

**The Culture of Prenatal Care in Regina, Saskatchewan:  
An Exploration of the Experiences of Aboriginal Women**

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By

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## **Abstract**

The purpose of this study was to explore the experiences of Aboriginal women in Regina, Saskatchewan, related to prenatal care within a cultural context, with the intent of informing future programs of research and giving voice to a population not often heard. More specifically, the objectives of the study were to develop an understanding of the behaviours, values, and beliefs that urban Aboriginal women possess related to prenatal care, as well as to identify how prenatal care could be made more culturally appropriate for this population. The method that was utilized in this qualitative study was interpretive description. Interviews were used as the data collection method to collect information from Aboriginal women residing in an urban center who had given birth within the previous six months. A data analysis method congruent with interpretive description including using inductive reasoning to conceptualize the findings was employed to address the research purpose and questions. The significance of this research is that findings have provided the opportunity to recommend improvements to prenatal care for urban Aboriginal women, which may ultimately lead to better birth outcomes in this population.

**Key Words:** Aboriginal, Prenatal Care, Interpretive Description

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## Table of Contents

PERMISSION TO USE	i
ABSTRACT	ii
ACKNOWLEDGEMENTS	iii
TABLE OF CONTENTS	iv
1. CHAPTER ONE - INTRODUCTION AND BACKGROUND	1
1.1 Introduction	1
1.2 Background	2
1.2.1 Canadian Health Care	3
1.2.2 Aboriginal Health Care	3
1.2.3 Aboriginal Women and Childbearing	4
2. CHAPTER TWO - THE LITERATURE REVIEW	7
2.1 Literature Search	7
2.2 Review of the Literature	7
2.2.1 Research Purpose and Questions	10
3. CHAPTER THREE - THE METHOD	12
3.1 Interpretive Description	12
3.1.1 Methodological Approach	12
3.1.2 Setting	14
3.1.3 Sample	15
3.1.3.1 Participants	15
3.1.3.2 Sample Size	16
3.1.3.3 Sampling Method	17
3.1.3.4 Gaining Access	18
3.1.3.5 Recruitment	19

3.1.4	Data Collection	20
3.1.4.1	Interviews	20
3.1.5	Data Analysis	22
3.2	Credibility	26
3.3	Ethical Issues	28
4.	CHAPTER FOUR - THE RESULTS	33
4.1	Being Healthy during Pregnancy is Valued	33
4.2	Prenatal Care is Important, But is Not Without Challenges	36
4.3	Prenatal Care Providers May Not Be Healthcare Professionals	44
4.4	Attendance at Prenatal Care is impacted by Interactions with Healthcare Professionals	48
4.5	A Continuum of Knowing Exists	54
4.6	The Importance of Culture is Multifaceted	58
5.	CHAPTER FIVE - DISCUSSION OF RESULTS	61
5.1	Factors Affecting Health during Pregnancy	61
5.2	Factors Affecting the Perception of the Importance of Prenatal Care	64
5.3	Prenatal Care within the Context of Primary Health Care	66
5.4	Awareness of Prenatal Care Services within the Community	68
5.5	Significance of Support Systems during Prenatal Care	68
5.6	Providing Culturally Safe Prenatal Care	69
6.	CHAPTER SIX - RECOMMENDATIONS	74
6.1	Recommendations for Practice	74
6.2	Recommendations for Research	76
6.3	Recommendations for Education	78
6.4	Recommendations for Policy	79

7. CHAPTER SEVEN – IMPORTANCE AND LIMITATIONS	80
7.1 Importance of the Study	80
7.2 Limitations of the Study	80
7.3 Knowledge Exchange	81
8. CHAPTER EIGHT – CONCLUSION	83
REFERENCES	85
APPENDIX A: Recruitment Poster	92
APPENDIX B: Consent Guide	93
APPENDIX C: Participant Handout	95
APPENDIX D: Demographic Form	96
APPENDIX E: Interview Guide	97
APPENDIX F: Transcript Release Form	98

**The Culture of Prenatal Care in Regina, Saskatchewan:  
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**CHAPTER ONE**

**Introduction and Background**

As a Registered Nurse working on a busy Labour and Birth unit in a tertiary care centre, it appeared to me that an increasing number of women were presenting in labour who had received either very limited or no prenatal care at all during their pregnancy. In addition, it seemed that a significant proportion of these women were of Aboriginal descent. As a result of this observation in my practice, I wanted to further explore Aboriginal women's experiences with prenatal care which ultimately lead to the development and completion of this study.

**1.1 Introduction**

Despite the fact that health care services are considered to be accessible to all Canadians, disparities continue to exist in some areas and populations (Health Canada, 2009). One of these disparities is related to the prenatal care of Aboriginal women (Tough, Siever, & Johnston, 2007). Although prenatal care is available for all women, access to this service is often limited in the Aboriginal population (Smith & Davies, 2006). One factor compounding this issue is that Aboriginal women tend to have higher rates of risk factors that lead to poorer birth outcomes (Sokoloski, 1997; Wenman, Joffres, Tataryn, & The Edmonton Perinatal Infections Group, 2004). Prenatal care is a time when risk factors such as poor nutrition, stress, and lack of support can be identified and minimized through intervention and education (Sparks, 2009). Although the reasons for lower rates of attendance at prenatal care in Aboriginal women have been studied in depth, there is limited research as to how this service could be made more culturally appropriate to encourage attendance and potentially improve birth outcomes. Using an



interpretive description approach, this study explored the behaviours, values, and beliefs related to prenatal care of Aboriginal women in an urban setting leading to the development of recommendations for how prenatal care could be improved and made more culturally appropriate for this population.

## **1.2 Background**

By understanding how health care is provided for all Canadians and more specifically, Aboriginal people, insight can be gained into how the system functions to provide services. Although the Canada Health Act, enacted in 1984 (Department of Justice, 2011), identifies that all essential health care is to be available to all individuals, Aboriginal people continue to encounter challenges when accessing health services which leads to an increased rate of health challenges (King Blood & Roberts, 2008). A plethora of reasons exist to suggest why the health of Aboriginal people lags behind that of the general population including factors influenced by the social determinants of health, as well as the five principles of the Canada Health Act.

The social determinants of health according to population health promotion are “income and social status, social support networks, education, employment and working conditions, safe and clean physical environments, biology and genetic make-up, personal health practices and coping skills, early childhood development and health services” (Cohen, 2008, p. 98). In addition, the Public Health Agency of Canada (2010) includes social environments, gender, and culture in their discussion of the key determinants of health. The World Health Organization (2010) identifies the social determinants of health as “poverty, gender inequality, ethnicity, unemployment, unsafe workplaces, urban slums, globalization, and lack of access to health systems” (para. 2). These interrelated conditions influence the health status of populations

(Cohen). Therefore, it can be expected that if the determinants of health are negatively impacted, the health of the population will suffer.

**1.2.1 Canadian health care.** In 1984, the Canada Health Act was enacted (Department of Justice, 2011). It was a significant accomplishment for Canadians who had lobbied for accessible health care for all individuals. Under the Canada Health Act, five principles including public administration, comprehensiveness, universality, portability, and accessibility were adopted as the foundation for a system that was not predicated upon the ability to pay or the province or territory in which one resided. The intent of implementing these principles was to support a system in which health care would be administered by a public authority accountable to the provincial government. All health services offered by hospitals, physicians, and dentists were to be provided to all individuals, including the most vulnerable, in order to ensure that all Canadians could have access to the health care that they required (Falk-Rafael & Coffey, 2008).

Despite the basic principles identified in the Canada Health Act created in an attempt to ensure equal access to healthcare for all Canadians, disparities continue to exist in some populations. For instance, the health of Aboriginal people considerably lags behind that of the general population; moreover, Aboriginal women have reported significant barriers in accessing health services (King Blood & Roberts, 2008; Young, 2003). Prenatal care has been identified as one of the services that Aboriginal women often have difficulty accessing, and evidence suggests that when Aboriginal women do access this service complexities exist in retaining the women (Smith & Davies, 2006; Tough et al., 2007).

**1.2.2 Aboriginal health care.** In order to develop an understanding of the disparities related to the prenatal care of Aboriginal women, it is beneficial to first understand the health status of Aboriginal people, with specific emphasis on women. In addition, an appreciation as to

how the larger health care system operates, and how services are provided for the Aboriginal population should also be recognized. By developing an understanding of existing policy, nurses working with Aboriginal people can increase the effectiveness of care delivery (King Blood & Roberts, 2008).

The term Aboriginal includes any person who is Indian, Inuit, or Métis as defined under section 35 of the Constitution (Waldram, Herring, & Young, 2006). Through the First Nations and Inuit Health Branch, the federal government is responsible for providing support and health services for First Nations and Inuit people living on reserve and provincially funded health care is reimbursed by the federal government for those living off reserve (King Blood & Roberts, 2008). The provincial government is accountable for the services provided for Métis people (King Blood & Roberts). Although fiscal responsibility for healthcare is the responsibility of the government, Aboriginal people continue to face barriers in accessing services for their health.

The challenges that Aboriginal people face related to their health care needs are unique. In particular, Aboriginal women experience poorer health when compared to other Canadian women and present many distinct challenges for the health care system (Heaman, Blanchard, Gupton, Moffatt, & Currie, 2005; King Blood & Roberts, 2008). Aboriginal women encounter barriers in accessing services related to pregnancy and childbearing such as distance from health services, lack of transportation, feeling uncomfortable with the physician, and not wanting to attend programs that do not meet cultural needs (Baldwin et al., 2002; Long & Curry, 1998; Sokoloski, 1997; Tough et al., 2007).

**1.2.3 Aboriginal women and childbearing.** The current Aboriginal birth rate is about one and a half times larger than the overall Canadian birth rate (Statistics Canada, 2007). Between 1996 and 2006, the Aboriginal population grew by 46 percent, and is expected to

continue to increase rapidly (Statistics Canada, 2008). For these reasons, it is highly likely that nurses working in the area of maternal and newborn health will be providing care for an increasing number of Aboriginal women in the antenatal period.

Prenatal care, as defined by Longe (2006) is “health care given to a pregnant woman and to the developing fetus until the time of delivery” (p. 2206). Prenatal care provides an optimal time to identify women at risk, and implement appropriate interventions and health promotion strategies. This creates the potential to reduce perinatal morbidity and mortality, especially if care is obtained in the first trimester and continued throughout the pregnancy (US Department of Health and Human Services, 2010).

The Society of Obstetricians and Gynecologists of Canada (1998) recommend prenatal visits every four to six weeks in early pregnancy, every two to three weeks after 30 weeks gestation, and every one to two weeks after 36 weeks gestation, which continues to be the current practice guideline. Prenatal care must be initiated early and visits should be continued throughout pregnancy in order to medically manage health complications, provide advice on lifestyle, and offer referrals when necessary (Johnson, Thiede Call, & Blewett, 2010). Ancillary public health programs that promote health and provide support for pregnant mothers are also seen as important supplements to prenatal care with a primary care practitioner (Alexander & Kotelchuck, 2001; Public Health Agency of Canada, 2011). In this study, the utilization of prenatal care by Aboriginal women in the urban location of Regina, Saskatchewan was explored.

Aboriginal women have been identified as having poorer pregnancy outcomes and higher risks of complications when compared to other Canadian women (Sokoloski, 1997; Wenman et al., 2004). Risk factors common to Aboriginal women likely contribute to the poorer outcomes and increased rates of complications (Wenman et al.). Risk factors such as previous premature

infants, smoking, and poor nutrition, can lead to poor birth outcomes such as stillbirth, low birth weight infants, and prematurity (Sokoloski; Wenman et al.). One of the most effective means of improving pregnancy outcomes for women at risk is early and continued access to and utilization of prenatal care (Long & Curry, 1998). In addition, when women have access to improved monitoring during the prenatal period, the risk of infant mortality is decreased (Adelson, 2005). By completing this study, and talking to Aboriginal women themselves, an opportunity arose to develop recommendations for improving prenatal care for Aboriginal women in Regina, Saskatchewan. If implemented, these recommendations may ultimately lead to better birth outcomes in this population.

Late, limited, or even no utilization of prenatal care by Aboriginal women is well documented in the literature (Castor et al., 2006; Long & Curry, 1998; Smith & Davies, 2006; Wenman et al., 2004). Since prenatal care offers a time to provide intervention for women at risk, lack of attendance and retention may increase the likelihood of poor birth outcomes. In order to improve the utilization of prenatal care by Aboriginal women, it has been suggested that more culturally appropriate care relevant to the needs of the population is necessary (Smith & Davies). Traditional prenatal care operates under the Western model of medicine, without consideration of the traditional beliefs systems of Aboriginal people (Long & Curry). This type of care does not provide culturally sensitive services and may be inappropriate for the Aboriginal population. Considerable reflection and evaluation of how services are provided has been explored in order to determine how a more appropriate means of meeting the needs of Aboriginal women could be developed.

## **CHAPTER TWO**

### **The Literature Review**

A review of the literature related to Aboriginal women and prenatal care revealed that scientific knowledge in the area does exist. However, the information is both limited and dated.

#### **2.1 Literature Search**

The search strategy included searching the following databases: CINAHL, Medline, PubMed, The Native Health Database, and Google Scholar. The key words used were Aboriginal, First Nations, Indian, prenatal care, and antenatal care. These words were searched individually and in various combinations. In addition, the references of the relevant articles that were obtained were reviewed in order to locate further literature that may not have been found during the original search. Aboriginal prenatal care did not appear to have been studied in depth in Canada in recent years. Much of the literature was published prior to the past five years, especially articles focusing on Canadian Aboriginal women. Although the existing literature related to the cultural appropriateness of prenatal care is dated, it does provide important information related to the experiences of Aboriginal women.

#### **2.2 Review of the Literature**

Scientific literature has identified that Aboriginal women have lower retention rates and higher attrition from prenatal care in both Canada and the United States, and that Aboriginal mothers receive late or even no prenatal care at all at a rate of twice that of the general population (Castor et al., 2006; Long & Curry, 1998; Smith & Davies, 2006; Wenman et al., 2004). Healthcare providers need to recognize that this issue has a significant impact on the health of Aboriginal women. Smith (2003) suggests that by improving prenatal care attendance, the significant health disparities that exist among Aboriginal women, when compared to the rest

of the population, could be reduced. Since Aboriginal women often present with pregnancy risk factors, it is increasingly important to identify and address a means for improving prenatal care attendance in this population.

Despite the documented benefits of reducing risk factors during prenatal care, barriers continue to exist that impede Aboriginal women's ability to access this service. Distance from health services and limited transportation have been identified as barriers to accessing prenatal care (Baldwin et al., 2002). Psychosocial factors such as not feeling comfortable attending prenatal care have also been suggested as obstacles that impede attendance at prenatal care (Tough et al., 2007). In order to overcome such barriers, programs need to meet the needs of the client and cultural variables must be considered (Tough et al.). Prior to developing new programs, input from women less likely to complete prenatal programs would be of benefit as women may be more likely to attend programs when they are modified to meet their needs (Tough et al.). Although the barriers addressing why Aboriginal women may not attend prenatal care have been well documented, there continues to be a need to identify how these barriers can be removed in order to provide more culturally appropriate prenatal care.

Long and Curry (1998) recognized the need to address how prenatal care could be made more culturally appropriate for Aboriginal women. Several factors were suggested that influence the poor use of prenatal care including the lack of traditional cultural beliefs and the predominately Western model of medicine utilized in prenatal care, which was identified as culturally inappropriate for Aboriginal women. Long and Curry recommended that prenatal care be reconceptualized so that traditional cultural beliefs be incorporated. Despite the findings of their study and the amount of time that has passed since its completion, it is interesting to note that no further research has been conducted to address this issue.

A literature review completed by Sokoloski (1997) adds to the evidence suggesting that there is a need for continued research in this area. In her review, Sokoloski cites six studies that have explored Aboriginal women's beliefs related to childbearing practices, only two of which were conducted in Canada with the most recent completed in 1990. Like other studies, she identifies barriers to accessing prenatal care and the need for more culturally appropriate care; however, a means for how this care should be provided is not suggested (Sokoloski).

Aboriginal women's beliefs related to prenatal care were also explored in order to identify if this issue still exists and how prenatal care can be made more culturally appropriate. Aboriginal women have been identified as a vulnerable group whose needs should be met in a more culturally appropriate manner (Salmon, 2007; Watson, Hodson, Johnson, & Kemp, 2002; Young, 2003). By listening to the stories of the women and incorporating their voice into research, Aboriginal women's experiences are less likely to be misrepresented (Salmon). When participating in interviews, Aboriginal women in this study were free to discuss their experiences related to prenatal care, which provided an opportunity to give voice to a population that is not often heard.

Young (2003) provides evidence that Aboriginal women should be the center of future research. A review of 254 published journal articles related to the health needs of the Aboriginal population suggested that although Aboriginal people have been involved in many studies, the research has not represented some subgroups of the population. In Canada, the empirical literature strongly under represents Aboriginal women as well as Aboriginal people living in urban centers. Future research involving Aboriginal women, especially those living in urban centers should be considered because these individuals may have different health needs and



challenges when compared to Aboriginal people as a whole living in rural or northern communities (Young).

Although several possible reasons have been suggested to identify why the Aboriginal population has poorer rates of prenatal care utilization, a means to addressing how prenatal care could be made more culturally appropriate, was not evident in the current literature. More significantly, there is a lack of recent Canadian literature in the area. Research suggests that Aboriginal women and Aboriginal people living in urban centers have been significantly underrepresented in the scientific literature as the focus of previous research has often been in rural areas. Aboriginal people living in urban areas may have needs that differ from Aboriginal people living in rural areas. By identifying these gaps in the recent literature, an opportunity exists to add to the current knowledge. In this study, it was my intent to address this issue by giving voice to urban Aboriginal women and focusing on identifying a means to creating culturally appropriate prenatal care for this population.

**2.2.1 Research purpose and questions.** Although poor use of prenatal care and the need for more culturally appropriate services have been well documented in the literature, a need existed to explore urban Aboriginal women's experiences related to prenatal care. The purpose of this research was to explore urban Aboriginal women's experiences related to prenatal care within a cultural context with the intent of giving voice to a population not often heard. The objectives of the study were to develop an understanding of the behaviours, values, and beliefs that urban Aboriginal women possess related to prenatal care as well as to identify how prenatal care could be made more culturally appropriate for this population. Through this research, a more comprehensive understanding of urban Aboriginal women's beliefs related to prenatal care

was revealed, which provides the opportunity to recommend improvements to prenatal care for urban Aboriginal women, which may ultimately lead to better birth outcomes in this population.

Based on the objectives above, the following research questions were identified for this study:

1. What are the behaviours, values, and beliefs of Aboriginal women related to prenatal care in the urban setting of Regina, Saskatchewan?
2. Do urban Aboriginal women perceive the prenatal care that they receive to be culturally appropriate?
3. How can prenatal care be made more culturally appropriate for this urban Aboriginal population?

## CHAPTER THREE

### The Method

The method utilized in this qualitative study was interpretive description. Interpretive description is identified as an inductive approach that “extend[s] beyond mere description and into the domain of the ‘so what’ that drives all applied disciplines” (Thorne, 2008, p. 33).

#### 3.1 Interpretive Description

Interpretive description provides a logical structure using qualitative methodology to generate credible and meaningful disciplinary knowledge in the applied sciences especially when the purpose of the research involves understanding clinical phenomena (Thorne, Reimer Kirkham, & O’Flynn-Magee, 2004). Because this study aimed to answer questions related to a clinical context with the intent of informing the future practice of urban Aboriginal prenatal care, the method of interpretive description seemed to be an appropriate fit. Interpretive description is a methodology that has moved beyond some of the more traditional forms of qualitative research such as phenomenology, grounded theory, and ethnography (Thorne et al., 2004). While these methods are very useful for some studies, nursing scholars have found that the strict rules of these more traditional approaches often make it difficult to answer questions related to the applied disciplines (Thorne et al., 2004). For these reasons, interpretive description provided an ideal approach to address the clinical research questions outlined in this study.

**3.1.1 Methodological approach.** In comparison to other methods, interpretive description, developed in the 1990’s by Thorne, Reimer Kirkham, and MacDonald-Emes (1997) is relatively new and was created in response to the need for an approach that would generate an understanding of clinical phenomena within nursing and other health disciplines (Thorne, 2008). Until its development, qualitative nurse researchers were often forced to utilize one of the three

more dominant methods of grounded theory, ethnography, or phenomenology; however, research in the health sciences sometimes deviated from the strict frameworks outlined in each of these approaches (Thorne). In some cases, researchers would claim to utilize one of the aforementioned frameworks; however, the design of the research would stray from the rules outlined in the particular method in order to meet the needs of the research (Thorne et al., 2004). In response to this concern, Thorne et al. (2004) developed an approach that was useful when research questions were not easily answered by following traditional frameworks, resulting in interpretive description (Thorne; Thorne et al., 1997; Thorne et al., 2004).

In interpretive description, data is produced that is applicable to the clinical setting of nursing practice. This creates the ability to build a body of knowledge related to clinical phenomena and its implications. Both practical observations, and the understanding of what is and what is not known based on the existing empirical evidence is important, acknowledging both the practical and the theoretical knowledge that the researcher brings to the project (Thorne, 2008).

After the purpose is identified, questions are generated and fieldwork is completed in a systematic manner. Data are obtained and the researcher extends the interpretive mind to create new knowledge to inform clinical practice. Interpretive description is the answer to the “need [for] new knowledge . . . not so that we can advance theorizing, but so we can have sufficient contextual understanding to guide future decisions that will apply evidence to the lives of real people” (Thorne, 2008, p. 36). Interpretive description does not suggest a specific recipe with clearly identified steps to develop new knowledge; however, it provides options that include some of those steps that are common to qualitative research in general (Thorne).

In order to differentiate interpretive description from other qualitative methods, a constructivist and naturalistic orientation to inquiry is followed. Emphasis on the importance of “the constructed and contextual nature of human experiences that at the same time allows for shared realities” is maintained (Thorne et al., 2004, p. 3). Thorne et al identified three philosophical underpinnings on which the methodology is based using the key axioms of naturalistic inquiry as defined by Lincoln and Guba (1985): “there are multiple constructed realities that can be studied only holistically. Thus, reality is complex, contextual, constructed, and ultimately subjective”; “the inquirer and the ‘object’ of inquiry interact to influence one another; indeed the knower and the known are inseparable”; “no *a priori* theory could possibly encompass the multiple realities that are likely to be encountered; rather, theory must be merged or grounded in the data” (Thorne et al., 2004, p. 3). *A priori* has been defined as deriving reasoning from self-evident logic without observed fact (Merriam-Webster, 2010). Therefore, the third underpinning of interpretive description suggests that theory cannot be developed from logic but is derived from data obtained through empirical research. For this reason, no theoretical base was selected for this study, as it was expected that multiple world views may emerge from the data.

**3.1.2 Setting.** The setting for recruitment of participation for this study was the Al Ritchie Health Action Centre in Regina, Saskatchewan. Regina, the second largest city in the province, is the capital of Saskatchewan and has a population of 194,971 people providing the urban setting necessary for this study (City of Regina, 2010). The Al Ritchie Health Action Centre is a community health centre that aims to promote the health of their clients (Regina Qu’Appelle Health Region, 2010). Any individual may access services at the health centre (R. Witt, personal communication, August 12, 2011). Multiple programs are offered for pregnant

and newly postpartum mothers (Regina Qu'Appelle Health Region) and it is estimated that three quarters of the women who attend programs at Al Ritchie are of Aboriginal descent (R. Witt, personal communication, March 12, 2010).

The Al Ritchie Health Action Centre, as well as programs offered within the centre that target pregnant women and new mothers, are funded by the Regina Qu'Appelle Health Region, the Canada Prenatal Nutrition Program, and the Public Health Agency of Canada (R. Witt, personal communication, August 12, 2011). The Baby's Best Start Program is an example of a community based program that is offered at the Al Ritchie Health Action Centre through the Canada Prenatal Nutrition Program which is funded by the Public Health Agency of Canada (Public Health Agency of Canada, 2011). The Baby's Best Start Program targets any woman with a low to middle income who desires support during pregnancy and up to six months postpartum (R. Witt, personal communication, August 12, 2011).

**3.1.3 Sample.** Specific inclusion and exclusion criteria were utilized to identify eligible participants for the study. In addition, sample size is discussed including sampling method and participant recruitment.

**3.1.3.1 Participants.** The sample for this study was postpartum women who self-identified as Aboriginal, living in Regina, Saskatchewan and who had attended at least one prenatal visit with a health care provider. Although there may exist differences in how First Nations women perceive prenatal care when compared to Métis women, this distinction was not made in this study. Women who self-identified as being Aboriginal and had given birth within the previous six months were included. Interviews were completed after the birth of the baby because at this time, the women were able to provide a retrospective reflection of their experience with prenatal care throughout their entire pregnancy. The timeframe of six months

was chosen because it was expected that the women would still be able to provide an accurate recollection of their experiences at this time. As the time from prenatal care to the interview lengthened, the women may have had more difficulty recalling their experiences.

Since the purpose of the study included exploring Aboriginal women's experiences related to prenatal care, inclusion criteria involved attending at least one prenatal visit with a healthcare provider so that the woman could provide an account of her experience. Therefore, women who had not attended any prenatal care with a primary care physician or other healthcare practitioner were excluded.

In order to avoid issues that may arise with finding translators and translating data from another language, only English speaking women were included in the study. Since the interviews took place up to six months following the birth of the baby, the possibility that potential participants may be pregnant again was recognized; however, this was not encountered. If a participant had self-disclosed that they were pregnant with a subsequent pregnancy, they would continue to be eligible to participate in the study because it was felt that their experience with prenatal care was still important. Women who had given birth to their first baby as well as women who had given birth to more than one child were eligible for participation in the study. Criteria for inclusion in the study did not include whether or not the individual was receiving social assistance. Ethical approval was obtained from the University of Saskatchewan Behavioral Research Ethics Board as well as the Regina Qu'Appelle Health Region prior to beginning recruitment.

**3.1.3.2 Sample size.** In qualitative research it is difficult to determine sample size prior to beginning the research. This is because "qualitative researchers sample for meaning rather than frequency" (Morse, 2007, p. 530). Interpretive description studies can be conducted with

varying sample sizes, but almost always are relatively small between five and 30 participants (Thorne, 2008). The notion of saturation involves sampling until no new information occurs and even when more participants are added to the study, no new information is gained (Morse). For these reasons, interpretive description studies are justifiably small, with the recognition that there will always be more to study in larger and more complex research designs (Thorne).

Although I planned to obtain a sample size that was congruent with saturation as defined above, it was beneficial to have an idea of the number of participants that would be required prior to conducting the research, and a number was necessary from an ethics point of view. As well, by identifying a potential sample size, a better estimation as to the timeframe and the financial needs of the research was determined. An idea of the estimated sample size can be obtained by reviewing previous studies with similar topics. Overall, similar qualitative studies used a variety of sample sizes ranging from 7 to 195 (Heaman & Morris, 2009; Sokoloski, 1997; Steinberg, 1996; Watson et al., 2002).

As a graduate level student, the intent and timeframe for the research is less than for that of many of the studies reviewed above, many of which involved the use of multiple co-investigators in which the research was conducted over a period of several years. In this study it was anticipated that saturation would occur within interviewing 25 women; however it was achieved following the interview of the seventh participant. An eighth participant was interviewed after data analysis had begun in order to clarify some of the emerging data.

**3.1.3.3 Sampling method.** In order to obtain information from a variety of individuals with differing viewpoints and information to share, purposive sampling was utilized. In purposive sampling, the researcher deliberately seeks out individuals who can inform the research (Morse, 2007). By utilizing this method, I was able to obtain a good quality of rich data



without using a large sample size by seeking out individuals whose experiences differed from one another (Thorne, 2008).

As an example, purposive sampling was utilized when it was identified after four interviews that all of the women who had participated had given birth to more than one child. I felt that the experiences of women who had given birth to their first baby may have been different when compared to those who had several children. The nurse at the health centre helped me to identify women who had previously expressed interest in participating in the study and who had given birth to their first baby. I was able to organize interviews with two of these women; however, one did not show up for our arranged meeting time and could not be contacted following. Even though some of the participants had given birth to several children, they were able to share with me their experiences with their first pregnancy which added to the data in this area. In addition, purposive sampling was also utilized to interview a woman who the nurse felt had unique experiences that would benefit the findings of the study. Using purposive sampling allowed me to identify areas where substantive data did not exist; therefore, creating the opportunity to specifically sample in those areas and build upon the existing data (Thorne, 2008).

**3.1.3.4 Gaining access.** Since barriers often exist in obtaining access to a particular group or setting, the researcher will often choose to conduct research in an area where they are already an insider (Thorne, 2008). Despite the benefit of avoiding the early introductions with already being an insider, there are definite drawbacks to conducting research in a familiar setting (Thorne). For example, it may be very difficult for the researcher to separate themselves from the clinical role often finding that it is difficult to avoid being drawn back to clinical activities during research time (Thorne). For this reason, I chose to conduct my research at a health centre that I was familiar with, but that I did not have any previous clinical relationships.

Since I did not possess any previous clinical relationships at the health centre, I needed to take the time to develop a relationship with the staff and the participants. This was done by spending time at the centre and by communicating clearly in a respectful manner, explaining the background of the study, and accommodating the needs of the staff whenever possible. By developing a working relationship with the staff at the health centre, they recognized the importance of the study and eagerly assisted me with participant recruitment. Because the staff already has a preexisting rapport with the clients utilizing services at the centre, they provided an optimal means for helping me to gain access to the population.

**3.1.3.5 Recruitment.** The nurse and the nutritionist who work together at the Al Ritchie Health Action Centre were essential in helping with participant recruitment. The involvement of the nurse and the nutritionist in the study had been discussed with each of these individuals prior to recruitment beginning and they each expressed interest in assisting with the study. It was anticipated that I would identify potential participants when I attended the postnatal activities that occurred at the health centre. It was felt that by being present during the postnatal activities, and by asking the nurse or nutritionist to introduce me and briefly describe the research that I was conducting, the clients attending the services would become familiar with me and the research that I was conducting and would agree to participate.

Once ethics approval was obtained, I met with the staff at the health centre to identify when I would start attending their postnatal programs. It was decided that the nurse would mention the study at a program that was occurring that week to prepare the women for when I would start attending activities the next week. Once the nurse mentioned the study during her postnatal program, several women approached her about wanting to participate. In addition, I had placed posters advertising the study at the Al Ritchie Health Action Centre so that potential

participants were aware of the research being conducted. A sample of the poster that was utilized is included in Appendix A. I received two phone calls from potential participants who had seen the study advertised on the posters.

An honorarium of 30 dollars was provided to each of the participants at the completion of the interview to compensate them for their time. The amount of the reimbursement was not disclosed to the participants prior to the interview in order to avoid any perception of coercion based on financial gains of being in the study. In her work with Aboriginal people, Salmon (2007) has found that providing an honorarium ensures that people benefit from being involved in research and creates the opportunity for the researcher to give back to the participants in a reciprocal manner. Childcare and transportation were also reimbursed if required. The interviews took place during December 2010 and January 2011.

**3.1.4 Data collection.** The data collection method that was utilized in this study was interviews, a common data collection source in interpretive description. In the clinical health field, interviewing is a common practice for practitioners and bringing “subjectively derived knowledge into the disciplinary armament is what draws most health care professionals into qualitative inquiry in the first place” (Thorne, 2008, p. 78). A review of the relevant literature was also used in order to triangulate the data.

**3.1.4.1 Interviews.** As previously identified, eight participants were interviewed using purposive sampling with assistance from the staff at the Al Ritchie Health Action Centre. The nurse provided a brief background of the study at one of her postnatal activities in order to prepare the women for my presence at their next program; however, after mentioning the study, several potential participants approached the nurse and the nutritionist to find out how they could participate. The nurse and nutritionist obtained permission to pass the contact information of the

potential participants on to me. I then phoned each of the women and provided a more thorough explanation of the research and offered to meet with them at their convenience. The participants were given the choice to meet at the Al Ritchie Health Action Centre or in another private meeting area. All of the women chose the health centre.

For thousands of years, Aboriginal people have passed on knowledge using oral traditions between generations (Stout & Downey, 2006). For this reason, the ethics board within the Regina Qu'Appelle Health Region felt that it was more culturally appropriate to obtain verbal consent rather than written consent from the participants. Subsequently, obtaining verbal consent was also approved by the research ethics board at the University of Saskatchewan. The consent protocol included reading a consent guide to the potential participant. After the consent guide had been read and the potential participant indicated that they understood its contents, it was dated and signed by the researcher (Appendix B). After the verbal consent was obtained, the researcher provided the participant with a handout (Appendix C) that included the contact information of the research supervisor and the researcher as well as the research ethics offices at both the Regina Qu'Appelle Health Region and the University of Saskatchewan.

Demographic data as outlined in Appendix D was obtained at the beginning of the interview to ensure the participant met the inclusion criteria. This information was not of a sensitive nature and assisted me in developing a rapport with the participants prior to beginning the open-ended questions. Exploratory, open-ended interviews were conducted with each of the participants. An example of the interview guide that was utilized in the study is located in Appendix E. The participant's perspective about cultural knowledge, beliefs, and practices related to prenatal care was obtained during the interviews. All interviews were audio taped.

At the end of the interview, each participant was asked if they would like the opportunity to review their transcript once it had been transcribed to add, delete, or make any changes that they felt necessary. If they chose not to take advantage of this opportunity they were asked to sign a written statement confirming this as located on the Transcript Release Form (see Appendix F). None of the participants chose to review their transcribed interview.

If a participant had expressed an interest in reviewing their transcript, they would have been asked to identify the best way to be contacted and this information would have been recorded on the consent form. Since it may have been difficult to locate some individuals while maintaining their confidentiality in the study, they would have also been provided an opportunity to sign a written statement on the Transcript Release Form that would have allowed me to use their transcript if I was unable to contact them after making three attempts over a period of fourteen days.

All interviews took place at the Al Ritchie Health Action Centre, although participants were also provided the opportunity to meet in a different private meeting area. One woman who had given birth to her first baby was interviewed, while the remainder of the participants had other children.

**3.1.5 Data analysis.** The objective of the data analysis was to answer the research questions: What are the behaviours, values, and beliefs of Aboriginal women related to prenatal care in the urban setting of Regina, Saskatchewan? Do urban Aboriginal women perceive the prenatal care that they receive to be culturally appropriate? And, how can prenatal care be made more culturally appropriate for this urban Aboriginal population? Prior to beginning the data analysis, the data was prepared by transcribing all of the interviews verbatim (Thorne, 2008).

New researchers should complete the transcription process themselves in order to hear and to focus on what is being told (Thorne) and is the reason why I chose to do this myself.

Once the interviews were transcribed, I listened to the audiotapes while reading the transcriptions to ensure accuracy. I also read and reread all of the transcripts in order to allow for immersion in the data (Thorne, 2008). None of the participants chose to review or to add, delete, or make any changes to the transcripts that they saw necessary as discussed above. For confidentiality, all of the participants' names were removed during transcription as well as the names of family members or friends and any health care professionals that were identified during the interview.

Participants were each given the opportunity to create their own fictitious name so that I was easily able to identify the participants from one another while maintaining confidentiality. If a participant had wanted to use her own name in order to be linked to her story this would have been allowed although it did not occur. All documents will be kept in a locked cabinet in my thesis supervisor's office and will be destroyed five years after the completion of the study. Electronic files will also be kept under password and will be destroyed five years after the completion of the study.

Although a recipe providing the precise steps for data analysis is not provided by Thorne, she does provide many examples of how to complete a meaningful analysis that may be suited to the individual researcher (Thorne, 2008; Thorne et al., 2004). Data analysis began shortly after data collection started because as pieces of data were collected, I immediately began to make interpretations related to what was seen and heard. In the initial phases of data analysis I was careful to react to what was being collected with caution so that I did not focus on what was likely to be found. In addition, Thorne suggests looking for the case that was in contrast to the

others and exploring it further, congruent with purposive sampling. This creates the ability to see patterns in what is common and what is not as common. As a result, a participant who had given birth to her first baby was recruited as well as a woman with unique experiences. These early steps in data analysis helped me to see patterns in the many pieces of data that had been accumulated (Thorne).

In order to obtain a sense of the data, Thorne (2008) suggests using a coding process, although she does caution the researcher of premature coding which may lead to mistakes in analysis that are difficult to undo later. ATLAS.ti 6.2 software was utilized to assist with the coding process. Thorne does not identify a method of coding that is hallmark to interpretive description; instead, she emphasizes the importance of building a theoretical picture that explains variation in phenomenon. Early coding should be broad, so that the researcher does not get derailed in the data. Once broad codes are identified, the researcher can group together these small pieces of data to see how they may be thematically related. This broad based coding is emphasized until the researcher is more familiar with the data and can see the implications of more fine-tuned coding (Thorne). In keeping with the methodological approach of interpretive description, I cautiously used broad coding until I was sure of the direction of the data analysis. I then utilized more fine-tuned coding to help to identify patterns. In addition to coding, Thorne suggests that the researcher will also want to flag important pieces of data such as a model case or important quotes that may be used in the final conceptualization. This ensures that these important bits of information do not get lost or forgotten in the data and is a helpful feature of analysis that I utilized.

After the pieces of data have been organized into patterns, the next step was to identify the relationships that exist between patterns. This involves shifting thinking from individual

cases to the data as a whole, which helps the researcher to identify relationships and intimately understand the data. Thorne (2008) suggests borrowing a technique from one of the other qualitative approaches to guide the researcher in recognizing relationships. One suggestion she makes is to use constant comparative analysis which is common to the grounded theory approach. In using this approach, the researcher compares pieces of data with others to see where relationships exist. This analytic approach is useful in studies where the researcher is attempting to discover relationships related to the human experience and is the reason that it is chosen for identifying relationships in this study. As suggested by Thorne, I used a blank notebook as a journal to document analytic thinking throughout this process (Thorne).

Once relationships have been identified, the researcher must move beyond simply reporting the findings to understanding what the findings mean as a whole, or conceptualizing the findings. This challenged me to identify something new about the phenomena under study, which created the very important interpretive aspect of the research. Thorne et al. (2004) states that the researcher takes ownership of the interpretations “and present[s] them in a manner that transforms raw data into a structure that makes aspects of the phenomenon meaningful in some new and useful way” (p. 6). In order to do this, I asked myself questions such as: Why is this here and why not something else and what does it mean (Thorne et al., 2004)? This helped to drive the interpretive process and created meaningful findings in the research (Thorne et al., 2004). By viewing the findings as a whole, I have been able to suggest recommendations for practice which creates valuable information for healthcare providers working with Aboriginal mothers.



### 3.2 Credibility

Thorne (2008) identifies some common errors researchers may make, to which special attention must be paid in order to ensure credibility of the results. Many of these mistakes can occur during the data analysis portion of the research. For example, new researchers in particular may prematurely close the analysis compromising the credibility of the results and basing the entire analysis on the first piece of understanding which may prevent the researcher from fully understanding the data. The researcher is cautioned to not superficially link data based on preconceived ideas that may have been developed from the literature or from previous clinical experience, especially if the data seems to fit very quickly. Thorne also cautions the researcher to be careful of misinterpreting frequency. If a certain piece of data occurs often, it does not necessarily mean that it is more important. In addition, Thorne states that just because you do not see something in the data, it does not mean that it does not exist. By being aware of these common errors, I was able to self-reflect upon the data analysis as I completed it to ensure that these common mistakes did not occur. In addition, I reviewed my analytic thinking with my thesis supervisor throughout the data analysis process in order to confirm my findings.

Thorne (2008) identifies steps that should be taken as the researcher moves towards the goal of completing a meaningful interpretive description study. The first step is to “confirm your bases” (Thorne, p. 158). As data collection is completed, the researcher must continually step back from the process and ask themselves questions about the findings of the analysis. This includes asking questions related to what is being seen and why it is being seen. This forces the researcher to see different perspectives on what might be found in the data and ensures that the researcher does not become incorrectly absorbed in the data and does not develop biases based on preconceived ideas from clinical practice or the preexisting literature (Thorne).

In order to ensure that my study is credible in this area, I kept a research journal. In this journal, I documented my observations throughout data collection and analysis. This helped me to not only follow the analytic process that I used in the data analysis, but also encouraged me to identify any biases that I may have had in relation to the research. For example, I am an upper middle class non-Aboriginal researcher with previous experience working as a Registered Nurse with pregnant, Aboriginal women who are often of a different social class. It was important to ensure that my own personal feelings and beliefs did not affect the outcome of the research. In order to ensure that this did not occur, I utilized the research journal to self-reflect on my own personal feelings and beliefs throughout the data collection and analysis process. This also helped me to pay attention to what the women were saying, assisting me to hear the perspectives and meanings through their words while ensuring I consciously suspended any preconceived biases and beliefs based on previous clinical experiences and knowledge.

Thorne (2008) discounts the member check that is common to other qualitative research methodologies. She suggests that going back to participants and asking them if the results confirm what was said can be misleading. This is because, in interpretive description, the researcher does not simply recount what the participants say, but instead uncovers insights and interpretations related to the data as a whole. For this reason, the participants were given the opportunity to review their transcripts and make any necessary changes; however, they were not provided with the opportunity to confirm interpretations. A condensed report written in lay terms, including the results of the study will be created and provided to the participants if they chose.

Multiple data sources can be used to triangulate the findings of the study (Thorne, 2008). Sandelowski (1995) refers to triangulation as using one source of data to support data from

another source. I achieved triangulation by comparing the results of this study to the existing literature, congruent with interpretive description.

Finally, the final research product must be critiqued (Thorne et al., 2004). Although self-reflection is important, the new researcher may want to also elicit help from those with experience in the area. In order to ensure credibility of my data, I personally read and reflected upon the transcripts, and data analysis, as well as had my supervisor do the same, as she provides another objective perspective. My thesis committee reviewed and provided feedback on the final product.

### **3.3 Ethical Issues**

It was anticipated that this study would pose very minimal risk to the participants. The research was approved by the University of Saskatchewan Behavioral Ethics Research Board as well as the Regina Qu'Appelle Health Region Research Ethics Board. Participants were required to provide a verbal consent for interviews. A precedent had previously been set in the Regina Qu'Appelle Health Region to approve studies involving Aboriginal people that utilized verbal consent as opposed to written consent as it was seen as more culturally appropriate. Rationale for this included that historically, the Aboriginal culture has been an oral society (Stout & Downey, 2006). Therefore, obtaining written consent may be inappropriate in this population. For these reasons, the use of verbal consent was approved by both research ethics boards and was utilized in this study.

One ethical issue that was considered was the age of consent for potential participants in the study. It was felt that participants attending postnatal programs at the Al Ritchie Health Action Centre may be adolescents who live independently from their parents or guardians and obtaining parental consent would be difficult. By excluding potential participants because of the

inability to obtain parental consent, a significant number of the target population would be unjustly excluded. However, an argument could be made for having these individuals sign their own consent.

Most notably, these individuals are responsible for providing consent for their child. If they are able to provide consent for their child, they should be able to provide their own consent to participate in a study that poses only minimal risk. Research has suggested that adolescents as young as the age of 14 are able to provide their own consent in a competent manner when they are provided with complete information (Lind, Anderson, & Oberle, 2003). Within the Regina Qu'Appelle Health Region, adolescent mothers are able to provide their own consent for procedures such as induction of labour and caesarean section (G. Rosseker, personal communication, April 23, 2010).

Ethics review boards have waived the requirement for parental consent in studies where there is minimal risk to the participants and where obtaining consent is not practical (Rew, Taylor-Seehafer, & Thomas, 2000). The Regina Qu'Appelle Health Region and the University of Regina established such a precedent in 2007 for a research project entitled *Understanding Nurses' Practice with Adolescent Mothers: A View From Both Sides* which required only the consent of the adolescent mothers participating in the study (R. Evans, personal communication, April 26, 2010). As a result of this information, the process for consent for participation in my study did not require parental consent for the adolescent mother; however, the youngest participant in the study was 19 years of age.

The historical context related to research involving Aboriginal women was considered in terms of ethics. Historically, Aboriginal people have been an oppressed population (Castor et al., 2006). In order to not create further oppression by conducting this research, I wanted to ensure

that I was culturally competent to conduct the research. The Canadian Institute of Health Research (2007) has developed guidelines for research involving Aboriginal people. I utilized these guidelines to guide my research and to ensure that it was culturally appropriate for the Aboriginal population.

In accordance with the guidelines, this included undergoing training in cultural competence as well as reviewing the proposal and interview guide with an Elder to ensure that it was appropriate for the Aboriginal population. I completed the Aboriginal Awareness program offered at the Regina Qu'Appelle Health Region and have taken an undergraduate Native Studies course. The intents of the research, the recruitment poster, the consent form, and the interview guide including the demographic data were reviewed at Circle of the Sun, Native Health Services in the Regina Qu'Appelle Health Region as well as with an Elder who has experience working with Aboriginal mothers. All documents were deemed as culturally appropriate.

The anonymity of the participants was respected at all times. Participants were notified that they could withdraw from the study at anytime and that their healthcare would not be affected if they should choose to no longer participate in the research. Finally, participants were provided with the researcher and the research supervisor's contact information, as well as the contact information for the research offices at both the University of Saskatchewan as well as the Regina Qu'Appelle Health Region, should they have any questions about the study.

Although unlikely, because the interview questions were not of a sensitive nature, arrangements were made for participants to be referred to a perinatal nurse counselor, in the event of a negative emotional response or the emergence of any postpartum issues. This was discussed with a perinatal nurse counselor working in Regina, Saskatchewan who agreed to have

women referred to her if necessary. No circumstances in which a participant required referral occurred during the duration of the study.

As a Registered Nurse who works part-time in the Labour and Birth unit at the Regina General Hospital, I recognized that I may have provided nursing care in labour for a client who may have become a potential participant in my study. I recognized the power differential that may exist because of this; however, my role as Registered Nurse in Labour and Birth was not utilized to coerce potential participants into the study. Since an opportunity for bias might exist if the researcher had provided care for a client in labour who later became a participant in the study, any potential participant who had received care from myself was excluded from participating, this however did not occur. It should also be noted that I was on leave from my job as a Labour and Birth nurse from August 2010 to October 2011 while the study was occurring so the chance of this happening was lessened.

Lastly, as a non-Aboriginal individual conducting research with an Aboriginal population, I recognized that the potential for a power differential existed because of the differences in social class and ethnicity. In order to decrease the impact of any power differential in this area, I maintained sensitivity to this, and to any associated biases that may have arisen, throughout data collection and analysis. I also attempted to level the power differential that did exist related to the differences in social class between myself and the participants. For example, the participants were encouraged to choose their own pseudonym for the study. In addition, although I did provide some open-ended questions throughout the interviews, the participants were free to discuss whatever they wanted related to their prenatal care. I also dressed professionally when conducting the interviews; however, I ensured that I was not overdressed in expensive clothing. Each of these strategies was utilized in order to help

level the power differential. I ensured that I increased my cultural competence by taking both an undergraduate course in Native Studies as well as completing the Aboriginal Awareness program in the Regina Qu'Appelle Health Region. I also continuously self-reflected on my own values and beliefs related to Aboriginal women and prenatal care in order to ensure that my interactions with the women were culturally appropriate and safe.

## CHAPTER FOUR

### The Results

Eight interviews were conducted with women who were attending postnatal activities at the Al Ritchie Health Action Centre between December 2010 and January 2011. All of the women self-identified as Aboriginal and ranged in age from 19 to 32. The ages of the newborns at the time of the interviews ranged from four weeks to five months. Participants identified that they had visited their primary care provider between six and 27 times during their pregnancy. One of the women had given birth to her first baby while the remainder of the women had other children.

Data collected during the eight interviews were analyzed. During data analysis, six themes were identified: being healthy during pregnancy is valued; prenatal care is important but is not without challenges; prenatal care providers may not be healthcare professionals; attendance at prenatal care is impacted by interactions with healthcare professionals; a continuum of knowing exists; and, the importance of culture is multifaceted. In the following sections, each theme will be discussed in further detail, including exemplars to enrich the discussion of the findings. Participants are identified by their chosen pseudonym.

#### **4.1 Being Healthy during Pregnancy is Valued**

It was important for the participants to be healthy during pregnancy. The ultimate goal for each of the women was to achieve a healthy pregnancy so that she would be rewarded with a healthy baby. For example, Angela said, *“just caring for your health of your body and understanding that you need to take care of it in order for the baby to become healthy”* was significant to her. Several different behaviours contributed to a healthy pregnancy: eating healthy, taking vitamins, appropriate weight gain, exercising, abstaining from drugs and alcohol,



and utilizing written resources. It was identified that healthy behaviours lead to a healthy pregnancy which would result in a healthy baby.

Eating healthy was seen as beneficial in order to achieve a healthy pregnancy. When asked what could be done to attain this, “*eating right*” was identified repetitively. For Lisa this meant “*knowing what to eat and what not to eat.*” Examples of this included eating a lot of vegetables and fruits, avoiding junk food, and not eating out at restaurants. Eating small meals and snacking often as well as drinking milk and avoiding pop was useful in maintaining a healthy diet. Programs in which the women received milk vouchers were utilized and were perceived as beneficial in helping to achieve the recommended dairy intake. A healthy diet also included taking maternal vitamins during pregnancy in order to have a healthy baby. “*You’ve got to make sure you’re taking your multivitamins . . . and if you don’t . . . well not saying that . . . you’ll have an unhealthy baby . . . but still there are risks when you don’t take it [multivitamin]*” (Barb).

While the women wanted to engage in healthy behaviours, being healthy was not always easy. For example, although the women wanted to eat healthy, barriers were identified that created challenges to them doing this. Living with family members who often ate out at restaurants where there were not a lot of options for healthy food choices made it hard to maintain a healthy diet. Lisa said, “*It was kind of hard, because my family, we kind of eat out lots.*” Several participants had difficulty eating healthy because of limited financial resources. For example, it was difficult to purchase the more costly healthy foods and to meet the recommended caloric intake with enough proteins and snacks on a limited budget provided by social assistance.

*She [the healthcare worker] wanted me to get a certain amount of calories, a certain amount of proteins and stuff like that each day but it was like for me there were barriers .*

. . . *I was on [social] assistance, some of the things she was talking about like snack wise, wasn't realistic in my budget (Angela).*

Limited transportation created further challenges, and sometimes barriers, to the women in getting to the grocery store to purchase healthy foods. Vannah said, "*Because of money . . . [I] don't have really much transportation to get anywhere . . . Having the money to buy the groceries [is difficult] but also getting there is an issue too.*"

Eating healthy and exercising were also associated with appropriate weight gain. Jill identified that you had to eat healthy "*not to get over weight I guess. You got to watch your weight because sometimes you could gain too much weight and have a big baby.*" Exercising also contributed to appropriate weight gain with the main means of exercise being walking.

Remaining alcohol and drug free was optimal in maintaining a healthy pregnancy; however, difficulties associated with addictions were common. The women recognized that there were potential negative consequences to using substances. For example, Sally shared her experience with addiction in a previous pregnancy:

*I know from personal experience, from having one baby that I used [drugs and alcohol] with, I only used with one of my babies . . . she's not handicapped or anything, but she develops slower and stuff like that and you know, I don't know, it's just not healthy to be using or drinking when you're pregnant. And I always heard that, you know with my other kids that I had before, so I never did but I was just in a bad time and I never really thought about that, and I remember having her and being so scared. . . . That was the only one where I ever really got really, really scared . . . I felt really guilty . . . I did that to her.*

Lifestyle was a factor that impacted whether women avoided or used substances during pregnancy. For instance, Angela said "*there is stuff . . . that needs to be done if you want a healthy baby . . . girls that are in a negative lifestyle, just knowing that simple things like that [avoiding substance use] can prevent like FAS.*" Lifestyle choices were also perceived to impact the outcome for the baby. Barb stated "*you can't be drinking, you can't be smoking, you can't*

*be doing drugs. You don't want your baby coming out with disabilities and stuff like that.*" By being truthful about substance use in pregnancy, healthcare providers could assist the women in identifying the best means of getting help and having the healthiest baby possible.

*No matter what you've done or what you're doing, your number one priority has to be your baby. Just above everything. Just make sure that your baby is okay, you know, come in and get a milk voucher even if you're out of it and they know you're out of it or you're doing something you're not supposed to be doing - just like try to come make your baby healthy. It's your ability to do what you can* (Sally).

Access to written resources also encouraged a healthy pregnancy. Reviewing resources such as the Canada Food Guide and handouts on fetal development encouraged the women to be healthy and to control gestational diabetes. A book that explained the different stages of pregnancy promoted bonding with the unborn baby which helped participants to be motivated to remain healthy and choose healthy behaviours. *"Actually having . . . the hard copy in front of you, being able to see it . . . for myself, I find that to be a real motivator and help"* (Angela).

#### **4.2 Prenatal Care is Important, But is Not Without Challenges**

Prenatal care was obtained from a variety of healthcare professionals. All of the women had attended prenatal care at a physician's office and/or with a nurse practitioner and had accessed services at a community health centre. When asked who provided prenatal care the women included a physician, a family doctor, a gynecologist, an obstetrician/gynecologist, a nurse practitioner, and a nurse. Friends and family were also viewed as significant in providing prenatal care. Information offered by friends and family members who had already given birth helped the women to know what to expect in pregnancy and after the baby was born, and therefore was included in their understanding of prenatal care. You get prenatal care from *"a nurse or a doctor . . . or friends or family that already gone through it. . . I was mostly getting my information from my mom"* (Lisa).

A variety of activities occurred during prenatal visits with a healthcare provider: being weighed to ensure a healthy weight gain, having blood pressure checked, measuring the abdomen for fetal growth, checking which way the baby is lying, listening to the baby's heartbeat, checking glucose levels, having blood work done, having urine tested, having ultrasounds, and getting vitamins prescribed. During prenatal visits, the women were asked how they were feeling and whether they felt anything was wrong or if anything was bothering them. They were also encouraged to ask any questions that they may have in relation to their pregnancy.

When asked what prenatal care was to them, participants focused initially on assessments of both the mother and the baby to ensure a healthy pregnancy. For example, prenatal care to Jill was "*checking on the baby and making sure everything is fine with the pregnancy.*" Similarly Sam said "*making sure baby is healthy and I'm healthy, and make sure everything is going well.*"

After further discussion, it became clear that prenatal care meant much more to the women than simply assessing the mother and baby. The participants' perceptions of prenatal care encompassed a broad variety of assessments, information, services, and programs. For example, Sally said:

*It [prenatal care] just means like looking after the mom, making sure she's healthy and making sure she's alright. She has her vitamins, she has her food, you know, making sure she's taking care of herself properly. Like you know getting her any kind of resources she needs. If she's drinking or into drugs you know, just making sure you're offering everything you can for the mom to have a healthy baby I guess.*

Similarly, Lisa said, "*I think prenatal care is basically finding out like what you're going through, what your body is going through, the changes that are happening and what to expect and what to expect after your baby is born.*" This type of care was obtained not only during

visits with the physician or nurse practitioner, but also during attendance at programs offered at a community health center such as the Baby's Best Start program and other prenatal groups. These programs were perceived to be just as significant as the care that was received from the physician.

The women described participating in activities that helped them prepare for the arrival of the baby and to know what to expect before and after the birth of their baby as well as how to take care of the newborn when attending programs at a community centre. Barb said *"being able to have the resources and the information, what to do and how to do it"* was of benefit. Examples of topics included learning about: baby blues and depression, how to care for the newborn's umbilical cord, and what to do if you can't get your baby to stop crying. Lisa said that she liked when *"one girl actually came with her baby and we learned how to clean the baby's belly button"* and that she learned *"a lot about the baby blues and depression and what to do with it and if your baby won't stop crying, what to do and stuff."*

Information was also provided regarding the labour and delivery of the baby. For example, women described learning about caesarean delivery as well as operative vaginal deliveries. A hospital tour was also included in prenatal care. Vannah described her prenatal care as: *"they tell you like what to expect and everything and like slideshows of doing the umbilical cord and . . . caesareans . . . the different tools that they would use if you had complications giving birth . . . and I got the hospital tour."*

The women also perceived significance in other activities and services that may not traditionally be included when thinking of prenatal care. For example, cooking classes, in which the women learned how to cook healthy foods, were included when discussing prenatal care. Angela said *"I was coming . . . for cooking classes."* At the community centre, participants were

also provided with milk vouchers and linked to other community resources such as the Good Food Box which they considered part of their prenatal care. Vannah said *“getting milk for the baby and everything was good . . . and they . . . helped me as best, as much as possible like to get the Good Food Box.”* Barb said *“it [prenatal care] helps . . . you get seven litres of milk a week, that helps a lot. Because you’re supposed to get as much milk as possible when you’re pregnant.”*

Although the women all described different experiences, one belief that the women all shared was that prenatal care was important. They wanted to know that their babies were healthy and this seemed to be of the utmost importance to each of the women. They felt that by attending prenatal care they were able to find out if there was anything wrong with their baby and possibly prevent anomalies from occurring. Sally said that prenatal care is important,

*Because there is lots of things that you might not see without prenatal care. Like abnormalities or something going wrong with baby . . . and you wouldn’t know those things without ultrasounds or coming to the doctor and stuff like that. And then if you’re not getting it, ultimately your baby could die and there could have been something you could have did if you would have went and got prenatal care.*

Angela felt that if there was *“something wrong, being able to detect it earlier”* would be possible if the woman was attending prenatal care and Jill said that you have to *“make sure that you’re fine so that the baby is not sick.”* In the opinions of the women, the ultimate goal of having a healthy pregnancy and baby was achieved by attending prenatal care which encouraged healthy behaviours. It was a positive experience for many.

*I enjoyed it, being able to . . . care of yourself and your baby and eating healthy and doing what’s best for yourself and your baby, like your unborn child is the best thing possible for someone who is pregnant. Prenatal care means a lot to me basically. It’s very important. (Barb)*

Although prenatal care was seen as important, improvements were suggested to assist the women in more easily accessing the service. Accessing prenatal care was often difficult due to

location of services further complicated by difficulty with transportation. Issues with not having a reliable vehicle, having to borrow a vehicle, not having a valid driver's license, or not having the finances to pay for a cab or bus fare were common. *"See like right now I have my boyfriend's car. I don't have a vehicle"* (Angela). It was difficult to rely on friends or family members because most of them were at work when transportation was required. *"I was always home alone because my family worked . . . I don't have my license yet . . . I always had to find a ride"* (Lisa). Walking was a common mode of transportation if the woman lived close to where her appointment was; however, walking was not an option in poor weather, when several other children needed to be taken along, or in the case of Vannah: *"I tried not to do as much walking because of my first trimester, the bleeding."*

Although a lack of transportation was common for the women, being provided cab vouchers through community based programs to attend doctor's appointments, ultrasounds, and programs at the health centre was helpful. Women who had not received cab vouchers during part of their pregnancy or in other pregnancies found that it was very difficult and that they would often have to miss their scheduled appointments due to an inability to find transportation. *"I struggled with my other kids because I didn't know they'll give cab vouchers here [at the health centre] to go to the doctor and to go to . . . your ultrasounds and stuff like that whereas before [in previous pregnancies] it was . . . hard"* (Sally). Those who used the cab vouchers said that if they had not had them, they would not have been able to attend some or all of their appointments. *There was some times when [the nurse] would give me a cab and that was a very big help . . . because if it wasn't for that, I probably would have missed so many appointments"* (Angela).

Other children were a factor that impacted the ability to access prenatal care as it was often difficult to access prenatal care when other children had to be taken along to appointments. Participants who walked to their appointments or took the bus found it very difficult with other children. Angela often had to carry her other child with her when she walked to appointments. *“I was bigger, she [her daughter] was getting bigger . . . trying to lug her around and carry myself [was difficult]”* (Angela). When asked if it was difficult for her to access prenatal care, Angela, who had another small child said:

*It was yah, like daycare wise I had to always try find a way. Because she was so small it was so hard to take her to appointments so like that was a major barrier right there too. So like having small babies and still trying to make it to your appointments. In some cases I would have to cancel appointments just for the fact that you know maybe she fell asleep or something.*

Often the women had no choice but to struggle with taking their children with them or with missing their appointment all together because it was very difficult to find reliable childcare. *“I try to get a babysitter but everyone is working”* (Vannah). Barb said *“That’s the thing that kind of stopped me from getting the prenatal care . . . because my partner, he works too, so it would be kind of stressful trying to take all my babies to a doctor visit.”* If a child was ill, the woman would not be able to take them along to the prenatal visit and if there was no one available for childcare, the appointment would be missed. *“If my children were sick, I wouldn’t like to take them along with me . . . so that would kind of make it hard to go [to prenatal care]”* (Barb). At community based prenatal programs, where there was often childcare available for other children, the women found this very helpful. The women felt that it would be beneficial if there was someone to watch other children during prenatal visits with the physician as well. Angela said, *“Honestly, I guess having a reliable babysitter would have been something that would help . . . in regards to the prenatal care . . . you couldn’t just ask anybody to watch your*



kids” and Vannah said *“If they had somewhere to take the kid while you go into the appointments”* it would be helpful.

Participants felt that accessing prenatal care and getting around became increasingly difficult as they progressed in their pregnancy and got bigger in size. *I wasn’t real adamant about coming [to prenatal care] when I got bigger”* (Angela). This compounded factors related to location of services especially when attending prenatal care was already complicated because of issues with transportation and other children. Sally said it was a struggle *“especially when you have younger kids and you’re big and pregnant, trying to catch a bus around.”* Better options for transportation and childcare would assist the women in overcoming issues related to mobility during the later stages of their pregnancy making prenatal care more accessible.

Accessing prenatal care was difficult when the distance to a doctor’s office or a community health centre that offered prenatal programs was far, especially because transportation was an issue for many of the women. If they lived distant to where services could be accessed, it was difficult; if they lived close to their physician or community health centre, it was easier to access services because they could often walk to their appointments. For example, when asked what would have made it easier to access prenatal care, Lisa responded *“if it was like walking distance for me.”* Several women said that they had purposely accessed programs at a particular community health centre because it was close to where they lived. *“I came here because they offer the prenatal classes here and it’s closer to where we were living”* (Sam). But after relocating within the city, Sam said *“I’m way across town now, so it does make it harder to get here.”* Having a community health centre in each end of the city would make the services more accessible for the population. *“I think it would be nice to have one [community health centre offering prenatal programs] closer to home like at least one in each end of town”* (Lisa).

Difficulty in accessing prenatal care was also associated with issues in obtaining appropriate referrals. Angela said:

*There was a time there when I was I guess caught in between doctors and there was a point there where I hadn't seen a doctor for just about two months in the middle trimester . . . and because of the fact that I didn't see that doctor I didn't have vitamins for that long because I was told to wait to see that doctor, but you know the referral service, I don't know what happened with that situation.*

Vannah described a very stressful experience in trying to find a physician to provide care during her pregnancy: *"It was stressful . . . and I didn't know what to do."* When she could not find anywhere else to go she presented to the Emergency Department. *"So I just went to Emergency and they did an emergency ultrasound but everything was all right, but then I asked them if I could get referred to an OBGYN so they referred me."* She felt that had she not gone to the Emergency Department, it likely would have been several more months before she would have seen a physician: *"I probably wouldn't have gone to an OBGYN till later when I was a couple more months [pregnant]"* (Vannah).

Although several of the women had difficulty in obtaining referrals for physicians, women who attended services at the health centre first and were later referred from the health centre to a physician found the process extremely straightforward. Established relationships with the staff at the health centre often resulted in a referral to a physician that would best meet the preexisting needs of the client based on her personal circumstances.

*They pair you up with doctors here [at the health centre] that are used to . . . deal[ing] with moms that have used [drugs] or drank you know so that they're not brand new to the situation . . . they try to accommodate your needs* (Sally).

The barriers that the women were confronted with could be lessened if they were able to receive all of their care in one place. As an example of this, Vannah described how it was easy for her to get prenatal care from a care provider who worked at the hospital because she could

get her blood work done simultaneously. *“It was in the hospital . . . so it was easy to get there and if I needed blood work done, it’s right there so I don’t have to go somewhere else to do it”* (Vannah). Sally accessed her prenatal care from a health centre; however, during the late stages of her pregnancy she had to be referred to a physician in a different setting. She felt that having a physician working at the health centre to see prenatal patients while accessing other services would have been very beneficial. *“That would have been better to have one [physician] that comes in . . . that would be good. . . . Come [to the health centre], see your doctor, get your milk voucher, and all the other things that you would do”* (Sally).

Long wait times to see physicians in an office were common and not appreciated. *“Waiting [was bad] . . . it took awhile and the OBGYN was always backed up”* (Vannah). However, when services and programs were attended at a community health centre, the activities were often conducted in a group setting. When activities were conducted in a group setting, women did not have to wait for a specific appointment time, which was beneficial.

#### **4.3 Prenatal Care Providers May Not Be Healthcare Professionals**

The support people were the ones that were there for the women during their pregnancy. *“Having support, that’s really important. I found it very, very helpful to always have someone there to talk to . . . or [answer] questions”* (Barb). On the most part, women felt very well supported during their pregnancy; however, a few of the women had very limited supports within their family. These women relied on other women and healthcare professionals for support. The women included their family members, partners, friends, other mothers, and health care professionals as supports during pregnancy. A variety of family members served as main support people including: partners, fathers, mothers, mother-in-laws, grandmothers, sisters,

aunts, and other children. The support that these individuals provided for the women included answering questions, listening, and helping them to find programs and resources.

Women counted on their support people for help when it otherwise would have been difficult to attend prenatal care. They provided child care or transportation for the women, when possible, so that they could attend services. In addition, they provided reminders for the women to attend prenatal care and programs and to take vitamins.

*If I would forget to take my vitamins . . . they would ask me if I took them. Or if . . . I needed a babysitter . . . if my dad wasn't working . . . or my sister [they] would come. . . . You know, they helped out. . . . That's when the whole support system comes in and having somebody there [is] a major thing to prenatal, for the fact that [without support] I wouldn't have ever been able to go (Angela).*

On the most part, support people shared the same beliefs as the women related to prenatal care and the importance of attending. When asked what she felt her support people believed related to prenatal care, Sally said *“that it's important to go and that you know it's not so much where the mom's coming from but like what kind of care she's getting and how good of care she's getting for that baby.”* Lisa said that her support people felt that prenatal care *“is necessary and you should do it if there is an opportunity for it.”*

Although it was clear that prenatal care was important to the women and to their support people, there were differing experiences related to the service across generations. One participant suggested that older people had a different way of thinking about prenatal care because it was not around for them. *“They are very old so they, they think different from way back in the day, not to now”* (Tara). Angela stated that the younger generations such as her sister and her friends have *“the up to date mentality that it [prenatal care] has to be done.”*

The women felt that prenatal care did not exist when their mothers and aunts had their children. Because of this, the participants felt that women in this generation did not know what exactly occurred during the care.

*My mom, she never attended prenatal care . . . so whatever she knew, she just tried to teach me too . . . but she didn't know what you shouldn't be doing when you're pregnant . . . she didn't take prenatal vitamins and what they have now to make sure your baby is the healthiest baby possible (Barb).*

The women did recognize that even though many of their support people had not attended prenatal care, these individuals were still supportive of them and encouraged them to attend the service. *"My mom and them . . . when they were pregnant . . . I don't even think they had prenatal care . . . [but] my mom would drive me to my appointments and take me for the blood work"* (Jill).

The women were not able to identify what the beliefs of their partner would be related to prenatal care; they stated that it was something that they did not talk about. *"My partner . . . he doesn't really talk about it [prenatal care]"* (Jill). However, their partners were viewed as supportive, encouraging them to attend care. Many of the partners attended prenatal visits with the women. *"He was very supportive through the pregnancy . . . helpful, understanding. And he came to . . . all my doctor's appointments, he never missed. It was very, very important to him"* (Sam).

Support from other mothers was important. Participants felt supported by other mothers when they attended group prenatal activities and shared their experiences. *"When I'd come here to the prenatal classes, I found support through the other women"* (Sam). In her discussion of support from other mothers, Jill said:

*It's still good to come and have other mothers to talk to . . . and sometimes there's even new mothers that you could pass some of whatever on to them, like information.*

*Sometimes moms just want to have someone just to listen . . . they don't have that at home sometimes.*

Angela received support from other mothers while attending a cooking class: *"there would be just chatting, you know, having girl talk in the kitchen and there is stuff that you know you pick up and you're like, wow, I didn't know that."* Vannah also valued the support she received from other mothers:

*Like we talk about housing and . . . websites where you can get free stuff or like cheap stuff or if someone wants to give something away, they let the moms know. Okay, I've got this to give away and they will ask if you want it or if you need it. Yah, and then . . . they'll discuss about the kids and everything else.*

Angela suggested that more support groups for pregnant mothers with high-risk pregnancies would be of a benefit because the women could get support from each other. *"A group . . . [of women that have diabetes] . . . that would be a resource to people especially with prenatal care"* (Angela). She felt that the women could learn from each other and share what was working or not working for them in relation to their diabetes.

In addition to receiving support from other mothers, the women discussed the significance of getting support from role models who had previously had similar experiences. For example, the participants suggested that it was beneficial for younger female siblings to observe the women attending prenatal care so that they understood the importance of regular attendance. Angela said: *"For my sister I think just seeing me going through the steps of actually having to go to the doctor and showing that it's important"* was good. In addition, Barb said that getting support from women who had older children was important to her, *"especially like women who are a bit older and they have like children who are older, I look for their support because my children are still young, it's very helpful . . . passing information down to each other."* Knowing what other women had done previously with their children was beneficial

because often information was revealed on what worked and what did not work for other mothers.

#### **4.4 Attendance at Prenatal Care is impacted by Interactions with Healthcare Professionals**

Interactions with healthcare professionals directly affected the desire to attend prenatal care. If interactions were positive, the women felt comfortable and wanted to attend care; if interactions were negative, they were discouraged from continuing to utilize the services on an ongoing basis.

Several attitudes and behaviours displayed by healthcare professionals encouraged the women to want to return and continue to attend care. Words that were used to describe the positive behaviours that healthcare professionals displayed included: non-judgmental, happy, interested, open, honest, open-minded, friendly, helpful, nice, kind, and a good listener. It was when these behaviours were displayed that the women felt welcome at prenatal care and wanted to continue to attend. Of the positive behaviours that the participants discussed, it was when the professionals displayed non-judgmental attitudes that the women truly felt comfortable in developing relationships with the providers.

*They didn't make you feel like they were judging you. They just really let you know that they were here for you, to support you. . . . [The nurse] didn't make me feel anymore [badly] than what I was feeling. . . . It's like they were there to help you, not to judge you (Sally).*

Feeling supported during prenatal care, no matter what their lifestyle choices included, was essential to the women. Participants felt supported by healthcare professionals when explanations were provided, questions were answered, resources were offered, and when the healthcare providers were available when the women needed to talk.

*[They were] really supportive for anything, I could have phoned them and asked them for any kind of programs or anything and they would have gone to the limits to try and help me out to make sure I got whatever it was that I needed" (Sally).*

The women wanted to feel comfortable when interacting with the professionals and Sally said this was accomplished by “*having the right people*” who provided support to the women. The nurse provided support for Sam: “*She [the nurse] was very helpful and listening when I needed to talk, when I felt stressed.*” Healthcare professionals who were perceived as supportive at times became the women’s main support, something which was very important to them.

Some behaviours helped the women to feel supported. When the healthcare providers concentrated on what was being done that was positive instead of always focusing on the negative the women felt comfortable in repeatedly returning for care. “*They obviously knew that you had issues . . . but they didn’t try and concentrate on too much of that, they try to concentrate on what you were doing positive to help yourself*” (Sally). Sally, who struggled with addictions during a previous pregnancy said:

*I came here, for like my last couple of months and I mean they supported me, as much as they could, you know. Like not condoning what I was doing, they knew what I was doing. But just making sure that I still had, you know, bread or like milk, or juice, or like making sure that the baby was still okay and growing and stuff like that.*

When Sally stopped using drugs during a subsequent pregnancy she felt supported by one nurse when she said “*she was so excited to see me in there the second time. And she was like ‘oh you’re clean and baby is healthy.’ She’s like ‘you’ll get to take this one home.’*”

Lisa felt supported when she was encouraged to attend programs that occurred at the community health centre. She described getting a phone call from the healthcare providers in the morning before a program was occurring. This helped her to feel welcome at the program and also reminded her to attend. “*I got the wake-up call . . . because I was always sleeping . . . [they] asked if I was able to get up and I’d get up and get ready*” (Lisa). The women also felt supported when they were given the contact information of other community resources which



linked them to other services. This included being provided with information related to support groups and other services such as The Good Food Box and Baby's Best Start Program available in the community.

When the women were familiar with the healthcare professionals and the setting that the care was provided, they were more likely to continue to attend the service. Sally, who had attended programs at the health centre in a previous pregnancy said, *"Then when I got pregnant with my last baby, this is where I came, like right away."* Sam described how she had moved across the city and was now living closer to a different health centre. When asked why she continued to attend programs at the original health centre even though she lived very far away Sam stated *"this is where I started my prenatal care and I feel comfortable here, I know these ladies here. . . . I kept coming back because it was a good place to come."* In subsequent pregnancies, the women would return to the same physicians and programs because they had already established positive relationships in a familiar setting.

When prenatal care was flexible and altered to meet the needs of the client, experiences were positive. For example, one participant, whose pregnancy was complicated with gestational diabetes, had a very positive experience with a nutritionist. The nutritionist helped her to develop a diet plan that was flexible and met her dietary needs while being realistic and affordable on a limited budget provided by social assistance. *"The nutritionist . . . he did a good job trying to give me more leniency . . . giving me more ideas than just telling me this is what you need to [eat]"* (Angela). This flexible care met the needs of the client while respecting her individual situation. Vannah had a positive experience with appointment times in the care that she received from her physician. *"If I couldn't make it then I would phone and let them know*

*that I would be there for a later time” (Vannah).* This flexibility enabled the women to meet their needs while still receiving the best care possible.

The women appreciated when the care that they received was personal. They preferred when healthcare professionals knew who they were and provided care that was personalized to meet their specific needs. They disliked sitting in a physician’s office for several hours only to be quickly seen by the physician in an impersonalized manner. The women preferred to be provided care from an individual who knew who they were and who would adjust the care to their specific needs.

*It was just more personal here [at the health centre] and you’d think a doctor’s office would be more personal but he wasn’t. It’s kind of like just a number and you’re sitting there forever waiting to get in whereas here [at the health centre] . . . it’s very, very welcoming (Sally).*

Unfortunately, not all interactions with healthcare providers were positive. A lack of respect for the women and their life situations often complicated interactions. When this occurred, the women did not want to attend prenatal care which consequently led them to missing appointments or to not going at all.

There existed a lack of confidence in the care that was being provided. For example, Jill, who had attended prenatal care during several other pregnancies, perceived a lack of confidence in a new physician. She felt that this particular physician was not completing all of the assessments and tests that should have been done. She felt as if she had to constantly ask her physician to do assessments that had been completed in previous pregnancies. In her description of her lack of confidence in her care she said,

*I didn’t like it, I felt like I wasn’t getting good care. . . . She was supposed to do PAP tests and stuff. I didn’t get that done. . . . I had to tell her a lot of stuff. . . . I’m supposed to be the patient . . . am I supposed to look after myself now, or what’s going on?*

Jill decided to change physicians because of her lack of confidence in the care that was being provided.

Vannah was frustrated when her due date had been written incorrectly at her physician's office, so that when she ruptured her membranes the healthcare providers treated her as if she was six months pregnant instead of being full term. She stated that everything was really confused and difficult, but that she gave birth to a healthy full term infant. She described feeling disappointed in relation to her care:

*My water broke and they were like we only have you marked as six months [pregnant]. I was like, no, I'm full term. . . . They had everything confused . . . I wasn't too happy. . . . I just felt like they weren't on top of things (Vannah).*

Lisa, who suffered with severe morning sickness, did not feel confident in the care that she received because her physician did not provide her any treatment for her nausea and vomiting despite continued weight loss. She said that she felt mad when one of her family members told her that there was a medication that could have been prescribed and that she had never been offered this treatment.

*I couldn't keep anything down. . . . I found out from one of my uncles that there is a pill or some vitamin that they can give you that helps . . . but I wasn't offered that. . . . It made me feel mad and sad because I lost lots of weight . . . it was just hard (Lisa).*

The care that was provided was often perceived as authoritarian in which the women were told what they had to do even if it did not meet their needs, or was unrealistic with their given lifestyle. For example, Angela, who had been diagnosed with gestational diabetes, said “*I kind of felt pressured into something that was a little beyond my control since I was trying to adjust to the diet she [the nutritionist] was I guess giving me, yah I guess giving me.*” She felt that she was given a very strict diet plan that was unrealistic for her circumstances and was therefore unachievable. Participants with a history of substance abuse were often told to quit

using drugs or alcohol without being given adequate support or resources to be successful, making quitting very unrealistic. *“Just show them all of their options instead of just sitting there and being like, oh you gotta quit [using drugs and alcohol], oh that’s no good for baby. They know those things already”* (Sally).

Participants perceived that incorrect judgments were made as a result of healthcare providers using stereotypes. The women felt that they were often looked down upon by some professionals which caused them to not want to access care at all. Tara, who had previously struggled with drug addiction, said *“I didn’t feel comfortable going to things because everyone thinks once you’re a drug addict . . . you’re always a drug addict . . . if they know that you were addicted to something, that’s how they treat you. They think you don’t care.”* Sally, who had a similar experience said:

*I had gone to a doctor and I [felt] . . . really looked down upon and I already felt [bad] about myself for doing what I was doing. So then I stopped going for prenatal care because I was too embarrassed. . . . I never went back to the doctor for another four months after that.*

Even when she returned for care, she said that she felt stereotyped that she was just another Aboriginal woman who was using alcohol and drugs and who was going to lose her baby. She said:

*You gotta remember in like healthcare, there’s people coming from all walks of life and you don’t know where they are coming from or what they’ve been through . . . I think it would be better for healthcare people to have more open-minded and . . . [be] not so judgmental* (Sally).

When asked how healthcare professionals could provide care that was not so judgmental, Sally said:

*They know what they are doing is wrong already; you don’t need to point that out to them. Like maybe just show them their options, like maybe different treatment centers or detox . . . or maybe trying to tell them just to cut down . . . . Or offer them counseling or something.*

#### 4.5 A Continuum of Knowing Exists

There existed a continuum of knowing as women progressed from experiencing prenatal care during their first pregnancy to experiencing prenatal care after several pregnancies. One common finding was that no matter how many times the women had been pregnant they continued to feel that prenatal care was important. Jill, who had given birth to several children said, “*even though some of the stuff I hear over and over again . . . it’s still good to come*” in her discussion of attending programs at a health centre. Sam said that she had forgotten a lot of things from her first pregnancy. When she was pregnant with her second baby, it was important to attend prenatal care with the physician as well as programs at a community health centre so that she could have her questions answered and so that what she already knew could be reinforced:

*My youngest was four when I had gotten pregnant with James. I forgot a lot of the stuff . . . any questions I had . . . like you know in the middle of the night . . . the next morning they’d be like oh it’s okay and they would explain to me . . . it was like, now I remember (Sam).*

Barb said “*every pregnancy I did learn a lot more*” and Tara found that there was often new tests and procedures offered as she had more babies that had not existed with her first pregnancies.

The participants identified that they simply did not know about programs that were offered at community health centres during their first pregnancies. Jill said “*when I was having my first baby I think I mostly just stayed home. I didn’t really have programs to go to.*” A common finding was that women did not find out about programs in the community until after the birth of their first baby. Jill said she was informed about community prenatal programs after the birth of her first baby from her social worker and also when she took her baby for immunizations. She said:

*After I had my first daughter . . . I think my social worker told me [about prenatal programs] . . . and [at]immunizations too . . . they told me that they had that program there and I was like oh okay well it's a little too late now (Jill).*

She suggested that women need to know about programs during their pregnancy as early as possible. During her second pregnancy, Jill started attending prenatal programs at a community health centre.

Tara also found out about community programs with subsequent pregnancies from social workers. She felt that she could have benefited from these programs with her first pregnancy because she could have used the extra knowledge and support. Vannah said she did not have any support with her first baby and felt that she needed to get out of her house, learn new things, and get support with her second baby. She independently found out about programs at the health centre by utilizing the internet. *"I just wanted to do something to get out of the house and get help, support and looked on the computer and found Baby's Best Start . . . if I needed someone to talk to, they were there"* (Vannah).

Barb said with her first pregnancy,

*It was kind of difficult at first because I didn't have no resources or where to go and stuff. Who to ask for help, like some family members, like I had some family members who would help me but then it would be kind of hard and stressful at times because I wouldn't, like with my first pregnancy, I didn't have the resources and everything . . . . Once I heard about Healthiest Babies Possible, they help you with transportation to like doctor's visits and . . . I found it very helpful like because trying to get to a doctor's was kind of hard.*

When the women were pregnant with their first baby they felt that prenatal care and community programs needed to be better promoted and that emphasis should be placed on early education regarding the importance of the service. They felt that this was especially true for young parents. Angela said:

*I think it's education, and for the fact that it's young girls, I think that some of this stuff should be taught at a younger age . . . just letting people know and getting that message out there is a major factor in helping people get that care that they need.*

Jill emphasized the benefits of focusing towards younger mothers, *"I guess some mothers don't know about the programs so you got to reach out and let the younger moms know."*

Angela had been informed about programs in the community at school as she had become pregnant with her first baby while still in high school. However, if women are not attending school or become pregnant for the first time after finishing school, they will not be part of this target audience. Angela also stressed that education by healthcare professionals is extremely significant early on because first time moms need to know about the importance of taking vitamins before they are pregnant:

*When I was in high school I remember getting this like presentation done about taking care of yourself before you have a baby and some of the things that could happen if you don't. So I think stuff like that, educating people about how important it is . . . that would give them information. . . . I think that some of this stuff should be taught at a younger age.*

In addition to using schools, the women suggested several other means of advertising prenatal care and community prenatal programs so that first time mothers would be aware of these services prior to giving birth. They suggested that if the pregnancy is confirmed by a physician, the physician could provide information on community programs. *"Probably your doctor . . . the family doctors that tells [you you're] pregnant [should] tell them. . . or put posters in doctor's offices"* (Jill). They also suggested that advertising the programs by using posters and bulletin boards may be beneficial.

As the women gave birth to more babies and had more experience with prenatal care, they became more confident and independent in accessing the care that they required. It appeared that as the women had more children, they recognized their need for more support from

the community which resulted in independently seeking out resources. Barb said *“I think nowadays it is very possible to make sure that you are getting prenatal care and finding information that you need.”* Jill said she did not wait around for the resources to come to her. *“I’m pretty independent. I don’t wait around for stuff to happen . . . I just do what I have to do”* (Jill). She also stated that she felt that the younger and first time moms were less likely to take the initiative to access resources and thus require more guidance and support. *“The younger moms don’t really know, like new moms. . . . I had my second daughter and then I started finding out about programs”* (Jill).

Another participant had been involved in community programs in another city, so upon moving to Regina she took the initiative to find out about programs in her area. *“I hadn’t known about these programs here in Regina so it was something that I seeked out. . . . I knew there was programs where it helped the mothers. . . but that was only through school”* (Angela). Jill said that when she identified that she would require more support, she used the phone book to find community resources that she could be involved with during her pregnancy. Sally said:

*You’re going to get the kind of care that you want to get. You know, if you want to get good care and you want to reach out there and try to find all of the resources that you can you’ll find them. And if you don’t, you won’t. People can have good things like this going but if you’re not willing to try look out there to see what’s out there for you then it’s not just going to be there for you.*

All of the women who said that they would take the initiative to seek out the resources and programs that they felt they required had given birth to several children. It was clear that as the women experienced life with more children they had a way of knowing that they needed to access more services which would provide them with increased support and resources.



#### 4.6 The Importance of Culture is Multifaceted

The women possessed very differing beliefs related to the prenatal care that they received and how that care could be made more culturally appropriate. Several of the women believed that incorporating cultural beliefs into prenatal care and making it more culturally appropriate would enhance the care; however, other women believed the opposite in that their care was perfectly fine the way it was during their pregnancy.

Overall, some of the women felt that the care that they received was affected by the historical stereotype that all Aboriginal people make negative choices related to their health and that they are unwilling to change or to access the resources that may benefit them. Sally explained feeling that same stereotype while accessing prenatal care and felt that healthcare professionals judged her based on preconceived ideas related to her culture:

*You know typical Native women, she's a drunk, or she's a druggie . . . she's just a waste of time. Just sweep her under the mat or just sweep her out the door. Just give her . . . attitude all around . . . like that, I was stereotyped.*

Tara who also felt stereotyped said *“when they know you're Aboriginal . . . they think you don't give care, you don't care what happens to the baby.”*

Several of the women felt that prenatal care would better meet their needs if more of their culture was reflected in the care. By incorporating more cultural beliefs and teachings into prenatal care, women may take more pride in being able to take care of their pregnancy. *“It [culture in care] definitely . . . would give a sense of more pride in actually being able to take care of themselves and knowing that it's part of the culture”* (Angela). Aboriginal women may be more likely to attend care if it was modified to meet their cultural needs. Suggestions the women made that they felt would encourage more culture in care included: providing care in a group setting where women could share their experiences, having a smudging circle, learning to cook

traditional meals, and doing cultural crafts. They also felt that they would be more receptive to care providers that were of Aboriginal descent.

Other women felt that the care that they received was appropriate the way it was and that by adding cultural beliefs into the care it would become too complicated. Eliminating barriers to access appeared more important than developing prenatal programs focused strictly towards Aboriginal culture. Sam said culture in care *“really doesn’t have a big concern to me . . . I was just happy . . . if I could get here [to prenatal care] . . . I’m way across town now, so it’s . . . harder to get here.”* Vannah said *“I don’t think it [culture in care] matters it just makes everything more complicated. . . . It [prenatal care] was good. Except for trying to get an OBGYN”* and Jill said *“I think it’s [prenatal care] good the way it is . . . . It’s pretty much about having a ride and a sitter and . . . somewhere to go.*

A few of the participants provided insight into why incorporating traditional beliefs into prenatal care may be more important to some women when compared to other women. Angela felt that women would have differing views related to how culture affected their care and how prenatal care could be made more culturally appropriate depending on their cultural upbringing. Angela was raised in a very culturally influenced environment. She discussed being taught to take care of herself and the importance of taking care of your children and felt that these teachings were an important factor in her accessing consistent prenatal care. *“It’s part of the culture and that taking care of your kids is something that needs to be done. It’s not a job, it’s a necessity.”* She felt that a lot of women, especially those in urban areas, did not have a chance to experience their culture and as a consequence would not want it to be incorporated into their prenatal care.

*I grew up in a really culturally influenced [home]. It was something that we grew up with being able to take care of ourselves and take care of our babies . . . . So I think that*

*that's another factor in . . . me getting prenatal care and making sure it was consistent. But for some people it's not like that. Like for some people here in the city, [they] don't even have a chance to be able to experience their culture . . . . Some people are willing [to have culture in prenatal programs] and some people aren't so you don't want to force them (Angela).*

Another participant, Tara, also discussed being raised in a very traditional Aboriginal home; however, she identified that she did not believe in what she had been taught and therefore incorporating more culture into prenatal care would not be important to her. She felt that incorporating culture into prenatal care would be optimal for those women who “*believe in Native ways;*” however, it would not be beneficial for those women who do not follow the traditional beliefs.

## **CHAPTER FIVE**

### **Discussion of Results**

The purpose of this research was to explore urban Aboriginal women's experiences related to prenatal care within a cultural context with the intent of giving voice to a population not often heard. Three research questions were developed for this study including:

1. What are the behaviours, values, and beliefs of Aboriginal women related to prenatal care in the urban setting of Regina, Saskatchewan?
2. Do urban Aboriginal women perceive the prenatal care that they receive to be culturally appropriate?
3. How can prenatal care be made more culturally appropriate for this urban Aboriginal population?

Interpretive description places utmost importance on the interpretive aspect of analysis, or moving beyond simply reporting the findings to understanding what the findings mean as a whole (Thorne et al., 2004). As a result of this research, six themes emerged from the data. These themes reflect the behaviours, values, and beliefs of Aboriginal women related to prenatal care. Reflecting upon these themes resulted in conceptualization of the findings. This was accomplished by asking questions such as: Why is this here, why not something else, and what does it mean for practice? Conclusions that are relevant to creating more culturally appropriate prenatal care for urban Aboriginal women have been derived in terms of recommendations as a result of this process.

#### **5.1 Factors Affecting Health during Pregnancy**

Importance was placed on achieving health during pregnancy which would ultimately be rewarded with a healthy baby. Previous research involving Aboriginal women has had similar

results (Lia-Hoagberg et al., 1990; Sokoloski, 1997). Although both of these previous studies are dated, it would appear that Aboriginal women continue to currently have similar beliefs related to being healthy during pregnancy. Unfortunately, achieving health during pregnancy is often complicated for Aboriginal women.

Health is affected by factors both inside and outside of the healthcare system (Public Health Agency of Canada, 2010). These factors include the social determinants of health in which health is affected by social conditions (Young & Wharf Higgins, 2008). When the social determinants of health negatively affect a population, the health of the people may suffer (Cohen, 2008). Although the social determinants of health were not directly explored in this study, the results suggest that some of the determinants may have affected access to prenatal care and the ability to achieve health during pregnancy, both of which were perceived as important. The social determinants of health that appeared to most significantly affect the women in this study during their pregnancy included: income and social status, health services, gender, and culture.

The Public Health Agency of Canada (2010) suggests that income and social status may be the most important factors in determining health. Aboriginal women in this study experienced challenges in accessing prenatal care and maintaining health during pregnancy because of poor social and economic status. Women were confronted with issues related to obtaining transportation and childcare during prenatal care often because of a low income. Sparks (2009) suggested that access to nutritious food during pregnancy can be complicated when inadequate incomes exist and there is poor access to grocery stores that provide healthy foods. For the women in this study, choosing healthy foods and having access to grocery stores in order to maintain a healthy pregnancy were often compromised due to the inability to afford the more costly healthy foods on a limited income, often provided by social assistance.

Health services that are aimed at promoting health and preventing disease improve the health of the population (Public Health Agency of Canada, 2010). Health promotion and disease prevention are important aspects of prenatal care; however, services related to prenatal care such as those offered at a physician's office or at a community health centre were not consistently accessible for the Aboriginal women in this study. In order to improve the health of this population during pregnancy, the challenges that the women face in terms of access must be addressed so that future work may include lessening these barriers.

Many health issues are related to gender (Public Health Agency of Canada, 2010). Consequently, Aboriginal women may experience poorer health related to gender alone. Achieving a healthy pregnancy may be compromised when preexisting conditions exist that negatively affect health. In addition to the effects that gender may have on Aboriginal women, simply being Aboriginal has a significant impact on health status. Aboriginal women are more likely to have poorer health when compared to other Canadians as evidenced by increased rates of diabetes, obesity, arthritis, allergies, hypertension, asthma, stomach problems, rheumatism, osteoporosis, and depression (King Blood & Roberts, 2008). Health risks "determined by dominant cultural values that contribute to the perpetuation of conditions such as marginalization, stigmatization, loss or devaluation of language and culture and lack of access to culturally appropriate health care" are common in the Aboriginal population (Public Health Agency of Canada, para. 1). In this study, Aboriginal women lacked access to culturally appropriate prenatal care. In addition, the women perceived that stereotypes related to culture were common which deterred them from obtaining consistent prenatal care on an ongoing basis.

King Blood and Roberts (2008) suggest that changes must be made to the social determinants of health for Aboriginal people, especially income, in order to overcome the

poverty experienced by so many which consequently effects health. A significant need to address the social determinants of health for Aboriginal women and how they relate to prenatal care exists. Aboriginal women recognize that positive behaviours are essential in maintaining a healthy pregnancy; however, barriers, often related to the social determinants of health, prevent women from maintaining a healthy pregnancy. Support is needed in order to lessen the challenges and the negative effects of the social determinants of health that Aboriginal women face in accessing prenatal care and achieving health during pregnancy.

## **5.2 Factors Affecting the Perception of the Importance of Prenatal Care**

Attending prenatal care was perceived as important by the women in this study. Previous research has had conflicting results related to the beliefs Aboriginal women possess regarding the importance of prenatal care. In her review of the existing literature related to women's prenatal care experiences, Novick (2009) found that women felt that pregnancy outcomes were improved when they attended prenatal care. However, other research has suggested that some women believe prenatal care is important, while others see no benefit or feel that it is unnecessary (Sokoloski, 1997). Given the variation in the publication dates of these two studies, it may be reasonable to suggest that the perception of importance related to prenatal care may currently be different than it was in the previous generation of Aboriginal women. In the current study, the participants perceived prenatal care to be important. They felt that women in their mother's generation did not attend prenatal care because it did not exist.

In their meta-synthesis of barriers related to the prenatal care of marginalized women, Downe, Finlayson, Walsh, and Lavender (2009) found that on the most part, women perceived no clear benefit in attending prenatal care. However, some women willingly attended prenatal care because they saw it as an opportunity to change or improve their current lifestyle (Downe et

al.). Similarly, Smith, Edwards, Varcoe, Martens, and Davies (2006) found that pregnancy was viewed as an opportunity for change. Participants placed value on their children, creating a motivator for making and sustaining healthier choices (Smith et al.). The finding in the current study in which all of the participants perceived prenatal care to be important may be related to the fact that they had all accessed prenatal care as well as services at a community health centre. When attending prenatal activities at a community health centre, women were supported in accessing services through programs that offered transportation, childcare, and a connection to other services within the community. In addition, women in this study viewed achieving a healthy pregnancy as essential in being rewarded with a healthy newborn. Like the women cited in the previous literature, the women in this study may have chosen to attend prenatal care in order to sustain or improve health for themselves and their newborns suggesting that they already perceived the care as important.

Prenatal care with a primary care practitioner was identified as important; however, care obtained while attending other programs such as those offered within community health facilities were viewed as equally beneficial and were included in the women's discussions of prenatal care. In addition to the traditional care that is provided by the physician and other primary care practitioners, incorporating ancillary public health programs and social support are important supplements to prenatal care with a primary care practitioner (Alexander & Kotelchuk, 2001; Public Health Agency of Canada, 2011). Novick (2009) found that women whose care included ancillary services were more satisfied with the care that they received. All of the women participating in this study sought care from a primary care practitioner as well as attended programs at a community health centre during their pregnancy.



### **5.3 Prenatal Care within the Context of Primary Health Care**

Aboriginal women in this study perceived prenatal care to include much more than what might traditionally be thought of when thinking about this type of care. This was evidenced when women included both prenatal visits with the primary care practitioner as well as services offered within the community including programs that provided food and milk when defining prenatal care. Health Canada (2011) refers to primary health care as an approach to healthcare that encompasses services beyond the traditional healthcare system. By discussing prenatal care under such a broad definition, Aboriginal women demonstrate a complex understanding of primary health care. Healthcare professionals themselves have struggled to develop such an understanding and to implement programs that move beyond treating disease and illness towards a system in which health promotion and disease prevention are foremost (Saskatchewan Health, 2002). In order to maintain and improve the health of individuals, practitioners must change the way that they think about primary health care (Saskatchewan Health).

Exploring the principles of primary health care and how they apply to the prenatal care of Aboriginal women may provide some solution for healthcare professionals in developing a more complex understanding of the care and how it might be improved. The principles of accessibility, public participation, health promotion, appropriate technology, and intersectoral cooperation can be examined in association with how prenatal care is provided.

Findings of this study confirm that prenatal care is not consistently accessible for all Aboriginal women. Previous literature has identified similar barriers in accessing care (Baldwin et al., 2002; Heaman et al., 2005; Lia-Hoagberg et al., 1990; Novick, 2009; Phillippi, 2009; Shah, Zao, Al-Wassia, & Shah, 2011; Sokoloski, 1997; Tough et al., 2007). Despite the fact that much of this literature is dated, Aboriginal women continue to identify the same barriers in

accessing prenatal care. This suggests that although a considerable amount of work has been done to identify the barriers that impede Aboriginal women's ability to access care, little has been done to help the women consistently overcome these challenges.

Although the Canada Health Act (Department of Justice, 2011) identifies that all essential health care is to be available to all individuals, Aboriginal women continue to face barriers in accessing prenatal care. How and where care is currently provided must be reevaluated so that barriers are lessened and services are consistently accessible. Including Aboriginal women in the design and implementation of alternative prenatal care programs is essential and creates opportunity for the very important principle of public participation. The complex understanding of primary health care that has been displayed by the Aboriginal women in this study confirms how significant their ideas are in improving services. Incorporating health promotion into prenatal care would provide opportunity to address the negative impact of the social determinants of health as well as would help to identify women at risk so that appropriate interventions could be implemented. Using appropriate technology, adapted to meet the needs of the women, would further decrease barriers that the women face in accessing care. Intersectoral cooperation is essential for successful prenatal care with Aboriginal women. Ensuring that professionals from many disciplines collaborate to provide the best care possible for the women creates the opportunity for a wide variety of services and ancillary programs, which have been perceived as important. By providing prenatal care using a primary health care approach, Aboriginal women would benefit from improved and increasingly accessible services and programs.

#### **5.4 Awareness of Prenatal Care Services within the Community**

In this study, women were likely to attend prenatal care with a physician during their first pregnancy; however, they frequently did not access other services from within the community. This was evidenced by the challenges that were incurred in attempting to recruit women who had given birth to their first baby into this research project. These women simply were not attending programs at the health centre where recruitment took place. Consequently, the women who agreed to participate in the study who had given birth to several children were asked to reflect on their experiences with their first pregnancy. It became clear that women often did not know about community resources when they were pregnant with their first baby and frequently found out about such programs after their baby was born. Women would benefit from the increased support and resources provided through community programs during their first pregnancies. The continuum of knowing documented in this study would appear to be a new finding in the literature as it has not been recognized in any previous studies reviewed presenting an opportunity for future work in the area.

#### **5.5 Significance of Support Systems during Prenatal Care**

Support systems are important to Aboriginal women, congruent with the existing literature. Tough et al. (2007) suggest that increased peer and family support may be a prenatal care tradition that is different from Western culture. The National Aboriginal Health Organization (2006) states that Aboriginal women report that they possess support systems that are utilized when they need to talk to someone; moreover, Aboriginal women were much more likely to confide in a friend or a family member when compared to their physician. Having and maintaining social support networks are important in sustaining health (Public Health Agency of Canada, 2010). These support networks are important when dealing with adversity and in

maintaining control over personal circumstances (Public Health Agency of Canada). This was true during prenatal care, as support systems played an important role in providing information that was considered part of prenatal care, as well as providing support and encouragement for prenatal care attendance. Since support systems are important to Aboriginal women, healthcare providers must respect the significance that these people play in the women's lives. Women should be encouraged to incorporate the support people of their choosing into their care, which should be welcomed by healthcare professionals.

### **5.6 Providing Culturally Safe Prenatal Care**

When interactions with healthcare professionals were perceived as negative, women were discouraged from attending prenatal care. Similar findings have been identified in previous research that spans several years (Dodgson & Struthers, 2005; Lia-Hoagberg et al., 1990; Novick, 2009; Phillippi, 2009; Shah et al., 2011; Sokoloski, 1997; Watson et al., 2002). Despite the considerable amount of literature that has documented this finding, Aboriginal women continue to describe negative encounters with healthcare professionals.

Providing care that is respectful of the client including her culture and her individual situation should be a priority for healthcare professionals. Nurses have a moral obligation to provide safe and competent care for their clients (Smith et al., 2006). In their Code of Ethics, the Canadian Nurses Association (2008) states that "when providing care, nurses do not discriminate on the basis of a person's race, ethnicity, [or] culture" (p. 17). Physicians also have an obligation to practice medicine in a manner in which patients are treated with respect (Canadian Medical Association, 2004). The Code of Ethics that governs the practice of physicians states that the provision of medical services should not discriminate against race (Canadian Medical Association). Providing safe and competent care for Aboriginal women should be a priority for

nurses, physicians, and healthcare professionals in general, as well as a minimum ethical standard (Smith et al).

In order to practice safely, inequities and discrimination must be addressed by both organizations and individual practitioners. Safe care includes developing organizations in which non-judgmental attitudes are displayed, as well as having care providers who are open, respectful, and who seek to understand rather than to judge (Smith et al., 2006). For vulnerable women, negative interactions with healthcare professionals may be perceived as culturally unsafe, consequently discouraging prenatal care attendance during both current and subsequent pregnancies (Downe et al., 2009). Safety is an important influence on use of care during pregnancy and complements the emerging body of evidence on cultural safety (Smith et al.).

Cultural safety is a relatively new concept developed in New Zealand and more recently adopted in Canada (Browne, Varcoe, Smye, Reimer-Kirkham, Lynam, & Wong, 2009). The concept of cultural safety recognizes the historical power inequalities between healthcare professionals and Aboriginal people, in order to bridge the differences that have developed (Stout & Downey, 2006). Browne et al. state that the aim of cultural safety is to remove the cultural risk that is encountered in healthcare including the situations that occur when one cultural group feels that they are disempowered by another cultural group. Cultural safety does not promote learning about the cultural characteristics of a certain ethnic group and then applying such stereotypical information to individuals (De & Richardson, 2008). Instead, in order to develop environments that are culturally safe, healthcare professionals must engage in critical self-reflection to identify their personal impact on therapeutic encounters (Browne et al.). Using the concept of cultural safety to improve interactions between healthcare professionals and Aboriginal women may encourage improved utilization of prenatal care services.

One step towards creating culturally safe environments in prenatal care includes encouraging healthcare professionals to develop an understanding of both the historical and the current challenges that Aboriginal people are faced with (Browne et al., 2009). This understanding may be developed by integrating the culturally competent guidelines created by the Society of Obstetricians and Gynecologists of Canada (Smylie, 2000) into practice (Shah et al., 2011). Although these guidelines are dated, they may still prove to be useful for healthcare professionals in implementing safe and competent care.

The recommendations developed by the Society of Obstetricians and Gynecologists of Canada (Smylie, 2000) include suggestions for healthcare providers to improve interactions with Aboriginal people by: having an understanding of the appropriate names to refer to Aboriginal groups; having an understanding of the sociodemographics and the challenges Aboriginal people face because of this; having an understanding of the geographic territories and languages of Aboriginal people; having an understanding of the impact of colonization on the health of Aboriginal people; recognizing the need to provide care as close to home as possible; and having an understanding of the government policies and obligations related to Aboriginal people (Smylie). Implementing these guidelines may help healthcare professionals to improve interactions with Aboriginal women during prenatal care. By consistently providing positive interactions with Aboriginal women, they may be more likely to attend services on a consistent basis.

Previous literature has suggested that in order to improve the utilization of prenatal care by Aboriginal women, more culturally appropriate care relevant to the needs of the population is necessary (Smith & Davies, 2006). Beliefs related to the cultural appropriateness of prenatal care varied among the participants in this study. Therefore, offering more culturally appropriate

activities during prenatal care may enhance experiences for some women; however, for others, there may be no benefit. The care that each individual desired appeared to be reflected in their beliefs of traditional Aboriginal culture. If traditional beliefs were important to the individual, they were more likely to desire that culturally appropriate activities be incorporated into their care.

This study was conducted in the urban setting of Regina, Saskatchewan. The number of Aboriginal people moving from reserve communities to urban areas is increasing as individuals seek out a better life for their families (King Blood & Roberts, 2008). Recent literature has suggested that Aboriginal women residing in urban centers may not follow traditional cultural beliefs (Valdez, Jim, Fullilove, Schrader, Albright, & Rayburn, 2009). In the current study, participants suggested that the importance of increasing the cultural component in prenatal care would be different for each woman dependant on her cultural upbringing. There also existed a perception that women who were raised in urban areas often did not have a chance to experience their culture and consequently would not want culture to be incorporated into their care. This may provide some explanation as to why incorporating culture into prenatal care was not important to some of the women in this study.

Further evidence explaining why some Aboriginal women in this study did not perceive culturally appropriate prenatal care as important may be related to challenges in accessing services. In an urban setting, the decision to not access prenatal care may be related to cultural barriers (Tough et al., 2007). King Blood and Roberts (2008) state that Aboriginal people living in urban areas are often faced with problems related to lack of childcare, food insecurity, lack of transportation, and poor access to health services, which was congruent with the findings of this study. When women are unable to secure basic necessities such as food for their families or are

unable to access basic healthcare the importance of incorporating culture into prenatal care may not be foremost. Although incorporating culture into prenatal care may be perceived as important to some women, more emphasis may need to be placed on eliminating barriers related to accessing services.



## **CHAPTER SIX**

### **Recommendations**

The results of this research present the opportunity to develop recommendations relevant to practice, research, education, and policy. By identifying such recommendations, an opportunity exists for work in several areas that could lead to improved prenatal care for urban Aboriginal women which may ultimately lead to better birth outcomes in this population.

#### **6.1 Recommendations for Practice**

Recommendations for practice includes developing enhanced prenatal care programs that better meet the needs of urban Aboriginal women while removing barriers to accessing care. An opportunity for women to receive all prenatal care services including visits with their primary care practitioner as well as ancillary community health programs should exist at one common centre. In order to lessen barriers that are encountered, transportation should be consistently provided to programs and services and childcare should be offered. Several centers providing care in this manner must be available throughout the city so that women can access services close to where they live. Prenatal care programs must be advertised to women who may benefit most with specific emphasis on promoting services to women who are pregnant with their first baby as they are less likely to be aware of such resources.

In addition to receiving all care at one centre, the idea of providing prenatal care in a group setting may also be of benefit. In their randomized controlled trial, Ickovics et al. (2007) randomly assigned women to receive care in either the traditional form or in a group setting in which “each 2-hour prenatal care session included physical assessment, education and skills building, and support through facilitated group discussion” (p. 1). Women who received care in the group setting were less likely to have suboptimal care, expressed greater satisfaction in care,

and had equal or improved perinatal outcomes at no additional cost when compared to traditional care delivery models (Ickovics et al.). Previously, waiting in offices has discouraged women from attending care. Since care in a group setting would be provided for several women at one time, long wait times would be avoided. Programs would need to be offered on a self-referral basis so that issues with obtaining referrals would not exist. Healthcare providers should be encouraged to utilize written resources during care delivery as long as they are reading level appropriate, as women have suggested that these resources have encouraged them to remain healthy during pregnancy.

Aboriginal women in this study received support from other mothers while attending prenatal activities that occurred in a group setting. Spending time with other women in similar circumstances presented the opportunity for the women to learn from one another and to share experiences related to pregnancy, childbirth, and raising children. In addition, Aboriginal women who had given birth to several children served as role models for younger mothers who looked to them for their experiences and advice. This finding may provide some insight and support into the positive effect that group prenatal care may have for Aboriginal women as it would provide further opportunity for women to share experiences and learn from each other which have been perceived as important.

The opportunity to attend culturally appropriate activities related to prenatal care should be available to women who are interested. Since the participants in this study have identified that including culture in prenatal care may be more important to some women than others, the option should be available but not mandatory. Activities such as smudging circles, learning to cook traditional meals, and doing cultural crafts could be offered as additional programs that the women may choose to participate in if desired. An attempt should be made to recruit Aboriginal

care providers for prenatal care programs that are offered for Aboriginal women. The possibility of having Aboriginal women themselves lead some prenatal activities should also be explored. This may increase the sense of value possessed by Aboriginal women. In addition, opportunities for employment would be created for some women, while others would receive the benefit of learning from peers, which was perceived as important in this study.

During prenatal care, the significance of the women's support systems should be recognized. Support systems are important to Aboriginal women and these individuals encourage women to access care when it otherwise might be difficult. Healthcare providers need to recognize the importance of Aboriginal women's support people and provide opportunity for these individuals to be involved in care.

## **6.2 Recommendations for Research**

The results of this study suggest several areas for further research. Most notably, an opportunity may exist to alter the current format in which prenatal care is provided for urban Aboriginal women. As identified in this study, barriers to accessing prenatal care may be removed when all care is provided at one centre in a group setting. The Canadian Institute of Health Research (2007) state that research involving Aboriginal people should be a collaboration between the community and the researcher. For this reason, a study involving a participatory action research design may be the obvious next step. Participatory action research is completed by the people that are affected by the issues and is often used to help counteract oppression (Chenail, St. George, & Wulff, 2007). In a shared process, learning priorities, project planning and execution, and evaluation are carried out collaboratively (Chenail et al.). A participatory action research design would encourage Aboriginal women to create and implement an

appropriate model of group prenatal care that would remove barriers that have often impeded access to this service.

Currently, limited research exists that has explored the effect that non-traditional formats of prenatal care have on access to the service (Phillippi, 2009). Following the design and implementation of a new model of care, further research should be conducted to ensure the effectiveness of the care delivery and that barriers have indeed been removed. Again, ensuring that the Aboriginal community is included in collaborating with the research is essential in determining the effectiveness of the evaluation.

The sample used in this study was limited to English speaking Aboriginal women living in Regina, Saskatchewan who had already accessed prenatal care services at a community health centre. Further research exploring the experiences of women who are not accessing services at a community health centre should be completed in order to determine whether their understandings of prenatal care differ from those of the women in this study. Future studies should be designed to explore the beliefs of Aboriginal women who reside in areas where prenatal care is not as readily available and may include remote and rural locations. In addition, women who have not attended prenatal care should be included in this exploratory study to help further identify barriers that these women have encountered in accessing care. In this study, the broad definition of Aboriginal and the self-identification of being Aboriginal were used to recruit a variety of women with differing backgrounds and experiences; however, Aboriginal women are not a homogeneous group. Future studies may explore the beliefs and needs of specific tribal groups including the Métis and may include non-English speaking women. The provision of social assistance was not included as a criterion for participation in this study. Future research may

explore the differences in prenatal care for urban Aboriginal women who receive social assistance compared to those who do not receive this support.

This study has suggested that a continuum of knowing exists in which Aboriginal women identified that they required increased resources and supports as they gave birth to more and more children. Women who are expecting their first baby may also require such support; however, they may not know to access services and resources that may be of benefit. Future study should focus on recruiting only women having their first baby to identify if additional barriers exist for these women and to discover how programs and services could be better promoted for this population.

Lastly, women in this study identified that they often experienced negative interactions with healthcare professionals. Future research involving an intervention based educational program to improve the delivery of care by healthcare professionals may be of benefit. In addition, a study involving provider type may also be useful in determining if the women perceive interactions to be more positive when care is provided from individuals from different disciplines.

### **6.3 Recommendations for Education**

An opportunity exists to improve prenatal care for Aboriginal women by consistently providing culturally safe care. Aboriginal women have identified that they are more likely to attend care when the interactions that they have with healthcare professionals are positive. For this reason, healthcare providers should be required to attend continuing education activities and in-services to ensure that they possess knowledge on providing culturally safe care.

Education to increase cultural competence is intended to improve knowledge of, and attitudes towards certain cultural groups (Seeleman, Suurmond, & Stronks, 2009). Guidelines

such as those developed by the Society of Obstetricians and Gynecologists of Canada (Smylie, 2000) to assist healthcare professionals working with Aboriginal people to provide culturally sensitive care should be reviewed by care providers and implemented into education programs on an ongoing basis. In addition, undergraduate education for healthcare professionals such as nurses, physicians, and midwives should continue to expand on existing curriculum for providing culturally safe and sensitive care for the Aboriginal population.

#### **6.4 Recommendations for Policy**

Considerable opportunity exists to improve the negative impact of the social determinants of health on Aboriginal women. Individuals who suffer from the consequences of poverty are the most likely to be unable to independently change their circumstances (Adelson, 2005). Programs and resources must be available and implemented to meet the needs of all women, but especially those at risk. Adelson states that “too many Aboriginal people in Canada are caught in a seemingly never-ending cycle of poverty, violence, educational failure and ill health” (p. S58). Regardless of economic status, all women should have equal access to prenatal care with the absence of barriers. Policy initiatives must provide additional funding for healthcare initiatives and research programs that would benefit the needs of urban Aboriginal women and help to improve the ill effect that the social determinants of health have on the population. Program planning must include Aboriginal women as they will be more likely to attend services and programs when they are modified to meet their needs (Tough et al., 2007). The government of Canada must develop initiatives to assist health care professionals, researchers, and educators to work collaboratively with community members to make access to prenatal care equitable for all Aboriginal women.

## **CHAPTER SEVEN**

### **Importance and Limitations**

While there are limitations to this study, the importance of the findings are significant. The following discussion of each outlines both the benefits of the study as well as areas that may require future work.

#### **7.1 Importance of the Study**

The benefits of this study are potentially numerous. First of all, it was an opportunity to explore the culture of prenatal care for Aboriginal women in Regina, Saskatchewan. As previously identified, there is a lack of research involving Aboriginal women, especially those who reside in urban areas. This study has added to the small amount of literature that exists for this group. By completing this research, I have addressed the cultural appropriateness of prenatal care for urban Aboriginal women in Saskatchewan including the development of recommendations to improve clinical practice in the area. This may lead to the development and implementation of programs and services that better meet the needs of this population. If services are more culturally appropriate and barriers are removed, an increase in utilization by urban Aboriginal women may occur, ultimately leading to better birth outcomes for the population. It is hoped that this study will be foundational for future research related to the development and implementation of more culturally appropriate prenatal care for urban Aboriginal women in Saskatchewan.

#### **7.2 Limitations of the Study**

The sample selection in this study has been limited to only those Aboriginal women who speak English and who have accessed services at the Al Ritchie Health Action Centre in Regina, Saskatchewan. By including participants who had accessed services at one health centre, the

diversity in perspective and in the women's stories may have been limited. I had originally intended to interview women attending programs at a second health centre. However, it was identified that users of the second health centre were included in a significant number of other research projects and it was felt that by being involved in this study users would become overburdened. I am aware I have excluded a portion of the population that has limited access due to the factor of language only. Future studies may provide the opportunity to sample women who do not speak English and who have not accessed any health services at all. Sample selection in this study did not differentiate between First Nations and Métis women. I recognize that Aboriginal women are not a homogeneous group and that future research may include exploring the perception of prenatal care separately for these two groups with specific emphasis on the experiences of Métis women.

### **7.3 Knowledge Exchange**

The study findings will be presented at a local, provincial, national, and international level. At a local level, preliminary results have been shared via a poster presentation at the Regina Qu'Appelle Health Regions 2011 Research Showcase. An abstract has also been accepted for presentation at the Saskatchewan Union of Nurses, 2011 Innovators Conference, held in September in Regina. In addition, the findings will also be presented to the obstetric nurses working in the Regina Qu'Appelle Health Region at the education day that occurs in June of each year. Nurses and physicians from the Labour and Birth unit, and the Mother and Baby unit, are invited to these educational sessions. A presentation of the findings of this study will also be offered for the Obstetrical Grand Rounds that take place monthly at the Regina General Hospital. These rounds are attended by nurses, physicians, residents, and jursis working in obstetrics.



In addition, an abstract has been accepted for a presentation at the Canadian Association of Perinatal and Women's Health Nurses (CAPWHN) Conference to be held in Victoria, British Columbia in October, 2011. An abstract will also be submitted for presentation at the Women's and Children's Health Conference, which occurs annually in either Regina or Saskatoon and is sponsored by the Perinatal Education Program at the University of Saskatchewan. An abstract will also be submitted for presentation at an appropriate international conference. At least one article from this study will be submitted for publication in a relevant peer-reviewed journal.

In order to ensure dissemination of the results with the Aboriginal community, posters will be used to advertise study results as suggested by the nurse working at the Al Ritchie Health Action Centre. At least one poster will be placed at the Al Ritchie Health Action Centre. Posters may also be placed in other facilities that have programs focused towards the Aboriginal community such as Four Directions Public Health Centre and the Eagle Moon Health office in Regina Saskatchewan. Permission will be obtained from these agencies prior to placing a poster in their facility. The results of the study will be made available to the staff at the Al Ritchie Health Action Centre and an opportunity for a presentation of the results will also be offered.

## **CHAPTER 8**

### **Conclusion**

This study provides further information about the importance of prenatal care in the lives of urban Aboriginal women in one community. Although maintaining a healthy pregnancy, which includes attending prenatal care, has been perceived as important, Aboriginal women often face barriers in accessing services. The issue of access to prenatal care is not a new problem for Aboriginal women. A significant amount of literature dating several years has recurrently identified the same barriers that Aboriginal women face in accessing prenatal care. Although much work has been completed to identify these barriers, an opportunity for further research exists to identify a means of removing such barriers, which may be the first step in providing culturally appropriate prenatal care.

This research has implications for healthcare professionals working with Aboriginal mothers, as well as researchers, educators, and policy makers. In clinical practice, how and where prenatal care is provided must be reconsidered so that the majority of services are provided in one location which is easily accessible within a community where Aboriginal women of childbearing age are located. Some community centres already exist that provide increased accessibility by placing multiple services together in the same location. These existing programs could be broadened to develop more inclusive centres with expanded prenatal care services which may assist in further eliminating barriers associated with access to prenatal care. Following the implementation of a new model of care, a participatory action research design may be used to assess the effectiveness of new programming. By using participatory action, the Aboriginal community will be involved in the research which will help to ensure that modifications to the care delivery model meet the needs of the women while removing barriers

to access. An opportunity exists for educators of healthcare professionals to modify current curriculum, which would help to increase knowledge related to providing culturally safe care. Policy makers must focus on improving the negative impact that the social determinants of health have on Aboriginal women. Providing culturally appropriate prenatal care in the absence of barriers must become a priority for not only healthcare professionals working with Aboriginal mothers, but also researchers, educators, and policy makers.

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## **Aboriginal Women and Prenatal Care Study**

- PURPOSE:** The purpose of this study is to explore Aboriginal women's experiences with prenatal care.
- BENEFITS:** You can share your thoughts on prenatal care which may help to improve this service for Aboriginal women in the future.
- You will be financially compensated for your participation in a one hour interview. Any transportation or child care costs associated with your participation will be reimbursed.
- ELIGIBILITY:** You must self-identify as Aboriginal  
You must have given birth within the past 6 months  
You must have attended at least one prenatal visit with a doctor or nurse practitioner or midwife  
You must be currently living in Regina, Saskatchewan
- CONTACT:** This study is being conducted at the Al Ritchie Health Action Centre in Regina, Saskatchewan. Interviews may take place at another location if you wish. This will be arranged when you indicate you are interested in taking part in the study.

**Please call: Jodie Bigalky, (306) 537-0929**  
Master of Nursing Student, University of Saskatchewan for  
more information.



## Consent Guide

You are invited to participate in a research project called *Aboriginal Prenatal Care in Regina, Saskatchewan: Exploring the Cultural Factors*. The information about this study will be discussed with you. This information will help you to choose to be a part of the study or not to be a part of the study. Please feel free to ask any questions or to have anything explained that is not clear to you.

**Purpose and Procedure:** The purpose of this research is to explore Aboriginal women's experiences related to their prenatal care. This will help health care workers to understand what is important to Aboriginal women and to explore how prenatal care could better fit the cultural needs of Aboriginal women.

**Participation:** You are asked to take part in one interview about your experience with prenatal care. The interview will last no more than one hour and will be tape recorded. The interview will take place at the Al Ritchie Health Action Centre, or in another private place in a public building, whichever you prefer. You have the right to refuse to answer any of the questions that you are asked without anything happening to you and you may continue to be a part of the study. After the interview, you will be provided with a small amount of money to thank you for your time. You will be repaid for any expenses such as child care or travel that you need in order to take part in this study. If you choose, after the interview is typed, you will have the chance to add, remove, or make any changes that you would like. The results of the study will be put into a final report and will include ideas for how prenatal care may be made better from the view of Aboriginal women. The report will be shared with health care workers who work with pregnant mothers and with the Aboriginal community by using posters in agencies that offer programs for Aboriginal people. Also, this study will be part of the researcher's thesis and will be published and presented. A short report of the results will be given to you if you want.

**Potential Benefits:** You may not benefit directly from this study; however, results of this study may be used to develop suggestions as to how prenatal care can be improved for Aboriginal women in the future.

**Potential Risks:** There is a small risk of emotional upset, embarrassment, loss of privacy, or stress from remembering unpleasant events in this study. If you find that you become upset by talking about your experiences, arrangements have been made for you to talk to someone not connected with the study.

**Storage of Data:** Interview tapes, the written information, and contact information will be stored in the supervisor’s office in a locked cabinet and will be destroyed after five years. Electronic data will also be destroyed.

**Confidentiality:** Although the information from this project will be published and presented, the information will be summarized so that in most cases no one will be able to tell that you said it. Although things that you say during the interviews will be reported, you will be given a fake name and any information that would make someone know that it was you that said it will be removed. It cannot be guaranteed that no one will know who has participated in the study or who has made certain comments. For example, if you have shared your experiences with others or told others that you took part in this study they may be able to identify something that you have said or something that has happened to you. Although the questions are not of a sensitive nature, anything that is said that is against the law will have to be reported.

**Right to Withdraw:** You can decide to not take part in the project any time that you want. Nothing will happen to you if you decide to stop at any time. You may choose whether the information that you may have already provided can be used in the study. You can say that you don’t want to be a part of the study at anytime. However, if you tell us this after the information that you give has been combined with what others have given, it might be hard to identify what you have said and remove it. You can decide to not answer any question at any time. If you decide to not answer a question, you can keep on taking part in the study. Nothing will happen because you decide not to answer a question. You may request that the recording device be turned off at anytime. You will be completely free to discuss anything that you want and you will not be forced into answering any question or giving any information that you don’t want. Even though the questions are not of a sensitive nature, if anything is said that is against the law, this will have to be reported.

I, \_\_\_\_\_, read and explained this Consent Form to the participant before receiving the participant’s consent, and the participant had knowledge of its contents and appeared to understand it.

\_\_\_\_\_  
Signature of Researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Participant Contact Information

Appendix C



Participant Handout

You have agreed to participate in a research project called *Aboriginal Prenatal Care in Regina, Saskatchewan: Exploring the Cultural Factors*.

If you have any questions concerning the research project, please feel free to ask at any point. You are also free to contact the research supervisor or student at the numbers provided if you have other questions:

**Research Supervisor:** Dr. Robin Evans, Associate Professor, University of Saskatchewan  
(306) 337-8483

**Student:** Jodie Bigalky, Master of Nursing student, University of Saskatchewan  
(306) 537-0929

This project was approved by the Research Ethics Board, Regina Qu'Appelle Health Region on November 19, 2010 as well as the University of Saskatchewan's Behavioral Research Ethics Board on November 19, 2010. Any questions with regard to your rights or treatment as a participant in this project or if you would like to discuss your participation in the study, contact the Regina Qu'Appelle Health Region Research Ethics Board at (306) 766-5451 or the University of Saskatchewan Research Ethics Office at (306) 966-2084 (collect).

Thank you for taking the time to participate in this project.

Appendix D

*Aboriginal Prenatal Care in Regina, Saskatchewan: Exploring the Cultural Factors*

Demographic Form  
(To be completed by the researcher)

Pseudonym: \_\_\_\_\_

1. Current Date: \_\_\_\_\_
2. Age: \_\_\_\_\_ years
3. Number of Prenatal Visits with Physician/Health Care Provider: \_\_\_\_\_
4. Baby's Date of Birth: \_\_\_\_\_
5. Self discloses as being Aboriginal: \_\_\_ Yes \_\_\_ No
6. Number of Children Given Birth to Including this Pregnancy: \_\_\_\_\_

## Appendix E

### *Aboriginal Prenatal Care in Regina, Saskatchewan: Exploring the Cultural Factors*

#### Interview Guide

1. What is prenatal care to you? Tell me about your experiences with prenatal care.
  - Prompt: Can you tell me about an experience that you have had with your health care before you had the baby?
2. What is the importance of prenatal care?
3. What are your health beliefs about prenatal care?
4. Who are your main support people? What are the beliefs of your support people related to prenatal care? How are they the same or different from your own?
5. What would have made prenatal care better for you? What made it difficult for you to get prenatal care? What made it easy?
6. Can you reflect on how your culture may have affected the prenatal care that you received?
7. Is there anything else that you would like to share with me about prenatal care?



Appendix F



*Aboriginal Prenatal Care in Regina, Saskatchewan: Exploring the Cultural Factors*

Transcript Release Form

I, \_\_\_\_\_, have reviewed the complete transcript of my personal interview in this study, and have been provided with the opportunity to add, alter, and delete information from the transcript as appropriate. I acknowledge that the transcript accurately reflects what I said in my personal interview with Jodie Bigalky. I hereby authorize the release of this transcript to Jodie Bigalky to be used in the manner described in the Consent Form. I have received a copy of this Transcript Release Form for my own records.

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Signature of Researcher

I, \_\_\_\_\_, choose not to review the complete transcript of my personal interview in this study. I hereby authorize the release of the complete transcript to Jodie Bigalky to be used in the manner described in the Consent Form. I have received a copy of this Transcript Release Form for my own records.

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Signature of Researcher

I, \_\_\_\_\_, agree that if Jodie Bigalky is unable to contact me after making three attempts over a period of fourteen days using the information that I have provided she may use my transcript anyway. I hereby authorize the release of the complete transcript to Jodie Bigalky to be used in the manner described in the Consent Form. I have received a copy of this Transcript Release Form for my own records.

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Signature of Researcher