both the research participant, the interpreter if applicable, and the investigator of the study. It was emphasized that participation in the project was entirely voluntary and that each participant could withdraw from the study or refuse to answer questions at any point. It was also highlighted that anything said would remain confidential and that participants would be

identified numerically on all transcripts and final papers, thus remaining anonymous to everyone except the researchers conducting the interview.

#### **4.6 Data collection and analysis**

The SLMHC study reflects data from twelve female First Nations elders across four communities. Seven of the interviews conducted were individually-based. Two group interviews were conducted in Sachigo Lake (a group of 2) and Mishkeegogamang (a group of 3) as it was requested by participants in terms of convenience and comfort. Moreover, it enabled the researchers to use less of the interpreter's valuable time, as often the women who offered to interpret, as was the case in Mishkeegogamang, were also nursing station employees. Of the nine total interviews conducted (7 individual, 2 group-based), 5 required the use of an interpreter. For the majority of the interviews, two researchers were present. One researcher asked questions and helped to facilitate discussion, and the other ensured that the interviews were audio taped appropriately, made notes throughout, and prompted the lead if any key aspects were overlooked in the interview (*See Appendix C for detailed interview guide*). Interview length ranged from 37 minutes to an hour and 25 minutes, depending on the length of responses from participants.

Interviews were transcribed and reviewed for accuracy by the research assistant (L. Payne). All personal identifiers were removed and each participant was given an identifying number. These anonymous transcripts were then distributed and openly hand coded by the research assistant and four other contributing researchers. Five coders, self-identifying as either Western European or First Nations, were involved, serving to eliminate bias and improve the credibility of the data (Denzin and Lincoln, 1994). Having

multiple observers of the data adds “alternative perspectives, backgrounds, and social characteristics and will reduce the limitations” that would be inherent if only one coder was used (Neumann, 2006, 150). It was also deemed important given the environment in which the research was conducted to have elder and community representation when coding the data.

We collectively agreed on a coding process involving an immersion/crystallization technique whereby topics were pulled out of the data, commonalities identified, and general codes developed. The process of immersion/crystallization, involving repetitive cycles in which the researcher “immerses” him or herself into the text and “emerges after concerned reflection with intuitive crystallizations,” was chosen as a process of analysis because it fit well with the depth and amount of information being studied (Crabtree and Miller, 1999). Rather than use a set of predetermined codes, we allowed the codes to emerge during the data analysis. Each coder hand coded the transcripts and independently identified themes. Collectively, all codes were then synthesized and after ample group discussion, consensus was reached and final themes were developed. These final themes were reviewed and approved by all five contributing investigators.

## ***5. Historical Perspectives on Childbirth in the Literature***

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Prior to developing the research tools used in qualitative interviews with elders in the northwestern Ontario region, the SLMHC felt it was important to review existing literature to understand what is known historically about indigenous birth in northern Canada and how that information has been presented. In this way, gaps could be identified and approaches evaluated to see how the SLMHC could improve on and contribute to both our understanding of Aboriginal birth in the region as well as the body of literature in general. The development of research tools themselves were also informed by a better understanding of major themes and differences in the existing literature.

The original scope of the literature reviewed discussing Aboriginal Canadian birthing meanings, beliefs, attitudes and practices was expanded to include both Canada and the United States, as information from Canada was limited. Views expressed in the literature vary substantially from region to region, between populations, and across time. It is important to note that many birthing practices, beliefs or attitudes reflect certain biases of the time, and are thus not necessarily reflective of the present day. This review therefore did not seek to generalize between groups, but hoped to illuminate both the wide expanse of birth practices and beliefs of Indigenous peoples across North America as well as the historical approach to Aboriginal culture in the context of birth in the literature. Researchers at the SLMHC felt that such an initial understanding was important prior to beginning data collection as part of the Odotsemag initiative. The following results, while not entirely relevant to cultural safety, shed light on the strengths and weaknesses of what has historically been a transcultural approach to Indigenous birth.

## ***5.1 Beliefs, Attitudes and Meanings***

### ***Worldview***

How pregnancy, birth, and newborns are viewed is in large part expressed in Aboriginal Canadian literature as determined by a population's overall view of health as well as of the broader environments helping to shape health status. A study of a group of Mi'kmaq women in Nova Scotia, for example, described a birth model based on the concept of health as a balance of mental, emotional, physical and spiritual spheres (Whitty-Rogers, 2006). Consistent with this model, many Canadian Aboriginal peoples and Native Americans view healing as holistic (Calm Wind and Terry, 1993; Cesario, 2001). Themes of spirituality and supernatural forces are also fairly common among many Indigenous peoples (Douglas, 2006; Moffitt, 2004; Loughlin, 1965). In Canadian Inuit populations, the connection between spirituality and birth is evidenced by the occasional use of shamans to combat perceived supernatural interference during labour (Douglas, 2006). Chippewa American Indians, according to Hildebrand (1970), believed names given to newborn infants by individuals with supernatural abilities were protective against evil. Among the Dogrib women in the Northwest Territories, the community was governed by spiritual interconnectedness; the idea that all living things depended on one another for survival (Moffitt, 2004). According to the Native Women's Association of Canada and Cesario (2001), this idea of interconnectedness with the natural worlds is shared by many Aboriginal peoples. "Spiritual preparation" for birth and a woman's literal and spiritual presence during birth were historically seen as important among various Aboriginal populations (Moffitt, 2004; Jasen, 1997; Fiske, 1993). The conceptualization of birth as a natural process was often described as partially a result of

the indigenous belief about trusting nature and, in some communities, trusting God (Koval, 1994). Lastly, the temporal orientation toward the present (rather than the future) among many indigenous North Americans and on personal and seasonal cycles is evident in views of pregnancy and birth (Cesario, 2001).

### **Childbirth**

Childbirth is overwhelmingly expressed from the perspective of Aboriginal and Native American communities as a “natural process” in need of little to no intervention (Sokoloski, 1995, 93; Webber and Wilson, 1993; Whitty-Rogers, 2006; Douglas, 2006; Bushnell, 1981; Rockwell, 1995; Koval, 1994; Long and Curry, 1998). This perspective has consequences for prenatal care (Sokoloski 1995; Long and Curry, 1998). Women often see the ability to bear children as a gift granted by the Creator, an “ultimate achievement” for a woman whose primary role is to produce children, and an economic necessity as children are important for a mother’s well being (NWAC, 2007; Rockwell, 1995; Sokoloski, 1995). As one interviewee from a Canadian urban centre study of English speaking First Nations informants said, “You are a woman and a woman is made to have children, to have babies, and if you don’t have babies, then you are looked at as being not really a woman” (Sokoloski, 1995). Birth is also seen as a time to share and reinforce “sacred knowledge” about birth with those attending, as well as a time to strengthen social relationships, reinforce ties to the land, and reconnect a woman with her heritage (NWAC 2007, NAHO, 2008). According to Van Wagner et al (2007), Moffit (2004), and Fiske (1993), birth is central to the greater well being of the community, as motherhood signifies “a creation of life itself” and is therefore integral to the maintenance

of indigenous cultural identity. Birth is correspondingly seen among many indigenous peoples as a community responsibility (Couchie and Sanderson, 2007; Sokoloski, 1995).

## ***5.2 Practices and Teachings***

### **Midwifery**

Calm Wind and Terry (1993) describe Nishnawbe-Aski Nation traditional midwifery practices in northwestern Ontario based on interviews with 19 traditional midwives from seven communities. They define seven roles of the traditional midwife: as a teacher, healer, caregiver, nurturer, dietician, deliverer, and do-dis-seem (a spiritual partnership made between midwife and child through a cutting of the umbilical cord). First Nations communities tend to have a more holistic view of health and healing than that advocated by biomedical practitioners, and many advocate for such holistic care provided by the midwife as a more culturally appropriate method of maternity care among Canadian Aboriginal peoples (Calm Wind and Terry 1993; Kreiner, 2009; Benoit, Carroll and Eni, 2006; NWAC, 2007; Couchie and Sanderson, 2007; Tedford Gold et al, 2007). Midwives possess multiple roles across different indigenous cultures and these unique roles should not be overlooked. In the Mohawk community, the term ‘midwife’ translates to “she is pulling the baby out of the earth”, among the Nuu-chah-nulth of BC it means “she who can do everything”, among the Ojibway it translates to “the one who cuts the cord” and in Cree communities midwives are “the ones who deliver” (NAHO 2008; Benoit, Carroll and Eni, 2006).

Nevertheless, across different aboriginal cultures, midwives seem to be historically central to birth as the primary caregiver to labouring women (in ideal situations) (Calm Wind and Terry 1993; Douglas, 2006; Ekho, 2000; Kaufert; NWAC,

2007; Bushnell 1981; Hildebrand, 1970; Koval, 1994; Neander and Morse, 1989).

Informants from a 1995 study with Cree, Saulteaux, and Ojibway First Nations peoples reinforced this view by stating that attendants during birth should be older, more experienced women, although physicians could be appropriate for medical complications (Sokoloski, 1995). Accordingly, a ‘rebirth’ of traditional midwifery, through the incorporation of existing Aboriginal midwives into primary care delivery or the establishment and implementation of an Aboriginal midwifery curriculum, has been heralded as a potential means to bring birth closer to northern communities (Van Wagner et al, 2007; Calm Wind and Terry 1993; Kreiner, 2009; Benoit, Carroll and Eni, 2006; NWAC, 2007; Couchie and Sanderson, 2007; Tedford Gold et al, 2007).

Midwives also have a historically important role in coaching other community members who would have to attend births when travelling or if isolated on trap lines. The transfer of knowledge from the midwife to other family member was therefore imperative for survival (Hildebrand, 1970; Ekho, 2000; NAHO 2008; Douglas, 2006). Stories of birth and motherhood passed between generations were also important for this purpose as well as to better understand the “meaning of ones existence” (Kaufert and O’Neil, 1990; Benoit, Carroll and Eni, 2006; Koval, 1994) Much aboriginal midwifery knowledge has been lost today due primarily to deaths of traditional healers, residential schooling, increased dominance of biomedical care, and the consequential generational divide (Long and Curry, 1998).

### **Pregnancy**

Pregnancy among Indigenous communities of North America is largely governed by a set of practices, either promoted or discouraged, that women have historically

followed and many presently subscribe to. Promoted practices, as normally outlined by community elders, more generally relate to remaining active, eating naturally, and maintaining a positive emotional state (Calm Wind and Terry 1993; Ekho, 2000; Van Wagner et al 2007; Kaufert and O'Neil, 1990; Sokoloski, 1995). First Nations and Inuit Canadians commonly maintain that a well-balanced diet in moderate proportions is ideal. A number of Cree, Sauteaux, and Ojibway First Nations interviewed by Sokoloski (1995), identified wild meat or fish, white carrots, potatoes, rice, and berries as healthy foods for a pregnant woman. According to NAHO (2008), Inuit peoples often cite caribou, seal, char and muktuk as proper "country foods" for pregnant women. Many Inuit; Cree, Sauteaux and Ojibway First Nations; and West coast Native Americans believed that a mother's emotions can be transferred to the fetus during pregnancy (Ekho, 2000; Sokoloski, 1995; Long and Curry, 1998). As a result, a woman was thought to begin to care for her baby during her pregnancy (Bushnell, 1981). Women are therefore encouraged to have pleasant thoughts during pregnancy and to communicate with the baby (Sokoloski, 1995). Exercise, as deemed a normal part of a woman's daily life, was expected to continue during pregnancy. The premium placed on exercise frequently stemmed from a fear that inactivity could cause the placenta to adhere to the uterus, or the baby to attach to the mother's womb (Sokoloski, 1995; Hildebrand, 1970). According to Bushnell (1981), eating less and keeping active were also thought to be important among Northwest Coast Native Americans as they were often perceived as means to keep babies smaller and therefore help ensure an easy labour.

While beneficial activities for a pregnant woman generally align with traditional daily living, across Indigenous populations a multiplicity of taboos existed in the past and

continue to exist for pregnant women, most of which vary substantially between populations. Women in Inuit, Alberta Woodland Cree, and West Coast Native American communities tended to be told by elders to avoid sleeping during the day, not to sleep in, not to linger in a doorway, and never to be lazy in order to avoid a slow and painful labour (NAHO models; Ekho, 2000; Long and Curry, 1998; Rockwell, 1995; Neander and Morse, 1989). According to Ekho (2000), Inuit women were taught that if a pregnant woman sat for too long, the baby would have a short neck and were also encouraged to massage their stomach until the baby could move independently to prevent the baby from sticking to the uterus. Knots were, and continue to be widely avoided during pregnancy and childbirth in many indigenous communities in order to prevent the umbilical cord from wrapping around the baby's neck (Van Wagner et al, 2007; Ekho 2000; Rockwell, 1995). According to Sokoloski (1995) and Long and Currie (1998), First Nations and Native American peoples thought that the consumption of chemical substances such as alcohol or 'unnatural' medications would endanger the health of the baby and that technological interventions were often detrimental. West Coast Native American women would frequently bathe in cold water in order to toughen the system as well as the baby (Long and Currie, 1998). According to Bushnell (1981), Rockwell (1995) and Loughlin (1965), many groups of indigenous women were also taught by elders not to make visible preparation for the baby in case it wanted to return to the spirit world; a belief largely speculated to be a result of the high rates of infant mortality at the time. Varying food taboos also existed across North American indigenous populations, that, when eaten, could cause any number of ailments and deformities (Hildebrand, 1970; Bushnell 1981; Rockwell, 1995).

## **Delivery**

The process of childbirth itself is also shaped by a number of practices and taboos that vary across North American Indigenous cultures. Researchers working with a variety of Indigenous North American populations cite that mothers are often encouraged to make very little noise during labour. Making noise during labour could indicate a lack of courage or concentration, or, alternatively, discourage a baby from coming out (Whitty-Rogers, 2006; Ekho, 2000; Kaufert and O'Neil, 1990; Plane, 1999; Jasen, 1997; Rockwell 1995; Cesario, 2001; Koval, 1994). Just as coming into contact with knots was discouraged during pregnancy in many Native American and Inuit populations, childbirth also required those present to untie all knots, such as hair ties and shoe laces (Van Wagner et al, 2007; Ekho, 2000; Rockwell 1995).

Women were supported by different individuals during labour, depending on circumstance and cultural tradition. According to Calm Wind and Terry (1993), a main challenge for Nishnawbe-Aski women in northwestern Ontario is the inability for the father of a child to travel with his partner to support her while in labour. Ideally, Inuit birth took place within the family group and was often assisted by an experienced midwife or husband, with three or more people preferably present at the birth (Douglas, 2006). A historical account of Canadian Aboriginal women from the 1600s to 1800s describes childbirth among Aboriginal women as taking place either alone or attended by one or two people (Plane, 1999). Another study involving 60 women from various First Nations in Canada identified two birthing scenarios: the first involved a woman being attended by female family members, one with experience, and the second involved a single attending midwife (NAHO, 2008). Bushnell (1981) describes the presence of a

generational divide related to birth attendant, as older informants thought it was best for midwives to attend a labouring woman and younger women thought doctors and nurses would be more appropriate. Birth would more often take place in a vertical position (hanging, standing, kneeling or squatting) among Inuit and Canadian First Nations communities rather than lying down (Plane, 1999; Jasen, 1997; Neander and Morse, 1989). Hildebrand (1970) states that Chippewa Native Americans primarily took a kneeling position, whereas Koval (1994) cites rural Alaskan Yup'ik women, both in the past and today give birth in a side-lying position or may squat. Douglas (2006) states that among Inuit communities there were regional variations which were often dependent on the choice of the woman. Additionally, in Inuit cultures, the individual who cuts the umbilical cord, known as the *sanaji* filled an important role in that child's life and maintained a close familial relationship (Douglas, 2006; Ekho, 2000). Discussions with Inuit elders revealed that a stillborn was treated as a person, wrapped and placed alongside an existing grave, but not named (Ekho, 2000).

### ***Newborn Care***

Breastfeeding was viewed as a natural way of life for many North American indigenous populations and lasted at least two years duration (Ekho, 2000; Hildebrand, 1970). Aside from a mother's milk, the first food given to infants among the Alberta Woodland Cree was a soup or broth made from meat or fish and introduced from between two months to a year of age (Neander and Morse, 1989). Plane (1999), describing First Nations newborn practices between the 1600s and 1800s, states that the baby was washed after the birth to "ensure hardiness" and to announce the separation of the baby from the mother. A similar practice was seen among the North American Navajo (Loughlin, 1965).

After birth, the baby was wrapped in beaver skins and placed on a cradleboard or a moss bag (Plane, 1999; NAHO 2008; Hildebrand, 1970; Neander and Morse, 1989). The cradleboard sat upright, with a hoop protecting it from falls and netting thrown over the hoop to protect the child from insects (Hildebrand, 1970). The practice of keeping the umbilical cord in a small bag as a sacred object was common to many communities (Plane, 1999; Hildebrand, 1970). Among the Chippewa, this container would be attached to the cradleboard for the child to play with and dropped on a hunting trip, as it was thought to help the child become a good hunter (Hildebrand, 1970). If the child was sick, goose grease or skunk or bear oil was rubbed on the child's body and it was held by the fire (Hildebrand, 1970). Naming the child varied depending on the population, but names were generally given by someone other than the parents (Hildebrand, 1970; NAHO models; Long and Curry 1998).

### ***Mother's Care***

The care of a mother after childbirth is also seen as important in the literature to ensure the well being of the child and the family in general. Care of the mother often took the form of isolation after birth and provision of natural remedies. According to a historical account of childbirth practices among Aboriginal women in New England and Canada from 1600 to 1800, women were required to stay in a "special house" for a minimum of a few days after childbirth (Plane, 1999). Similarly, Rockwell (1995) indicates that many Native American peoples isolated both the mother and newborn following birth. The new mother, states Rockwell, stayed in bed for a minimum of three days and was also required to refrain from eating meat or salt for nineteen days. She also

states that the mother was also isolated from the husband for forty days following the birth in order to space out future children (1995).

Among Canadian First Nations peoples, abdominal binding was often traditionally used to restore the mother's muscles and promote sufficient lactation. According to Hildebrand (1970), in Chippewa communities mothers were encouraged to walk about, but did not do work for two or three days following childbirth. Tea was seen among many North American indigenous populations to have healing qualities. Chippewa mothers were said to drink tea three to four times each day for roughly two weeks after the birth in order to prevent hemorrhaging (Hildebrand, 1970). Among women in rural Alaska, hemorrhaging and excessive blood flow was also thought to be prevented by drinking cranberry tea (Koval, 1994). A similar belief was held by the Alberta Woodlands Cree (Neander and Morse, 1989).

### ***5.3 What can be learned from this?***

The above review helps to express the breadth of birth meanings, beliefs and practices that often differ, and even conflict with the dominant biomedical paradigm of care. It is interesting to note that many teachings are also rather consistent with biomedical practice. However, given the paucity of literature documenting approaches to birth and birth practices in Aboriginal communities across North America, the review remains incomprehensive. Moreover, while a review was necessary to investigate what was already known regarding birth in First Nations communities served by the SLMHC, most of the results obtained are not generalizable to the SLMHC study. A few general broad themes may be relevant. Namely, judging from the review, it is likely that historically, beliefs and practices have been important in governing the birth process

within many Aboriginal communities. The role of midwives, elders, the community, and knowledge translation has also been integral to the health of mothers and their newborns. Thus, an approach to improve birth that involves First Nations elders discussing what they believe to be important in the birth process and allowing knowledge translation could perhaps be of benefit.

An interesting theme across the literature reviewed was the tendency for authors to seek to understand Aboriginal birth through an emphasis on beliefs and practices. This is an approach that is largely consistent with a central tenet of transcultural nursing theory – namely, that it is important to develop a certain level of cultural expertise (i.e. knowledge of beliefs and practices) to provide culturally competent care to individuals from a specific culture. Documenting Aboriginal beliefs and practices is imperative to developing such expertise in the realm of maternity care. Thus, while the above review is arguably not entirely relevant to cultural safety, it appears grounded in transcultural theory and also highlights a few of the critiques of such an approach. For instance, many of these observational and qualitative studies, especially those less recent studies, were written from the standpoint that traditional beliefs and practices are often in conflict with providing good biomedical care. Many authors also seemed to present culture as homogenous by over generalizing their findings to all members of a certain cultural group.

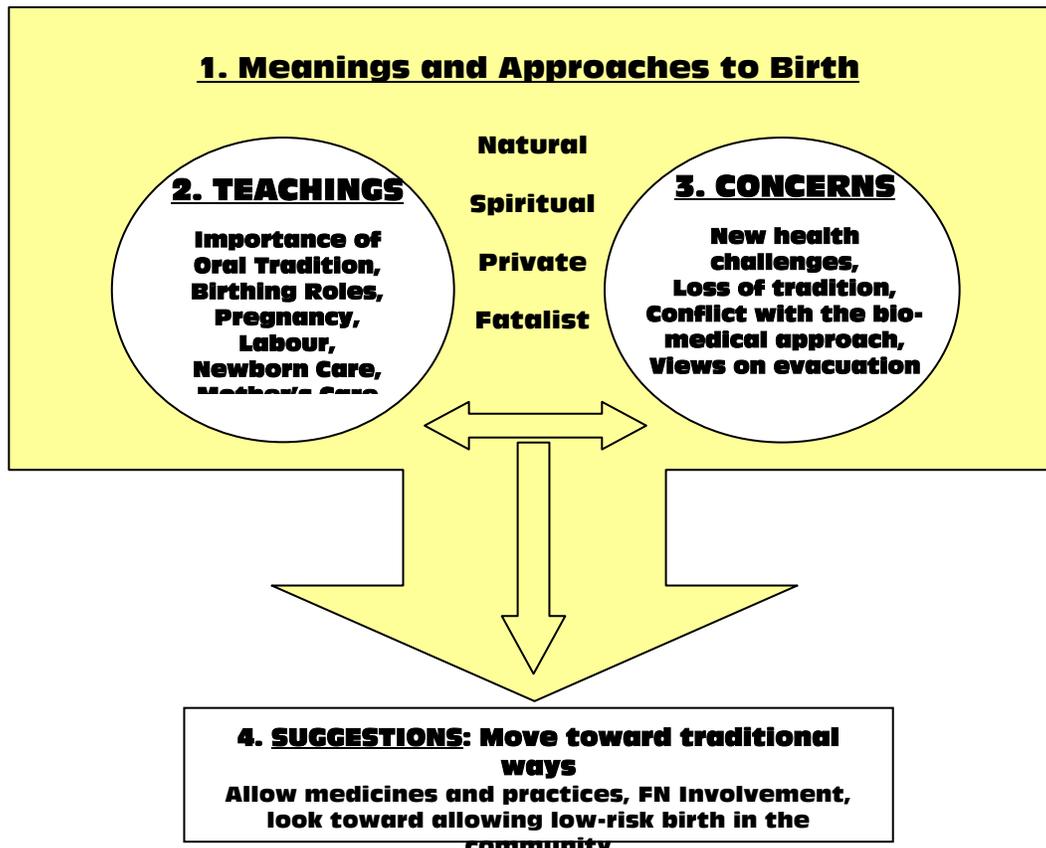
Cognisant of these errors, yet nevertheless informed by transcultural nursing theory, following chapter details the approach taken by the SLMHC to fill the knowledge gap identified in the literature by speaking with First Nations elders about meanings, beliefs, attitudes and practices surrounding birth in Northwestern Ontario.

## 6. Qualitative Interview Results

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Interviews with 12 female elders with experience or knowledge of birth in Northwestern Ontario First Nations gave rise to rich discussions about the birth process as well as other related topics. The elders we spoke with hold an incredible wealth of information in this regard. Topics arising from our discussions have been divided into four different broad themes: meanings and approaches to birth, First Nations teachings as described by the elders, concerns expressed about changing environments and the future of birth in the communities, and finally, suggestions made by the elders as to what could change to improve the birth experience. A schematic model depicting the proposed interaction between these four themes can be seen in Figure III.

Figure III. Themes emerging out of discussions with First Nations elders



## 6.1 Meanings and approaches to birth

### “Natural”

An overwhelming message throughout the interviews and in accordance with themes identified in the literature was the idea that birth is a “natural” or normal process in need of little intervention. Many women criticized the fact that birth is frequently pathologized in the biomedical sphere:

*And some of them they're getting a needle in their back, at their back. And then I told my daughters, don't even take that, it's not...it's [pregnancy] natural. It's not a disease, it's not a sickness or something that you can treat it when you get pregnant or even when you're in labour, even though we have pain, it's normal [Int. II]*

As such, the anxiety associated with pregnancy commonly seen in the western biomedical sphere, according to the elders, was historically not present in First Nations communities.

Very few preparations were made for the birth and daily life continued as usual:

*The childbirth was I guess... the woman at that time, when they got pregnant, never worried because they know they're pregnant, they're going to be having childbirth, but they didn't stop what they were doing. Like, to say, “where am I going to be? What's going to happen?” I don't think they ever said that. As long as there is somebody...one person there, wherever they're going to be [Int. II].*

This held true even under more challenging circumstances, such as when travelling:

*And sometimes they were travelling and they just stopped and gave birth. Like my mother did. I was born on a...they were travelling...After that they just stayed maybe a couple of days and that's it. That was it. [Int. 9]*

Elders frequently told stories reflecting the independence a labouring woman had.

The ultimate control a woman has over her own birth reflects the view that birth is a normal process. One woman, speaking about her work as a Community Health Representative in the 1960's, described an instance where a woman resisted her help, concluding that “some women can do it themselves” [Int. II]. Women were generally

assisted by a midwife or an older female relative, but remained very much in control of the process, as evidenced by the following quote:

*...when the woman...that mother, the woman in labour, she's just sitting around. She acts like nothing's wrong, like nothing...yeah. Then she'll tell my aunt, that her pains are more close. She will just tell, "pretty soon", she keeps saying that, "Pretty soon." Yeah. And then all of a sudden, she said, "Now you can grab the baby, it's coming out". And hear the baby's crying, and you didn't even see where did that baby come out? (laugh). She didn't even lie down! She was just sitting on the big blanket, or a moss mattress. [Int. II]*

In this instance, anxiety does not seem have a strong or visible effect on the labouring woman and she is very much central to the birth process.

### **Spiritual**

The meaning of childbirth as well as reasons for certain practices were often described from a spiritual or religious perspective, alluding to both *God* and the *Creator*. Pregnancy, from the perspective of the elders, is a blessing and a “miracle, because there's a lot of love in that” [Int. III]:

*Oh, it's really an important thing. From the religious view it's a miracle that God has created us, and created man, woman, and to have childbirth, and it's so important. I can't really explain how important it is to me (laughing). To see a human, another human being coming...yeah... in the world. [Int. I]*

*Spiritually speaking, I guess the mother was blessed that she gave birth to a healthy baby, because God blessed her with a healthy baby. [Int. VIII]*

One elder spoke of the abilities of midwives, who “would make that person heal up, in and out” [Int. VI]. Healing was described as a concept that extended far beyond the physical dimension. Elders often also spoke of a “special bond after between the mother and the midwife who delivered the baby” that would last throughout their lives [Int. VIII].

### **Private**

Pregnancy for many women is a very private matter, met with modesty and often even secrecy:

*Well, the way I seen it was... they didn't... The pregnant woman, she wouldn't... to me it was very secret. Very secret...I think that's the way it is, very important. You can't really talk about it. They wouldn't talk about it. Because it's a secret, how you get pregnant, yeah...the woman would only tell, I guess, the husband knows his wife is pregnant, but they wouldn't say anything. But whenever she's ready, she has to tell who is going to be a midwife for her, who's gonna deliver the baby. [Int. II]*

*Sometimes we didn't even know when somebody's pregnant. [Laughing]. They hide it eh? They young girls especially. I don't know why – you could see the child running around in the road! [Int. IV]*

The birth process is also reflective of this approach. During labour, a woman “used to wear a long skirt. And she would wear that and they'd cover her legs with the blankets” [Int. VI]. Three elders during a group interview also discussed the fact that “Native people, they don't spread their legs...” as is the case with birth in Canadian hospitals today [Int. 9].

### **Fatalism**

Fatalism is the view that people are powerless to do anything other than what they actually do (Rice, 2009). The role of fate is paramount to this view. Such an approach was evident through discussions and stories told by the majority of the elders:

*Then I asked, “What are you going to do?” I asked my aunt, “What if something happens?” I was kinda worried at that time. What if something happens? And she told me, “Nothing's going to happen, everything's going to be okay, she said, “If something happens, it happens” she told me. “Whatever I can do, that's what I'm gonna do”. She told me she's not worried and she's not afraid. She feels strong, and she can do whatever she can do to deliver the baby and to help my mom. That's what she told me. And I was kinda, like...how? She had nothing! Nothing...no equipment or anything. Yeah, all she had was scissors, that's it. [Int. II]*

It seems in this narrative that the aunt's confidence and sense of calm was directly related to her perspective that fate would govern the outcome of the birth. Reactions to infant death reflected the same approach:

*I guess you can't do much, because it's so small. That's what I said...I've seen some babies die when they are small and after they are born, a few days old, maybe from the first day to about ten days. Yeah, some babies died. And I guess they can't do too much unless...that's all they can do, I guess. [Int. II]*

*Well, she said when the baby is stillborn, they...they...didn't... like, I'm not saying they didn't do anything, but that's just... it. That it died. [Int. V]*

In fact, elders often inferred that infant and maternal deaths were accepted consequences of the birth process. As such, one elder highlighted the importance of those mothers and infants who survive:

*Interpreter: There should be a sort of a...celebration after the birth. And sometimes it's very difficult for...when they're in labour. It's difficult for...for them. Could have a hard time giving birth. It's very important to celebrate the babies that are successful. [Int. VII]*

Again, there is some sense that something beyond individual control determines whether or not a baby is successful.

## **6.2 Teachings from the elders**

### **Importance of Oral Tradition**

Birth knowledge, according to all of the elders, was "passed down" to younger generations by elders or other older women. Young women would be invited to attend births with midwives, generally starting between the ages of 12 and 14 [Int. 9]:

*But the persons that were there during the actual birth when she's in labour pains were like elders, or seniors. They were the ones that were there. And then the midwife, I guess did the...call up the other elder ladies to come and watch. And then there would be some younger ones. They would bring some younger ones to...you know, to see the midwife deliver the baby to learn... you know, to learn from them? [Int. V]*

A pregnant woman learned about how to care for herself and her child through discussions often with her mother or grandmother. This ability for younger women to learn from elders and older women is viewed by the elders we spoke with as crucial to the maintenance of successful birth from generation to generation in the community. As such, without learning these teachings, the abilities of future parents are perhaps compromised:

*Interpreter: I guess she's saying that in my opinion of today's parents, I would teach them how to be good parents to their child. And both parents should have a positive...positive teachings to their children. (Int. VIII)*

The implication is that young parents on the whole, in the opinion of this elder, have not been taught how to be good parents and that the dissemination of positive teachings is central to developing good parenting skills.

### **Birthing Roles**

Many of the elders spoke of differing roles each person might take on during the birth process and the requirements inherent in such roles. The role and characteristics of the midwife were consistent across all interviews:

*I guess that important qualities is that... it's not the same as in the hospital when they deliver babies. You have to be prepared for everything and... you know... They're really experienced ladies, they were, you know? That's how you know that you can depend on them to deliver your baby. 'Cause they're prepared. Be prepared and willing and courageous, like that. [Int. I]*

It is important to note that not all midwives were women, in fact, many men took on the role. In some cases these men were family members of the birthing woman:

*And my dad was sitting beside there telling us how to do it, when the baby was born. So...so...I asked my dad, "What do I do to make the baby breathe?" So he told me, "Use a clean cloth, put your hand in the mouth, eh?" So the baby was breathing right after I did that. [Int. IV]*

Midwives were described by many elders as the main providers of care, and as such, were incredibly important figures within the community. One elder, reflecting on her role as a midwife in the community in the past, described the importance of staying calm:

*What we were taught is that out here, there was nothing like the – like the nursing station here? Nothing like that. And we had to learn not to panic. You know? Just try and do what you can. Whatever you can, to do. ‘Cause if you panic or something, you don’t know...you just don’t know what to do! But if you don’t, then you just... you have to be calm to do whatever you have to do. Because you’re the only person, they depend on you, in the community. [Int. IV]*

The husband has various roles in the birth process. A few stories described the husband taking on the role of the midwife. Most elders maintained that it was important for the father of the baby to attend the birth, although some were unsure what his role should be. Elders described husbands as supportive figures, frequently involved in gathering items needed for the labour.

Other family members (aside from the midwife and another older lady assisting, a younger woman learning about the midwife’s practices, and the husband) were generally not present during the birth. Children were sent out of the house until the baby was born.

The individual who was described as having the role of naming the baby varied across interviews. It was rarely the parents who would name the child. Frequently, the midwife would name the infant. Some elders stated that the parents choose who will name the child. While the naming process seems to have significant meaning, reasons for its importance were not articulated in the interviews.

## **Pregnancy**

Elders described teachings they learned from their mothers and grandmothers in regard to how a woman should care for herself during her pregnancy. Generally, consistent with the idea that pregnancy and childbirth is natural, elders said that a

pregnant woman should continue to live her life as she would normally, with a few exceptions. Continuing to live such a traditional lifestyle was described as “being healthy” and would ensure healthy babies. Teachings relate to diet, activity, and lifestyle. Women are encouraged to “just be responsible” [Int. III]. A holistic approach is evident in these teachings:

*...yeah that's the way my mom told me. I have to look after myself, make sure I'm always wearing clean clothes, make sure I'm eating right, make sure I sleep, make sure I have enough rest, and make sure I have exercise, yeah. If I don't feel good, that's natural, that's normal. Especially for the first few weeks. [Int. II]*

All elders explained that diet for a pregnant woman should generally consist of traditional foods, rather than the more processed foods now easily accessible in northwestern First Nations communities. This diet is rich in protein, and fish is the dominant food:

*Fish. Mostly fish. And meat and wild berries. That's the only things that we had. Fish guts too, and fish heads and...all sorts of cooking they do with fish, you know? They hardly fried because we didn't have any oil or something. The only oil was theirs from the fish, we had that at that time. There's not much. It was simple. [Int. I]*

*Interpreter: Just traditional foods. There was no...no...white man's food. Just flour, lard, oats, tea...I think that's it. Oh! Potatoes, they used to garden potatoes! I think that was it. No sugar. There was no salt and there was no sugar. [Int. 9]*

Eating in this way would ensure a healthy pregnancy and a healthy infant:

*Interpreter: She says that they ate the traditional foods like geese, moose, fish...and the baby was uhh...very healthy when they were born. No mother was ever sick. [Int. VII]*

Another teaching discussed by all 12 elders was the importance of staying active during pregnancy. This is necessary to ensure the birth will be successful. However, many elders also cautioned that pregnant women should avoid heavy lifting or very rigorous activity to make sure not to hurt the baby. Elders spoke of the placenta becoming stuck or the baby becoming too big if a woman was not active enough:

*I guess the...they were aware that the uh...the placenta was very important to...to move around inside. So it wouldn't get stuck in the side of the uh...stomach. So that's why it was very important for a woman who was pregnant to move around. [Int. VIII]*

A number of elders also instructed pregnant women to be careful when lying down and turning. To turn, a woman must ensure she sits up prior to turning over. This was a common teaching and its purpose is illustrated in the following quote:

*She's explaining about the...when a mother has her baby inside, and when she lies down it's very important for her to lie properly...or to turn properly when we wants to turn. And it...when a woman lies down on the one side for too long that's when the baby inside is...has difficulties. What do you call that – when they get stuck inside on one side. And when they deliver the baby it's very hard for them to deliver the baby. [more response]. That pregnant woman should get up first when she wants to turn, turn the other way. [Int. VIII]*

## **Labour**

A number of practices were discussed as important during the labour process. Reflective of the private, modest nature of pregnancy and birth as described by the elders, the labour process is equally modest. As mentioned, women are encouraged to wear a long dress. One elder explained why this was a common teaching:

*She said they used to cover them up. Because they had...Indian people had, they said that the baby wouldn't come out if it's like, you know? They had to keep covering them up so the baby wouldn't get scared coming out. That's what they said.*

Many elders spoke of the importance of maintaining relative quiet when labouring. One woman explained that a labouring woman “must try and withstand the pain...if you want to have babies you have to learn not to scream or shout, or you scare the wits out of the person who delivered the baby!” [Int. III]. This teaching is exemplified by one elder's story of her last birth experience at a hospital:

*And the doctor was like, “Oh, it's a false alarm!” Because I was not shouting or screaming! I would just lay there quietly, enduring my pains. Then the doctor was*

*expecting me to scream or shout, I guess. But I didn't make a sound. That's why she said (it was a woman doctor), and she said, "This baby's not coming. False alarm." About an hour later, I told the nurse, "The baby's coming now." And she threw off the covers and she said, "Oh my goodness!" Then they dragged me away to the delivery room, very quick. Yeah and the baby was born. [Int. III]*

Elders also described a number of varying labouring positions, including sitting, kneeling, lying sideways, or supporting themselves in a vertical position by pulling themselves up on a rope tied horizontally across the room. None of the elders made reference to using a prone position. In fact, some women explicitly made reference to this difference:

*The woman used to lie sideways. Not on...the way we do it today. On the back. The women lie on the back, flat eh? But the old days I've seen them – I've seen my mum delivering her last child and she was lying sideways [Int. I].*

Traditional medicines were cited by many elders as having important roles in the birth process. If complications arose during labour, medicines could be used to speed up the birth or to stop a woman from hemorrhaging. The following quote reflects the importance and effectiveness of these herbal medicines in coping with birth complications:

*Interpreter: And after the birth, they had uh...herb medicine to stop the bleeding if somebody was bleeding hard. Yeah, lots. They had the herb medicine from the bush... And they had the herb medicines that – you know sometimes a woman has a hard time to give birth? You know? And they have the medicine for it, and they drank it, and the baby starts coming [Int. 9]*

All 12 elders spoke of the importance of keeping the placenta, or afterbirth, rather than disposing of it. One elder said that it is important not to let the placenta touch the ground. Generally, it would be wrapped and hung up in a tree where it would be protected from scavengers.

*You're supposed to hang it up in a bundle, or you can bury it under the foot of a tree. Just not to be so rude to through it away. You don't throw it in the garbage. You've got to keep it sacred as anything that comes along with the human. [Int. III]*

Some elders also said the afterbirth could be buried. The placenta is viewed as inherently linked to the newborn, and as such, must be treated with respect. One elder articulated this reasoning well in the following quote:

*I guess they just want to have that as a...to show that it's an important thing, that that baby was there and he lived and coming out with that too, that's important not to just throw it like that you know? [Int. I]*

## **Newborn Care**

Many practices were identified by the elders as important to care for a newborn. Breastfeeding was very important for both the baby's health and the relationship between the infant and the mother. In the past, if a baby could not breastfeed, the elders stated that they were generally fed fish broth and as the child aged, he or she was fed soft pieces of fish.

*And the other thing is, the very important thing is the breastfeeding, yeah, breastfeeding. And she told me that it's very important to breastfeed. And that the only way you can attach your baby, to really love your baby, to care for the baby, that's what she told me, yeah. If you don't breastfeed your baby, you don't really love your baby [Int. II]*

*Interpreter: And right away, after the birth, after they're trying to feed the baby with the breastfeed? So they let the baby know where he belongs. The baby belongs to the mother [Int. 9]*

One elder explained that a newborn should be given water prior to breastfeeding:

*Interpreter: She said they give it water first. Before they start nursing the baby? Yeah. She said they give it water first. I guess it's sort of purifying the inside and for the bowels to move quickly. That's what she says. But they boiled the water for the longest time and then let it cool off. Just lukewarm. And that's why they did that, she said, feed it water to cleanse the stomach and the bowels moving. [Int. V]*

Keeping an infant safe is an obvious priority for the mother. Elders stressed the use of the tikinagan (cradleboard) to help the mother, as well as enable her to continue to

accomplish tasks during the day. Many stated that in their experience, infants quite enjoy being in the tikinagan. The use of the tikinagan, however, should be restricted in some instances. Boys, as two elders explained, should not be upright in the tikinagan for too long because they could suffer from hernias [Int. IV]. Nevertheless, it is important to use the device in order to ensure a child will have strong, straight legs [Int. VII]. Three elders suggested that “nowadays those babies aren’t in tikinagans, that’s why they have...bowlegs” [Int. 9]. Another elder described her disappointment with the use of strollers:

*Interpreter: I guess the older ladies used to teach the younger moms to take care of their children properly. And she doesn’t...like...doesn’t like mothers that are carrying their babies in a stroller [laughing]. I guess it’s um [translation/response]...I guess it’s...the baby gets weak on its legs. Then I guess, she’s saying that the baby needs to stretch their legs while they are very young [Int. VII]*

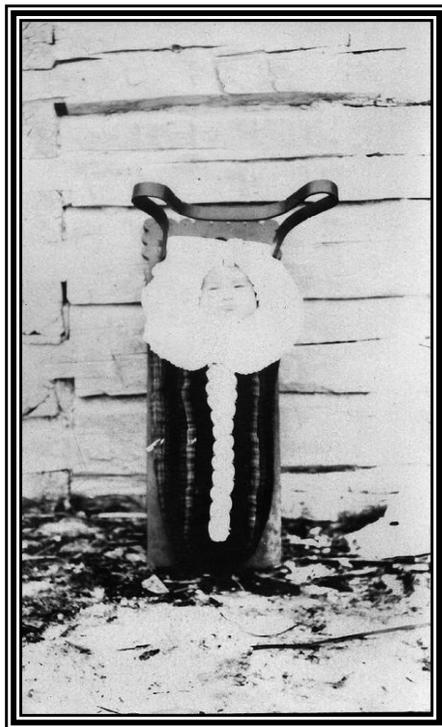


Figure IV: Photograph of a baby in a tikinagan

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More generally, a number of elders stressed the importance of being present, being responsible, and not leaving the child:

*You have to be there all the time. Just to keep your baby safe. You don't run out, not even for a moment. You have to be there with the baby all the time, that's the only way you can keep it safe. There's a legend that goes...I don't know whether it's true or not. Because my mother said, "Never leave your baby. Always be there for the baby, even for a moment. Because somebody's going to come in and snatch the baby. And then you'll wonder what happened." [Int. III]*

Native medicines were referred to by a number of elders as a method of newborn care for different preventative and curative purposes:

*They covered the baby with cedar, all over its body. And other kinds of herbs, different kinds...to give the baby by mouth. [more response]. Baby powder, they used – [more response]. You know that bark, that powdery bark? That's what they used for the baby powder. [Int. VIII]*

The majority of elders described the importance of keeping the umbilical cord once it has dried and fallen off the newborn. This cord has special significance for the child. It is put in a moose hide as is either kept by the mother or put on the tikanagan of the child so that it is visible. The following quote explains the importance of the cord to the child:

*Interpreter: Then they...when that umbilical cord came off, the one that they tied, then the one that came off...they wrapped it up and then they made it up in a moose hide and hung it on a baby's tikanagan. [translation/response] So that baby with that umbilical cord that was beaded, so the baby wouldn't cry that much. That's what they...I guess that's what they...believed. That umbilical cord...the baby wouldn't cry as much for that umbilical cord they lost. [Int. VI]*

The use of natural products in the realm of childbirth was evident throughout our discussions with the elders. Among other natural resources used for various medicines, moss was described as having many uses in both the birth process as well as in the care of mothers and newborns.

*Interpreter: In those days there was no...you know...pampers or anything. Just uh...moss. There's...I think there's two kinds of moss that they used. One was called...different kinds. They used to take them from the ground and take them and dry them in the summertime. And when wintertime comes they would gather up, gather them up. [Int. 9]*

Moss played a role in the creation of a birth mattress, to line tikinagans in order to make the inside more soft and safe for the infant, as diapers for infants, as menstrual pads, and more generally in the place of cloth or sponges.

*Interpreter: They used to dry it up in the winter to use on babies. And there was no cloth then... When they have that afterbirth, there was no...Kotex, or whatever you call those things. They didn't have them, they just used moss. [Int. 9]*

Indeed, large amounts of a few specific types of moss were collected each season and dried for a multitude of purposes.

### **Mother's Care**

It is also very important to care for the mother after she has given birth. To help the uterus return to its original size and position, six elders discussed the role of binding the abdomen to support it. The general thought throughout the interviews was that mothers would recover with time and community support, and were rarely ill:

*I'm not too sure, I never did hear my mother say about a sick woman, a pregnant woman. Because I don't know if there were sick women too. But as long as they got well after their baby is born, that's perfectly alright. Because they will clean up or get well by themselves [Int. III]*

It is also important to allow women ample time to recover. The time a mother is supposed to remain at home after the birth ranged between elders from ten to thirty days. During this time, the recovering woman's mother and/or the midwife would remain in the home to look after both her and the newborn. This recommended recovery time conflicts with the existing practice at the hospital of less than two days:

*Interpreter: Yeah, she says ten days! Ten days, even in summer and winter! She has to stay in her room, but she can get up and around, she can't go outside for ten days. She said she's – yeah, and she says after ten days, then they can go back to look after your home and look after your baby, and do your work. She said she's always surprised now when a mother has finished her baby, right away she's out of the hospital! (Int. V)*

It is also important to keep the mother warm. A few elders recommended giving women a type of mint tea for this reason as well as for its various healing properties:

*And right after the woman gives birth, what they used to do was they make some kind of tea – mint. You know the ones that are made of those leaves. They're along the riverbanks or the wet areas. They have lilac leaves and they smell like mint. And that's what they boil and they give it to that woman right away. To keep her warm and – it's like aspirin or something. It helps the woman. They always use that. They call it – [equay-wusk] – “a woman's medicine” [Int. IV]*

### **6.3 Concerns for the future**

In each interview the elders we spoke with discussed their worries about childbirth for future generations as well as their concerns and opinions of the current status of birth in their communities. As the source of teachings for younger generations in First Nations communities for centuries, elders have a unique and valuable perspective on changes that have taken place and how they have affected birth.

It is important to note that the themes identified below are not mutually exclusive categories, but rather are intertwined. One could conclude that many of these concerns ultimately stem from a history of colonialism and the current dominance of Western culture. This will be further addressed in the following chapter.

#### **New health and social challenges**

Elders expressed concern about the health challenges young women face today during pregnancy, reflecting that changes in social, political, and economic environments have contributed to an increase in unhealthy behaviours. Major concerns discussed by the

elders included high rates of smoking and drinking, a lack of physical activity, and a transition away from a traditional diet. These concerns seem to reflect an intergenerational gap in which teachings the elders learned from their parents have not been continued in younger generations. This divide and one elder's attempts to promote healthy behaviours is evident in the following quote:

*Today is really...has changed so much because it seems that there's nothing like we used to do. These days they don't do, they just sit around and eat... The biggest thing that I don't like is when they're pregnant they are smoking so much and that's not good for them. Sometimes I tell my grandchildren that they should not smoke when you're pregnant because everything that goes in you will go in the baby. [Int. I]*

This idea that a mother's actions will also affect the health of the child was common across interviews. For example, a woman's diet during pregnancy seems to influence her health and the health of her baby.

*Interpreter: She's talking about the...during the past, they ate traditional foods. And during pregnancy it wasn't...they didn't even really show when they were pregnant. Like today, the pregnant woman are like...way big! (laughing). And the babies are big! I guess it was the normal range for them, in the past. And now they are big babies. [Int. VI]*

In this way, a shift away from traditional foods to a less healthy diet was implicated by one elder in the increasing size of newborn infants. One elder also suggested that an unhealthy diet compromises the health via his or her immune system:

*The babies were more healthier in the past than now. They way they eat today, it's more uh...it slows down the uh...immune system of that baby. [Int. VIII]*

Elders also identified diabetes and labour complications as a worrying health concern:

*Interpreter: In those days, they didn't have problems. Nowadays, they have all kinds of sickness...the child. In the old days, there was nothing, there was no sickness, there was no – there was no diabetes or complications... Sometimes...she never did drink [alcohol], eh? She never did. I mean now too eh? She doesn't drink...She says, "If I want to get dizzy I'll just spin around!" [Int. 9]*

This juxtaposition between how the elders grew up and the challenging realities of the younger generations was common across interviews.

### **Loss of tradition in birth**

Perhaps the root of many of the new health challenges faced by pregnant women today, elders also lamented the loss of many native teachings and practices in the birth process. The women continuously contrasted the situation today with that of the past, highlighting the benefit of many of the “old ways”:

*In the old days, I guess they were just telling the woman how to protect herself and how to eat. It's not that different because we have the main things to eat all the time, edible things. Traditional food is all we had, so everybody knows how to... you know? But nowadays it's different. To prepare for how to look after herself, how to look after that baby inside her and... like that... it's important. [Int. I]*

It was also suggested that as a consequence of the introduction of hospitals and nursing stations, the loss of teachings has been exacerbated. In fact, the process of intergenerational learning and teaching young women how to be midwives has ceased:

*I guess there's hardly any more midwives around so...I guess she says that I wonder what's gonna happen if there...if the – those ones that are giving birth today...wonder what's – how they would manage without a midwife around here [Int. VIII]*

*Today, the native teachings seem to be disappearing. So the reason for that would be, nobody knows how to deliver babies since the hospital began. They think it's a lot more...easier. But I don't think so, it's just as easy at home, it would be, today. [Int. III]*

Elders also explained how difficult it was to pass on their knowledge to the young ladies today, as a partial result of language barriers:

*Interpreter: Cause nowadays, those kids don't understand native language, eh? Like when they teach. That's how it is now. Everybody talks in English. Most people don't...yeah. [Int. 9]*

This challenge further reinforces the existence of an intergenerational divide between elders and the younger generations.

### **Conflict with the biomedical approach**

Conflict with a western biomedical approach is largely linked to the loss of tradition, given that the biomedical approach is the dominant one, and women have “come to rely on doctors, to see what the doctors say” [Int. 9]. Many elders wondered what would happen now that the dominant western approach has compromised the dissemination of First Nations teachings:

*I guess there's doctors here who know how to use equipment just in case there's something wrong with the woman or the child. I guess that's why it started. I guess it's the way it is now, but the only thing is, there's hardly any old people nowadays. Who would know, who would tell how it is nowadays? That's what I think anyway, that's the reason why. Because the government provides these things for people just in case if there's an emergency. [Int. I]*

One elder exemplified the conflict between the “old days” and the birth process today:

*Everything is just...you only have to point at the machine, and out comes the baby! In those days you had to be patient, and be willing to help make sure the baby and mothers are safe. But today, nobody wants to do it themselves. [Int. III]*

Historically, with the introduction of biomedical paradigm came biomedical standards and qualifications. This set First Nations teachings directly at odds with medical accreditation:

*Interpreter (Elder 10): The reason is why...we had a meeting with Dr. X, because they're not allowed to have midwives anymore unless you're certified. That's what it is nowadays. You have to have permission to deliver babies now. Yeah, that's the thing [Int. 9].*

*Interpreter (Elder 12): She said, all they want is to make money so they can deliver babies and get paid. And in the old days, nobody would get paid for delivering babies. That's why they have to have a license to – they can't do it anymore. [Int. 9]*

Another elder, who had been trained by a First Nations midwife when she was an adolescent, and was subsequently trained as a Community Health Representative within the biomedical model, expressed her frustration with the two conflicting approaches:

*Watching the doctors, and we helped. Because they have to look at us, watch us, how we're going to deliver the baby. Here's the mother, lying almost naked on the examining table, on the table, and she'd be shivering and cold. Sometimes you can see the woman's bleeding a whole lot, because you can see the pus and clots, big clots. Now I always think about that and what the midwife told me. Never be like that when you deliver the baby, never let the woman get cold, always in a warm place, nice and warm. Make sure she won't have bleeding or clots. I don't know if it's true? It seems to be true though, the way I've seen it [Int. II].*

In contrast, one elder expressed her appreciation for the role of biomedical health care practitioners:

*Interpreter: But she said she's glad that there's nurses and doctors and you know, that they're in the community to help. You know? Grandkids and pregnant women and...she knows that there's...that there's people that will help take care of them and she doesn't have to worry about anything, she says. [Int. V]*

### **Views on evacuation for birth**

Mixed opinions emerged when discussing the process of evacuation. A few elders expressed feelings of loss and disappointment as a result of the process of moving birth from the community to the hospital in Sioux Lookout, although acknowledged the role of hospital when dealing with higher risk births:

*When I was a midwife, when I stopped, when the nurses were taking over, when they started sending out the prenats, I missed it, I really missed it. Like, why do they have to send everybody out? And then, I know there's a problem, there are complications, but you can tell whose going to have a problem. I know that when I did the...when I looked after the prenats, I know everything is okay, and I know when something's going to be wrong. [Int. II]*

Three elders wondered if evacuation to Sioux Lookout could be reserved for those pregnant women who were experiencing “problems”.

*She's saying that those who are in the healthy pregnancy, they could just stay here and give birth. I don't think they would have any problems giving birth if they were giving birth here. And she was saying that the recent one that was uh...that gave birth here, she didn't have any problems after. [Int. VI]*

Other women expressed a dislike of many aspects of the evacuation process, including the lack of escorts funded by the government, and the time away from home and family:

*Elder 4: One thing, you don't feel happy when she goes out. Leaving their family behind. Yeah, things like that.*

*Elder 5: And sometimes they have children, eh?*

*Elder 4: Leave little ones behind for a long time.*

*Elder 5: They're not allowed to take them. These days, because of non-insured is getting stingy [Int. IV]*

In contrast, three elders involved in a group interview from a drive-in community expressed a positive opinion of hospital birth:

*Interpreter: Yeah, they travel by uh...medicine van, medical van, just to Sioux Lookout. And some have complications, they send them out to Winnipeg or Thunder Bay...If it were me, she says, I would be happy to go and lay down in white sheets, she says! (laughter). [Int. 9]*

#### **6.4 Suggestions from the elders**

Perhaps as expected given the concerns expressed by the elders at the loss of First Nations teachings, suggestions made by elders generally promote a move to involve and incorporate more traditional ways, and to create environments in which to pass on native teachings. Many elders were uncertain about suggesting changes to the current birth process, as they did not know what happens at the hospital currently. A few elders would like to see the use of native medicines involved in the hospital process.

#### **Elder and Family Involvement**

A common request was to involve the elders, First Nations midwives, and the husband in the birth process at the SLMHC:

*The question I want to ask is, would it be good for the doctors to invite an elder or somebody when they deliver babies? So she or he can learn from them? That's the question I'm asking... so the elder will know how the doctor is doing? Like that sort of. [Int. I]*

*Interpreter: Nowadays they [could] have a man in that delivery room. To see what it's like to give birth. Of...how it's hard, sometimes, you know? To let them know how the woman feels when they give birth. That's why they – she says that's what I think [Int. 9]*

Another suggestion was made by three elders to perhaps run a workshop to enable them to pass on their knowledge to a younger, middle-aged generation:

*Interpreter (Elders 11/12): She says, they're saying that um...I guess they can do the, workshops, or for middle aged people, like? For native delivering, or, you know...midwives. Not just women. And men! Lots of men delivered their babies, a long time ago. Yeah. Lots of men, yeah... Sometimes a woman gives birth early? And they would be there to help. [more response]. Yeah, she says, that's how – she wants you to write that down. She'll be there if some woman is having trouble. [Int. 9]*

### **Allow the option of native ways**

In response to the problems with evacuation, a few elders wondered if a “healthy” woman could be given the choice as to whether she could give birth in the community:

*Well, if the couple is willing to do the old days, what they did in the old days when the woman got pregnant. How come they had their babies born at home? How did they do it? I would like to see that, the healthy mother – like, if they're willing to do that. The mother had... well, the prenatal [pregnant woman] wouldn't have to come out and stay at a hotel or in a hostel or in the hospital to wait for the baby to be born. I feel like its not right when the prenatales come out, leaving their families behind. And just the mother coming out and the husband behind. [Int. II]*

A number of elders also suggested that certain practices should be available for those who wish it. Given the common teaching that both the placenta and dried umbilical cord were important, a few elders suggested that women in the hospital should be allowed the option to follow these teachings. Two elders also suggested that women's abdomen

should be bound as they have been in the past, and many elders suggested that the mothers should be given more rest at the hospital after their labour:

*Elder 4: Support the stomach. But now I don't think they have anything to support the stomach, to get the uterus back in shape. Because those young girls are – their stomachs are just hanging every which way. [Laughing] At least they should rest one day or one night in the hospital. [Int. IV]*

## 7. *Discussion*

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### 7.1 Summary of results

Conversations with twelve female elders from four different communities served by the SLMHC identified numerous practices, First Nations teachings, and general meanings and approaches to birth common across interviews and specific to the elder's experiences and knowledge. In the opinion of the elders interviewed, teachings have important cultural relevance as they play critical roles in the realms of pregnancy, labour, newborn care and mother's care. Elders also highlighted broader social issues such as the loss of tradition, faltering generational relationships, and the social costs of such changes. Specific teachings were generally discussed by the elders within this broader context.

The elimination of these teachings and the meanings they represent is emblematic of the loss of Aboriginal community control over birth, arising historically as a result of colonial policy. Indeed, a suggestion unifying much of what was discussed among the twelve elders was that an improvement in maternal and newborn health could be accomplished by a systemic shift toward more traditional ways within the hospital context. Elders discussed the importance of First Nations teachings in preparing women for birth and in both labour and postpartum care and the health and social costs inherent in the loss of these teachings. Many elders were enthusiastic and willing to be more involved in the process at the hospital and in the community as a method of reducing the intergenerational gap that has developed largely as a result of evacuation. In accordance with this overarching suggestion, more attention should be paid to investigate the prospect of 'low-risk' pregnancies giving birth in the community, and helping to explore ways to develop community capacity to support this goal.

## **7.2 Validity, reliability, and generalizability of findings**

Ensuring reliable and accurate findings in qualitative research is a critical step in the research process. Qualitative reliability, indicating that a “researcher’s approach is consistent across different researchers and different projects” was met via transcript review to ensure there were no obvious mistakes prior to analysis, coordination among the five coders involved throughout the analysis, and the achievement of intercoder agreement (Creswell, 2009, 190). Consistency of coding was in agreement between 80% and 85% of the time, meeting Miles and Huberman’s (1994) criteria for qualitative reliability (Creswell, 2009).

Validity in this qualitative study is “based on determining whether the findings are accurate from the standpoint of the researcher, the participant, or the readers of an account” (Creswell, 2009, 191) Aspects of validity include a measurement of credibility, dependability, and confirmability, as described by Denzin and Lincoln (1994). Credibility refers to how effectively the researchers were able to capture the essence of the experience. Credibility was confirmed through triangulation of data via interviews, interview notes, and literature findings. Dependability is described as a measure of the ability of other researchers to follow our decision making process and come to similar conclusions. This report hopes to serve as a clear indication of the purpose, design, and methodology that will enable such a process. Lastly, confirmability is a reflection of freedom from bias in both the research process and product. In this study, the investigators continuously reflected on their own biases and were as objective as possible throughout the research process (Denzin and Lincoln, 1994).

Generalization of data is not a goal of qualitative research, as this type of research seeks to understand and explore themes developed from a specific context or environment. The value inherent in qualitative research is a result of this “particularity” (Creswell, 2009, 193). In fact, generalizing the results from this study to all Aboriginal peoples across Canada would be an error. However, the process taken by the SLMHC could arguably be transferrable to similar regional hospitals in Canada. The approach could be based loosely on the process taken by the SLMHC but would have to be catered to the specific context of the region.

### **7.3 Where do these findings fit in the discourse on cultural safety?**

The process the SLMHC underwent to address the First Nations component of the overarching Odotsemag project to improve maternal and newborn care in the region was informed predominantly by transcultural theory and was not viewed specifically through a lens of cultural safety. Importance was placed on the identification and understanding of First Nations beliefs and practices cited as necessary to achieving cultural competence, and this study was designed accordingly. However, what is interesting from the SLMHC study findings is the idea that First Nations birthing beliefs, practices, attitudes, and meanings, as described by elders from the region, were couched in overarching themes of loss of culture, tradition and intergenerational relationships, as well as the resulting health and social challenges. Despite our initial approach perhaps being overly targeted, focusing on beliefs and practices alone, semi-structured interviews and the openness of participants to speak about their experiences and knowledge gave rise to broad themes not only specific to certain practices or beliefs, but addressing larger structural and systemic issues. Elders suggested that some of the challenges young First Nations women

face today could be ameliorated by involving elders more in the birth process and incorporating traditional teachings into the hospital model. Depending on the lens one uses, these results could be interpreted multiple ways.

Critics of such an approach may suggest that an incorporation of ‘traditional ways’ into the hospital birth process would do little more than effectively “other” First Nations women. Projecting “assumed cultural characteristics” based on this study to all First Nations women who access the SLMHC, critics might argue, is a harmful, colonialist approach and serves to further exacerbate inequities. A culturally safe approach, in contrast, would avoid such generalizations and focus on patient-driven and centered care, acknowledging culture as a fluid concept and being constantly self-reflexive as health care professionals grounded in a colonial history.

However, a move to incorporate traditional teachings at the SLMHC could also be construed in a way that is consistent with cultural safety. Through a postcolonial lens, the approach taken by SLMHC study could be conceptualized as a potential method of putting the birth process increasingly back into the hands of the community, with elders as the leaders of such an initiative. Of course, this initiative would have to work alongside other efforts to shift individual provider attitudes and practices and thus help to foster an understanding the dominant health care structures may need to shift to reduce power inequity. The colonial policy of evacuation effectively eliminated First Nations involvement in the birth process, as teachings and traditions were seen as a cause of high perinatal mortality rates. It was therefore largely colonialism that removed such teachings from First Nations communities, created the rifts between the elders and their children

and grandchildren, and contributed to the numerous health and social challenges First Nations women face today in childbirth.

In practice, this understanding means that in order to create an increasingly culturally safe birth environment, colonial legacies should be addressed. Given the number of challenges facing rural and remote Aboriginal communities in efforts to allow women to give birth at home as well as increasing community anxiety regarding the safety of such a practice, it seems logical to target the negative manifestations of the policy of evacuation, rather than the policy itself in the short term. I would suggest that alone, individual practices of self-reflexivity and awareness of power dynamics would be largely ineffective in fostering a culturally safe hospital environment given that the system itself supports a loss of power and control among Aboriginal women in the context of birth. The current focus on individual attitude and behavior change at the level of providers must be supplemented by structural change in the health care system itself. Thus, a systemic shift away from such a model of maternity care which serves to disempower Aboriginal women and their communities is arguably essential to achieving cultural safety.

Ultimately, although the approach taken by the SLMHC was not originally governed by the concept of cultural safety, speaking with elders about meanings, beliefs, and practices related to birth could be a crucial step in promoting the concept in a clinical setting. Whether or not the qualitative results emerging from interviews with elders in the region will contribute to a culturally safe environment depends almost entirely on how these results are utilized. Analyzing the results of this study in a peripheral manner could lead to a harmful overgeneralization of the identified beliefs and practices to all First

Nations women who come to the hospital to give birth. Such a generalization could lead to very superficial changes to the hospital model. For example, remaining dependent on a predominantly biomedical model of care while incorporating a few First Nations practices such as retaining the afterbirth will not promote cultural safety. In fact, such an approach could potentially marginalize women further by assuming inherent differences exist between First Nations and non-First Nations women as a consequence of culture or race. If health care professionals gain only surface knowledge of some historical birth practices and beliefs from these results, the same effect could emerge in clinical practice. As highlighted by Dr. Catherine Elliott, a Canadian family physician working in northern British Columbia, such generalized knowledge could create a “false sense of confidence” among health care providers, serving to “impede curiosity about the individual patient’s specific beliefs and cultural practices...This approach can generate a static and stereotypical picture that inadequately describes the diversity of those it attempts to explain” (Elliot and de Leeuw, 2009). However, she clarifies, “If knowledge is used as a platform from which to engage our curiosity with each Aboriginal patient, it can build relationships” (Elliot and de Leeuw, 2009).

#### **7.4 Recommendations**

In order to prevent the results of this study from being misapplied, it is important to view the findings within the broader postcolonial context. In this sense, it is perhaps most important to acknowledge that dominant biomedical structures and practices may need to shift and work to identify areas for change in the SLMHC context. While I believe that themes emerging specific to First Nations practices should not be overlooked, I think the focus on what could be ‘deliverable’ from this study should be on correcting

power imbalances by returning control and tradition back to the community. To accomplish this end, it is important to address changes at the structural and patient-provider levels as well as create more long term goals. I therefore recommend the following:

#### ***7.4.1 STRUCTURAL AND PROCESS CHANGES***

##### **Funding and inclusion of escorts in the birth process**

Pregnant women should be able to travel to Sioux Lookout with a supportive partner, such as a husband or family member, to give birth. It is imperative that funding from the federal government to support this be strongly advocated for. Moreover, if a woman requests that her partner or escort be involved in her birth as well as pre- and post-labour care, the structures should be in place to allow it. A woman without an escort is likely to feel alienated, alone, and disempowered staying in a community for a number of weeks in which she often knows no one.

##### **Changes to birthing rooms to allow flexibility for women**

Acknowledging the view of childbirth as both a natural and private experience, it will be important for some women to give birth in an environment more conducive to these views. For example, giving birth wearing a hospital gown or lying horizontally in a hospital bed may not be the choice of some women. System changes might be required to allow women to give birth in alternative positions, if this were the wish of the patient. The SLMHC takes, as compared to most southern hospitals, a rather non-interventionist approach to birth (O'Driscoll, Personal Communication, 2009). However, the environment at the hospital remains quite 'medical' and efforts should be made to create a place of birth that is as comfortable as possible for the mother.

## **Continued elder engagement and programmatic changes**

Although many of the elders in this study expressed a willingness to be an educator for pregnant women and perhaps health care providers, this idea needs to be further explored. Community prenatal meetings, for example, could be led by community elders in partnership with resident nurses, allowing women to reduce the amount of travel required to Sioux Lookout and helping to promote strong intergenerational relationships and First Nations teachings. Elders might also be valuable at the hospital as resources for women who wish to engage with various teachings.

### ***7.4.2 PATIENT/PROVIDER INTERACTION***

#### **Increased control for pregnant women**

Pregnant women should be more involved in decision making with regard to their pregnancy. An effort should therefore be made by health care practitioners to encourage more involvement of their patient in shaping the type of birth experience that she would like at the SLMHC. Women should have the opportunity to request that certain practices be observed throughout their pregnancy and during labour and postpartum care. Thus, the beliefs and practices identified in this study would be useful for health care practitioners to understand the type of requests that could be made. Themes identified in this study, for instance, highlight the importance of: retaining the placenta as a sacred object, eating traditional foods and being active during pregnancy, keeping the umbilical cord for the newborn's benefit, the practice of binding a woman's stomach after birth, ensuring that a mother rests for a significant yet safe time period following labour, as well as the healing properties of traditional medicines.

### ***7.4.3 NEXT STEPS***

### **Listen to childbearing women**

Although the perspective of the elders is valuable, it is also important to speak with women who come to Sioux Lookout to give birth about the hospital experience they had. Understanding which aspects of care women enjoyed and which were negative experiences is important in identifying areas of change at the SLMHC. A second research project based out of the SLMHC aims to conduct such a study in the near future. It is also important to explore the possibility of speaking with First Nations fathers in this regard.

### **Opening up the dialogue surrounding community births**

Informal discussions with both community members as well as some of the physicians at the SLMHC highlighted an overall sense of skepticism and focus on risk when discussing community birth in contrast to the policy of evacuation. Although not necessarily representative, all health care professionals I spoke with did not think it was realistic to discuss the option and many community members were worried about giving birth without the help of doctors. However, although the SLMHC aims to improve the birthing experience for mothers who travel to give birth, unless the policy of evacuation for all women regardless of risk as the status quo is eliminated, negative health consequences will remain. Thus, in accordance with a suggestion made by many of the elders we spoke with during this study, a dialogue should begin to explore the possibility of allowing some 'low risk' women to give birth in the nursing stations and perhaps at home in their communities. This, of course, would also hinge on discussions with childbearing women in the region. What that might look like in practice and the capacities that need to be developed would be part of this discussion. Given that long term initiatives are necessary to accomplish such an end, it is important to start thinking

about needed steps and how they could be operationalized. Community engagement is crucial in opening up this conversation. If this is identified as a priority for the communities involved, change will likely have to come from community-driven requests and advocacy, as it did in Nunavik and the development of the Inuulitsivik model.

### **7.5 Implications for northern and remote indigenous settings**

The approach taken by the SLMHC has important implications for similar environments across Canada. While the results of this study have yet to be applied to the clinical SLMHC setting, the potential for change and improvement is great. The main message regional centres can take from the SLMHC experience is the notion that maternal care models must be shaped by and catered to the populations they serve. Moreover, fostering a greater understanding and involvement of Indigenous teachings surrounding birth through a postcolonial lens is an important step in returning control over birth to a pregnant woman and her community. A health care provider's understanding of such teachings enables them to acknowledge and respect various ways of knowing in the birth discourse. Ultimately, in regions where delivering in a woman's home community is prevented by health and social challenges, efforts should be made to reduce the negative impacts of the evacuation policy. Involvement and support from community elders is an important step toward this end. Therefore, the process taken by the SLMHC could serve as a model for similar regional centres across Canada to improve maternal and newborn care for Aboriginal women.

### **7.6 Limitations**

Limitations from this study stem from biases that may have arisen during both the interviews or through data analysis. Due to the limits of the interview guide that was

focused primarily on identifying birthing beliefs and practices as reflective of the initial end goals of this study, response bias may have arisen through leading questions. Researchers may have approached the interview with preconceived notions or agendas and this may have come through in the follow-up questions. Moreover, interviewers might have been less inclined to ask follow-up questions that were not firmly rooted in the initial goals of the study. However, although the interviews were in a semi-structured format, elders tended to use questions as a base from which to speak about what they felt was important to explain to the researchers. This led to a collection of results that were more representative of unstructured interviews. Researchers retained a high level of self reflexivity throughout the interviews in order to acknowledge any bias they may contribute to the process and act to eliminate such bias.

Interviewer bias may have also arisen based solely on the visible identities of the interviewers. Both the principal interviewer and co-interviewer were of Euro-Canadian descent, female, and under the age of thirty. As visibly white individuals, the possibility of our identities affecting the interview results, given a history of colonialism in which Euro-Canadians removed power from Aboriginal peoples, cannot be eliminated. Women may have felt that they could not share as much with us as they would have with someone from their community, for instance. This being said, the presence of interpreters may have had a positive effect on the level of comfort an elder had during the interview.

The presence of interpreters could have also significantly altered our findings, as results hinge entirely on how well the interpreter is able to express what is being said by the elder. Four different interpreters were involved in this study based on their willingness and availability. Interpreters were community members and were often

employed by the band offices in some capacity. Thus, interpretation was not consistent across interviews. Unfortunately, travelling with a single interpreter would have been financially prohibitive and challenging due to varying dialects.

Lastly, interviews were conducted based on the most convenient circumstance for interviewees. Thus, two interviews were group-based, as the community and the women themselves preferred to speak as a group. A few individual interviews which took place at an elder's home were conducted in the presence of her relatives who also lived in the home. The varying circumstances under which interviews took place were necessary to respect the wishes of the community and the participants. However, such variation may have also led to various biases in the results.

## **7.7 Reflections**

The following paper has detailed the approach, methods, and results of a project I worked on as a summer student over a three month period led by a team of hospital staff and physicians. I then spent eight months embedding this project within a broader theoretical framework by evaluating my three-month summer experience through a cultural safety lens. It is important to highlight and explore my numerous roles throughout this year-long research endeavour, as my identity, biases, and perspectives as well as those of the individuals I worked with played a significant role in how the process and results were shaped. Moreover, my position relative to various professionals I worked closely with has influenced my work and guided me in specific directions.

Although I found that while the spheres of both medicine and academia (in this case, medical anthropology and sociology) seemed to be working toward the common goal of developing more culturally safe health care services and systems, the approach

taken toward that end differed substantially, sometimes fundamentally, between the two fields. In my experience, I found that individuals with a medical background tended to approach the topic of improving birth for northern First Nations communities from an apolitical stance. Cultural safety theorists, however, maintain that cultural safety is rooted in the political context of the issue being addressed. As a student within both spheres, I was frequently faced with conflicting opinions. I believe that framing this thesis in a relatively political nature is important to further the discussion on cultural safety beyond what could be perceived as surface level change. It is relatively easy for me to do this, as I am not a medical professional and am very much removed from the day to day functioning of a hospital such as the SLMHC. In contrast, from the perspective of a medical professional or administrator, acknowledging birth among First Nations peoples in the north as a political issue brings to the forefront historical and systemic injustices and perhaps inadvertently targets medical professionals or administrators as the source of the problem.

I struggled directly with many of the same power imbalances and hierarchical structures conducting this research project and writing this thesis as I encountered when evaluating the state of childbirth and approaches to improve the process in northern Ontario. Perhaps effectively operationalizing cultural safety will not be possible if those individuals directly involved with changing and improving systems and services are not willing to acknowledge and address these imbalances. Thus, as predominantly an outsider hoping to encourage positive changes to the hospital model at the SLMHC, I have found that it is imperative to work within both the medical and academic paradigms and encourage cross over between different approaches in order to shape next steps. I

ultimately believe that the dominant biomedical approach to birth stands to improve significantly by drawing from alternative disciplines.

I also struggled significantly with power imbalances that seemed to exist prior to my involvement between the communities and elders I worked with, and myself as a non-First Nations graduate student. I wondered at the time whether my involvement with this research project, although well-meaning, may serve to further disempower the women I spoke with as well as their communities. To address this concern, I sought to be constantly self-reflexive and avoid the harmful tendency to see First Nations communities as the 'other'. While I believe that it would be ideal if the Odotsemag project was community driven and community led, a government driven, hospital led, and community involved initiative offers significant opportunity for positive change. I remain involved in and committed to this initiative and hope to help shape some of the changes at the hospital in efforts to foster a more culturally safe environment for birth.

## 8. *Conclusions*

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Although the obstetric policy of evacuation of aboriginal women in northern and remote regions of Canada to give birth in urban or regional centres has in many ways contributed to improved obstetrical outcomes, it has also had many negative impacts on the health of mothers, newborns, and their communities. Indeed, First Nations peoples continue to suffer disproportionately from poor maternal and fetal outcomes as compared to non-First Nations populations. Evaluating current models of hospital maternity care for aboriginal populations through a cultural safety lens could serve to address this disparity by highlighting both power inequities as well as harmful practices which serve to disempower aboriginal women and their communities. In this way, cultural safety is both a lens through which to identify problems within the health care structure as well as a framework to guide initiatives which seek to address such problems.

Given challenges faced by the SLMHC in delivering appropriate and effective maternal care to women in the region, targeting the hospital as an area for improvement allows the centre to maintain a high level of regional obstetrical care for higher risk women while implementing initiatives to reduce the harmful effects of evacuation. Discussions with elders have highlighted numerous areas for change at the hospital and are central to improving First Nations control over birth. Although speaking with elders in the region has been an invaluable component to the development of a culturally safe hospital birth model, the next step will be to speak with pregnant women at the hospital. It is important to understand the opinion of women from the younger generations in order to develop a birth model that is representative of the needs and desires of those who use it.

Ultimately, while the approach taken by the SLMHC was informed by transcultural principles that emphasized knowledge of indigenous beliefs and practices, the overarching goal to improve the birth model at the hospital through discussions with elders was necessary to promote cultural safety in the clinical setting. Without the existence of a hospital system which has either been developed by or in partnership with aboriginal communities and therefore serves to reduce power inequities, the effectiveness of individual cultural safety practices is arguably marginal. Attempting to achieve cultural safety solely at the level of the provider seeks to address power dynamics too far downstream where power relations have already been ingrained into the system. Thus, it is imperative that efforts to achieve culturally safe health care settings acknowledge the role of dominant health care structures and practices as potential barriers to cultural safety and target power imbalances at both the system and patient-provider levels.

In terms of maternity care in the region, cultural safety should begin with shaping how services are going to be provided. As such, the SLMHC serves as a positive example of how other regional hospitals across Canada could improve maternity care services and contribute to the development of a more culturally safe hospital environment. It is important for regional hospitals serving Aboriginal Canadians across the country to reevaluate how their maternity care services are provided, and through a cultural safety lens, develop a plan to reduce power inequities within the system. Through a systematic and stepwise approach, we may be able to return control over birth back towards the communities from which it came.

## *APPENDICES*

## APPENDIX A: Participant Consent Script

**Proposed Title of Study:** Understanding First Nations birthing beliefs and practices:  
A qualitative study of lessons learned from northern Ontario elders

**Investigators:** Dr. Terry O’Driscoll, Dr. Len Kelly, Lauren Payne

You are being invited to take part in a research study through the Sioux Lookout Meno Ya Win Health Centre which wants to better understand First Nations practices and beliefs about birth. We want to hear about your experiences with child birth and your stories of motherhood. Roughly 14 other elders from Fort Severn, Sachigo Lake, Webequie, and Wunnuman Lake will participate in this study.

We will be asking you questions relating to your cultural birthing practices and views about pregnancy and childbirth.

By understanding these practices and beliefs, the hospital hopes to incorporate some of what we find through these interviews into how we care for pregnant women and babies. We hope that these changes will make women more comfortable giving birth in Sioux Lookout and make the experience more positive. We also hope to publish these findings, so that other health care professionals may benefit from the knowledge.

Participation in this research is entirely voluntary. You are able to withdraw from the study at any point prior, during or after the interview has taken place. You have the option of removing what you say from the study. You may also refuse to answer any questions you do not wish to answer and still remain in the study. You may also stop the interview at any point. This interview will be recorded. Everything you say will be kept confidential.

Do you have any questions? Do you give your consent to participate in this study?

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### Oral Consent Given by:

\_\_\_\_\_  
NAME

\_\_\_\_\_  
DATE

### Witnessed by: Interviewer

\_\_\_\_\_  
NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

### Witnessed by: Interpreter (if applicable)

\_\_\_\_\_  
NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

## **APPENDIX B: Research Protocol**

### **Study Purpose and Rationale**

The Sioux Lookout Meno Ya Win Health Centre Odotsemag project is an important initiative developed following a request by the Ministry of Health and Long Term Care and the First Nations Inuit Health Branch to improve maternal newborn services in the region. Understanding traditional beliefs and practices related to birth is a necessary step towards providing more culturally responsive health care services to Sioux Lookout and its outlying northern communities, 82% of whom are First Nations. Through this understanding the SLMHC can better identify opportunities for incorporating traditional beliefs and practices into the current model of maternity care.

### **Description of the Population to be Studied**

The populations to be studied include First Nations elders with pregnancy, birthing, or newborn care experience or knowledge from five northern Ontario communities served by the Meno Ya Win Health Centre. Elders from Sioux Lookout, Webequie, Mishkeegogamang, and Sachigo Lake, will be approached.

### **Sample Size**

This study involves a purposeful sample of elders from the aforementioned communities. Roughly two or three elders will be interviewed in each community, for a final sample size of between 10 and 15 participants.

### **Design and detailed description of Methodology**

Following pilot testing, semi-structured interviews of approximately one hour duration will be conducted in four northern communities and in Sioux Lookout, although duration depends largely on the length of interviewee responses. The interview will be directed by a semi-structured interview guide. The guide will consist of questions relating to traditional First Nations' birthing practices and attitudes. Individual questions and responses will be translated as needed through an interpreter present at the interview. The interview will be audiotaped and transcribed. The data will then be analyzed for themes.

### **Definition of End Points**

The end points of this study include identifying and understanding traditional First Nations pregnancy, birthing, and newborn care practices and beliefs, describing the changes that have taken place in regard to traditional midwifery practices, and developing a more comprehensive understanding of traditional terminology to contribute to the SLMHC medical lexicon. The SLMHC ultimately hopes to identify practices that could be incorporated into the current maternity care model.

### **Measurements and Measurement Instruments**

This is a qualitative study using semi-structured interviews.

### **Data Analysis Plan**

A thematic analysis of the transcriptions and hand written notes will be conducted by the co-investigators using an immersion/crystallization technique. Member checking and triangulation will be used to ensure trustworthiness of results.

### **How Subjects will be recruited**

Subjects will be predominantly recruited with the help of the Special Advisor for First Nations Health and the Traditional Programs Manager at the SLMHC.

### **Compliance with Guidelines on Research with Aboriginal Peoples**

This project will be consistent with the OCAP principles, as identified by the National Aboriginal Health Organization. The project has the support of the Hospital elders council, a representative group of elders from all of the northern communities with the Meno Ya Win health centre's jurisdiction. The direction of the research as well as the tools created have been developed in collaboration with the Hospital elders in residence, the Special Advisor for First Nations Health and the Traditional Programs Manager. Approval will be sought from all communities before approaching individuals for consent and conducting interviews in order to ensure that we are granted appropriate access to traditional knowledge. The communities will be involved throughout the process, and the final report will be both presented and sent in hard copy for approval.

## APPENDIX C: Interview Guide

- I. I understand you have some knowledge or experience with delivering babies here in your community. Could you tell me how you learned about this?**
  - a. How was this knowledge passed on?
  - b. When did you start learning?
  
- II. What was role of the person who delivered babies many years ago in your community?**
  - a. How was this person viewed by the community?
  - b. What do you think were important qualities in someone who delivered babies?
  - c. What was the relationship between that person and the pregnant woman?
  
- III. What does pregnancy and childbirth mean to you? To the community?**
  
- IV. I'd like to talk about your experiences or knowledge of delivering babies.**
- V. What do you do to prepare for the birth? (Why?)
  
- VI. What is important to do if a mother is sick? (Why?)
  
- VII. When a woman is pregnant, what things are important for her to do? (Why?)
  
- VIII. What is important for a pregnant woman **not** to do? (Why?)
  
- IX. What happens during the birth?
  - a. Who is present?
  - b. Where does a birth take place?
  - c. What roles do family members and/or friends take on, if any?
  - d. What happens if the baby is stillborn?
  
- X. What is important to do after the birth? (Why?)**
  - a. Naming?
  - b. Umbilical cord?

- c. Afterbirth?
- d. What is important to do if a baby is sick?
- e. What should one do if a baby dies?

**XI. Within the first few weeks after the baby is born, what should be done to care for the newborn? (Why?)**

- a. Feeding, breastfeeding
- b. Diapering or moss
- c. Sleep
- d. Safety
- e. Tikinagan, wrap-around bag use

**XII. Do you know of any stories (you learned growing up) about motherhood? (If yes): Could you tell me about them?**

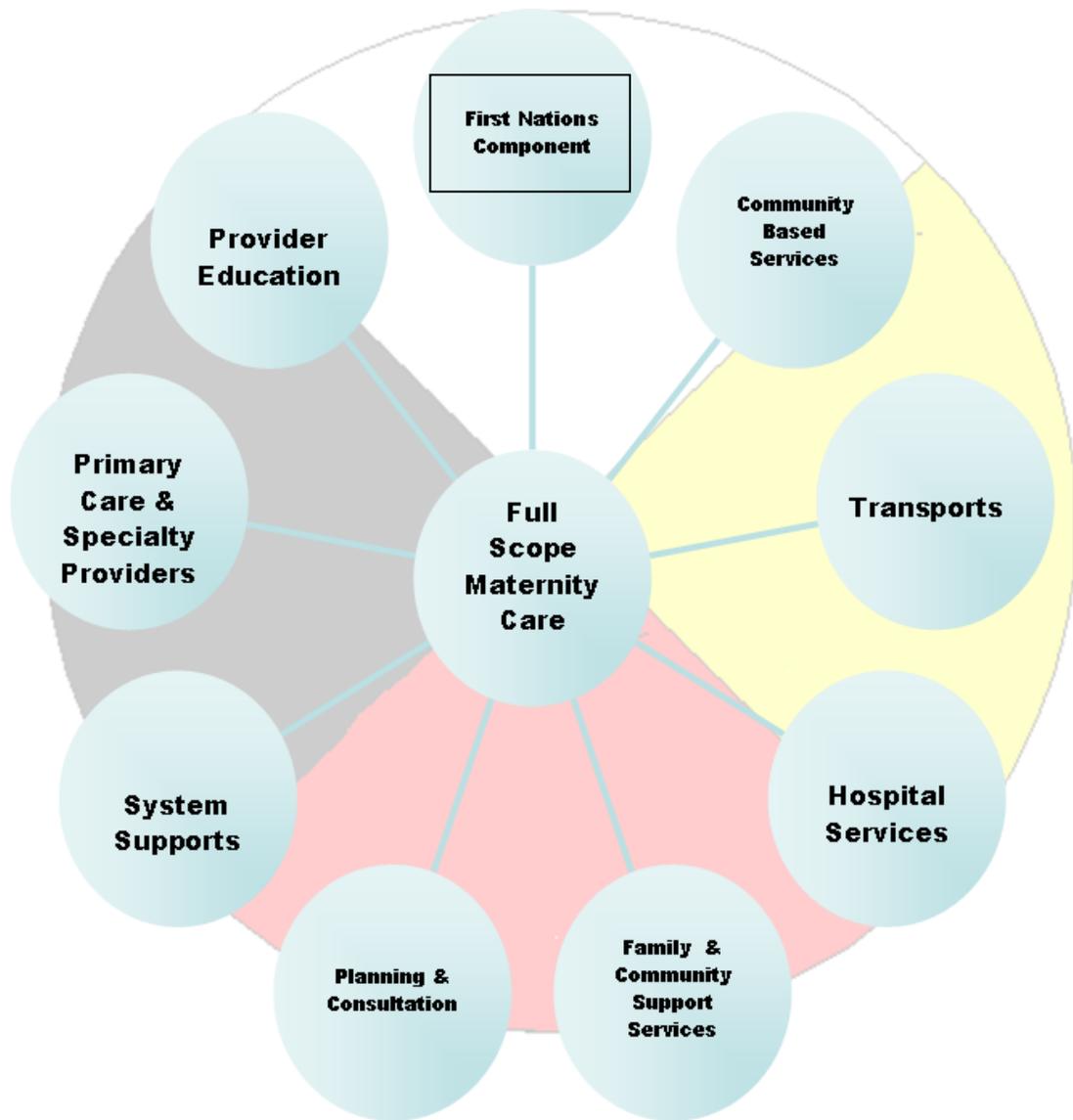
**XIII. What do you think about how women from your community give birth today?**

**XIV. The Meno Ya Win Health Centre is planning to better involve some of the practices you've talked about today into how they care for pregnant women and how they deliver babies. What practices do you think would be most important to include? Why?**

**XV. Do you have anything else you would like to add?**

**XVI. Do you have any other questions?**

**APPENDIX D: Odotsemag Maternity Care Preliminary Model**



*Subject to Change (O'Driscoll, 2008)*

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