

FOCUS ON FIRST PEOPLES, FIRST THOUSAND DAYS: CULTURAL SAFETY FROM
THE PERSPECTIVES OF SELECT ABORIGINAL WOMEN IN REGINA,
SASKATCHEWAN

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By

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ABSTRACT

Background. A wealth of data highlights the health disparities and barriers to health care experienced by Aboriginal women and children when compared to non-Aboriginal women and children. The first thousand days time period, from conception to the age of two, is an opportunity for health professionals to positively impact the health of Aboriginal children with effects lasting into adulthood. Cultural safety has been reported to improve access to health care for Aboriginal Canadians, but little is known about the significance of cultural safety from the perspective of Aboriginal women during the first thousand days.

Methodology. An interpretive descriptive design and a postcolonial perspective guided this study. In-depth interviews were conducted with six Aboriginal women at a community health centre located in the inner-city of Regina, Saskatchewan, between June and July of 2015. Data was analyzed using principles of interpretive description to determine themes.

Findings. Culturally safe and unsafe care was experienced during the first thousand days. Three themes common to participants included: the importance of being able to trust that they are safe when accessing health care, the overwhelming impact of poverty on their ability to achieve or maintain good health, and finally, the experience of worry related to the first thousand days including the worry about being worthy of respectful, culturally safe treatment by all employed in health environments.

Discussion. The perception of culturally safe care was significant in affecting access to health care for this group of participants. Findings of this study suggest that more attention needs to be paid to the development of trust in health care encounters, and future research could explore the concept of trust for Aboriginal peoples. Emphasis on awareness of the social determinants of health, including colonialism and racism, should be included in educational programming for health professionals locally.

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1 INTRODUCTION

Indigenous peoples worldwide are extremely diverse, but unfortunately experience a commonality of lower standards of health and are over-represented among the world's most poor and disadvantaged (Petrucka, 2014; World Health Organization, 2007). It is important to address these inequalities through engagement of Indigenous peoples and communities in research, and through the use of research as a method of exposing the lasting effects of colonization and the resulting marginalization of Indigenous peoples worldwide.

The first one thousand days is the critical time period that begins the first day of pregnancy and includes the first two years of life (Petrucka, 2014). It represents a time of significant potential to decrease negative outcomes for both mothers and their children. Improvements in health for pregnant mothers and their infants can have positive effects lasting into adulthood (Birch, Ruttan, Muth, & Baydala, 2009). Poor maternal and neonatal conditions, inadequate or inappropriate health services, and nutrition deficits are the leading causes of mortality and morbidities in this time period (Petrucka, 2014). This context has provided direction for this study's design and the rationale for the study's significance.

For this paper, the term Aboriginal will be used when referring to all Indigenous inhabitants of Canada including First Nations, Métis, and Inuit peoples (University of British Columbia, 2009).

1.1 Background and Significance

Saskatchewan's Aboriginal population is growing rapidly, and is predicted to make up one quarter of the province's total population by 2031 (Statistics Canada, 2011). Aboriginal people throughout Canada experience significant health disparities when compared to the non-Aboriginal population (Health Canada, 2009). Health Canada's statistical profile (2009) of the health of First Nations people points out disparities in life expectancy, rates of infectious and chronic diseases, and mental health issues such as suicide and substance abuse. For Aboriginal women and children, disparities exist in rates of gestational diabetes, high birth weight and low birth weight infants, and postnatal deaths such as those from Sudden Infant Death Syndrome (Birch et al., 2009). The infant mortality rate among Aboriginal children is poorly documented across Canada but has been estimated at 1.7 to 4 times higher than the non-Aboriginal infant mortality rate (Smylie, Fell, & Ohlsson, 2010). Currently, there is no national data available regarding Aboriginal women's usage of prenatal care; however, a study in Manitoba found there

was a significant difference in the number of Aboriginal women who received an adequate amount of prenatal care with Aboriginal women less likely to have adequate care, when compared to non-Aboriginal women (Heaman et al., 2014). Health disparities experienced by Aboriginal Canadians are the result of complex social, historic, political, and economic factors, often inextricably linked to Canada's colonial past (Adelson, 2005; Browne, 2005).

Disparities in health status point to a pressing need to improve access to health care services for Aboriginal people. Access to health services refers not only to the geographical location of the services but also to the ability of those services to be responsive and appropriate to the needs of the population (Smith, Edwards, Varcoe, Martens, & Davies, 2006). Discrimination and racism on interpersonal, institutional, and systemic levels affect Aboriginal peoples' access to health services and therefore perpetuate health inequities in Canada (Van Herk, Smith, & Andrew, 2011).

The National Aboriginal Health Organization (NAHO) conducted a national public opinion poll of Aboriginal people in 2003 to ascertain their beliefs about health and their health care. The survey was the first of its kind in Canada and provided relevant statistics demonstrating the need to improve the responsiveness of Canada's health care system and its personnel. Fifteen percent of the 1200 respondents perceived that they were "treated unfairly or inappropriately by a health care provider in the last twelve months because they are Aboriginal" (NAHO, p. 16). Seventy-five percent of these respondents reported that this unfair treatment occurred when health services were accessed off reserve (NAHO, 2003). The Indigenous Peoples' Health Research Centre (IPHRC) surveyed Saskatchewan Aboriginal people in 2006 about their health research needs. A key recommendation from this study was to improve the availability and quality of provincial health care services for Aboriginal populations by addressing systemic and institutional racism as well as discrimination on the part of health care providers (Sinclair, Smith, & Stevenson, 2006). The concept of cultural safety in health care has evolved as a way to address the impacts of experienced racism and discrimination on access to health care (Brascoupé & Waters, 2009).

1.2 Cultural Safety

The concept of cultural safety originated in New Zealand to address the health disparities of its Maori Indigenous population (Durey, Wynaden, Thompson, Davidson, Bessarab, & Katzenellenbogen, 2012; Papps & Ramsden, 1996). It was inspired by the *Treaty of Waitangi*,

the 1840 agreement between the Maori and British colonizers that included the principles of protection, participation, and partnership (NAHO, 2008; Papps & Ramsden, 1996; Woods, 2010). The purpose of cultural safety was to highlight the effects of colonization on the Maori peoples' health outcomes and to expose the significance of power relations in health care settings (Durey et al., 2012). Cultural safety is differentiated from the popular nursing concept of cultural competence. Cultural competence discusses the skills, knowledge, and attitudes needed by health care providers to provide quality care to individuals of different cultural backgrounds, but does not address the unequal power relationships that both result in, and are the result of, racism and discrimination (Van Herk, Smith, & Andrew, 2011). Durey et al., (2012), contrast cultural safety with cultural competence by referring to Sakamoto (2007) who stated cultural competence "does not theorize about power... or the use of racialized language" (p. 2). Culturally safe care is defined in the article as care that respects diversity, promotes an ethical standard of practice, and involves recognizing and respecting Aboriginal people's identity, well-being, and needs (Durey et al., 2012).

Cultural safety requires a great deal of awareness on the part of the health care provider (HCP), as the HCP must recognize his or her own culture, attitudes, and station of power which he or she brings to each relationship (NAHO, 2008; Reimer-Kirkham, Baumbusch, Schultz, & Anderson, 2012). Cultural safety requires health care providers to reflect on the realities of Aboriginal patients and recognize the meanings given to gender, social status, and culture that contribute to their context (Racine & Petrucka, 2011). According to Brascoupé and Waters (2009), cultural safety in health care encounters with Aboriginal patients requires the transfer of power to the patient to define the quality of care received. When cultural safety is present, there is a transformation of the relationship with Aboriginal people where their views and voices are able to take the lead (Brascoupé & Waters).

For the purposes of this study, cultural safety is defined using the National Aboriginal Health Organization's (NAHO) definition: "cultural safety moves beyond cultural sensitivity, which is knowledge of cultural differences, to analyze power imbalances, institutional discrimination and the effects of colonization" (p. 4). In contrast, culturally unsafe care is defined by NAHO as "any actions that diminish, demean or disempower the cultural identity and well-being of an individual" (2008, p. 4).

1.3 Significance of Cultural Safety to Canadian Context

The concept as it was developed in New Zealand came from the lens of “biculturalism” as it was focused on the relationship between two specific groups, the Maori Indigenous people and the dominant white cultural group (Browne, Varcoe, Smye, Reimer-Kirkham, Lynam, & Wong, 2009). Canadian society has a different context with multiple, diverse Aboriginal groups including First Nations, Inuit and Métis, all with variations in languages, traditions, and histories. Canada is viewed as a multicultural, pluralistic society, where diversity is acknowledged, but the focus is on ideals of egalitarianism and treating everyone the same (Browne et al., 2009). Multiculturalism’s focus on treating everyone equitably has been criticized, because it ignores unequal power relations and does not adequately acknowledge the important context of the lasting oppression and marginalization of Aboriginal people due to colonization (Browne et al.). Therefore, even with the acknowledged differences in societal and political contexts, cultural safety has potential applicability in Canada’s multicultural society (Browne et al.).

1.4 Significance to Nursing

Cultural safety, as a concept, critically explores the interactions between Aboriginal patients and a predominantly non-Aboriginal health care system in Canada in which nurses play a major role (NAHO, 2008). It is described as an ethical and moral concept for nurses (Racine & Petrucka, 2011). However, to date, nursing education in Canada has mainly focused on teaching the predominant characteristics of certain cultural groups, which may lead nurses to categorize people prematurely without examining their individual needs and beliefs (Browne, 2005). This type of cultural education has led many nurses to view culture in terms of “difference” which creates a discourse of ‘us’ versus ‘them’, where people are compared to the dominant white culture that is considered normal and often superior (Reimer-Kirkham & Anderson, 2002; Woods, 2010). The norms against which these differences are judged are rarely discussed openly, and therefore nurses may fail to recognize the influence of the dominant white discourse (Mohammed, 2006). In contrast, nurses practicing with cultural safety do not identify characteristics about people that are seen as ‘other’ and adapt their ‘normal’ practice accordingly (Woods, 2010). Cultural safety in practice recognizes how the social positioning of individuals can cause them to have inequitable access to health care and enables nurses to demonstrate a commitment to social justice (Browne et al., 2009). Nurses need to reflect on whether health services promote or compromise quality care for Aboriginal people. To do this, they must

envision the fit of their own practice on a continuum from discriminatory to culturally safe care (Durey et al., 2012).

1.5 Current Knowledge on Cultural Safety in Canada

Considerable literature exists about the significance of culturally safe interactions with the health care system for Aboriginal people in Canada (Browne & Fiske, 2001; Kurtz, Nyberg, Van Den Tillaart, & Mills, 2008; McCall & Pauly, 2012; Petrucka, Bassendowski, & Bourassa, 2007; Smith et al., 2006; Van Herk et al., 2011; Van Herk, Smith, & Tedford Gold, 2012).

Research indicates that culturally safe care improves access to, and increases satisfaction in, health services and can result in better health outcomes (Smith et al., 2006; Walker, Cromarty, Kelly, & St. Pierre-Hansen, 2009). There is evidence that culturally appropriate prenatal services have positive effects that include earlier initiation of care, increased breastfeeding rates and increased overall satisfaction with care for pregnant and parenting Aboriginal Canadians (Smith et al., 2006).

Studies have shown there is a mistrust of authority when accessing care due to the lasting impacts of colonization and colonizing policies (Van Herk et al., 2011; Van Herk et al., 2012). Negative outcomes of culturally unsafe care can include: delaying or avoiding health care services, especially services of a preventative nature, discontinuing recommended health instructions, and non-compliance with follow-up visits (Birch et al., 2009; Kurtz et al., 2008).

1.6 Added Vulnerability in Pregnancy and Parenting

Aboriginal women often face discrimination on numerous levels, based on race, gender and class, and are particularly vulnerable to culturally unsafe health care encounters (Van Herk et al., 2011). Browne (2005) points out that negative images of Aboriginal women as neglectful and irresponsible mothers were dominant in historical society and were influential in the colonial policies of placing Aboriginal children in residential schools throughout the 20th century, and the widespread policy of placing Aboriginal children in non-Aboriginal foster homes in the 1960s and 1970s. These negative stereotypes persist in today's society and as a result, it has been difficult to change the views of Aboriginal mothering as inferior and decrease the prevalence of damaging assumptions that create culturally unsafe environments (Browne, 2005; Van Herk et al., 2011). As such, Aboriginal women experience a high level of vulnerability when accessing health care in their role as mothers due to the implicit meanings attached to the identity of Aboriginal women as mothers in care encounters (Van Herk et al., 2011). The perception of

discrimination and culturally unsafe care compromises Aboriginal women's ability to access health services and therefore to achieve good health for themselves and their families (Kurtz et al., 2008; Van Herk et al., 2011).

1.7 Descriptions of Culturally Safe Healthcare Encounters

Current research stresses the need for a safe place in which to access care, and includes the importance of care providers having a "safe" attitude (Van Herk et al., 2012). Trust is key to a safe relationship and begins with the first person encountered when accessing a new service (Van Herk et al.). Safe environments have been described as those where Aboriginal people felt free from racism and discrimination, felt a sense of freedom to live out their cultural values, felt their concerns were genuinely heard and validated, and felt empowered to be active participants in their care (Birch et al., 2009; Browne & Fiske, 2001; Kurtz et al., 2008; Smith et al., 2006; Van Herk et al., 2012).

1.8 Problem Statement

A lack of access to culturally appropriate health information, a lack of understanding among health care professionals of Aboriginal health, and institutionalized racism in health policies and health care contribute to the poorer health of Aboriginal mothers, infants, and children (Petrucka, 2014). Improving access to health care is foundational to addressing health disparities experienced by Aboriginal women and their children (Adelson, 2005). Further, embedding cultural safety in health services improves access to health care for Aboriginal Canadians (Kurtz et al., 2008; Smith et al., 2006; Van Herk et al., 2011). However, in order to make recommendations related to Aboriginal maternal-child health practice and policy implications, an increased understanding of women's experiences and the impact of their experiences on their health and well being is required (Birch et al., 2009; Browne & Fiske, 2001)

1.9 Purpose and Objectives

The purpose of this research was to explore Aboriginal women's experiences of cultural safety in two crucial time periods: during pregnancy and while parenting children under two years of age. This research explores the factors in health care encounters that create cultural risk, and contributes to an increased understanding of how perceptions of culturally safe or unsafe care impact Aboriginal women in the context of the first thousand days. This research contributes to the current Canadian literature on cultural safety by adding Saskatchewan Aboriginal women's perspectives to what is known and also contributes a unique focus by

exploring Aboriginal women's experiences during the first thousand days specifically. It is hoped that what was learned may provide additional guidance for cultural safety training and education for health care providers, and cultural safety integration into health region programming and maternal-child health program development throughout the province.

1.10 Research Question

This study used interpretive description qualitative methodology to answer the question: What is the significance of cultural safety in the experience of Aboriginal women accessing health care services in the first thousand days period, which represents pregnant women or women with children less than two years of age?

2 THEORETICAL FRAMEWORK: POSTCOLONIAL THEORY

Postcolonial theory originated in the 1960s and 1970s with the intent of analyzing the effects of the colonial period and present day neocolonialism that continues the oppression of some groups (Reimer-Kirkham et al., 2012). It is an interdisciplinary theory with contributions from sociologists, anthropologists, and political activists (Reimer-Kirkham & Anderson, 2002) and belongs to the paradigm of critical theories (Racine & Petrucka, 2011). Postcolonialism is critical of western science as the only source of valid knowledge and is a way to bring forward ideologies and knowledges that have been excluded by the dominant ideology (Racine, 2003). Decolonizing nursing research requires reflecting on the value of non-western knowledge and ways of knowing and critically examining the domination of western science (Racine & Petrucka, 2011).

The purpose of using postcolonial theory in research is to hear subjugated or marginalized knowledge (Reimer-Kirkham & Anderson, 2002). Subjugation is the process used by colonizers to impose their superiority over colonized people (Racine, 2003). When using postcolonial theory, the perspectives of marginalized groups, as opposed to dominant western ideologies, are central to the discussion (Browne, Smye, & Varcoe, 2005). By doing this, postcolonial theory can help generate new types of transformative knowledge with the goal of connections between theory and practice (Racine, 2003).

Key concepts in postcolonial theory include: race, racialization, culture and othering. Race in postcolonial theory is seen as a social construct that is used to determine relationships between dominant and subordinate groups (Reading 2013; Reimer-Kirkham & Anderson, 2002). Racialization is the process by which people are labeled according to physical characteristics or other superficial categories and then treated by society according to these labels (Browne et al., 2009). Racine (2003) describes racialization as the ‘ideological ground’ contributing to the development of institutional and individual racism (p. 92). It may be conscious and deliberate, where there is explicit racism and discrimination, or it may be unconscious and unintended (Browne et al., 2005). The hierarchical organization of race, with implicit othering, was the basis for colonial policies in Canada including the *Indian Act* (Allen & Smylie, 2015; Reading, 2013). “Othering” occurs when assumed cultural characteristics are projected onto a group as a way of highlighting differences between groups and establishing dominance of one group. The other is

often seen as childlike, passive or exotic, which validates their subordination (Reimer-Kirkham & Anderson, 2002) as is evidenced in many of the colonial policies.

Culture in postcolonial theory is also seen as a construct as opposed to the essentialist view in which culture is a static and homogenous set of characteristics (Reimer-Kirkham & Anderson, 2002). Postcolonial theory rejects the essentialist view of culture as something that is common to a group of people that can be observed and written about in apparently neutral terms (Mohammed, 2006). Postcolonial theory addresses that culture is commonly viewed according to historical and colonial views of race, which perpetuates inequalities and domination by some groups. Most labels of culture are based on nationalistic titles, such as “Chinese” and “Indian,” when most current nations are in fact colonial creations (Reimer-Kirkham & Anderson, 2002). Culture used in this way also operates as an explanation for why certain groups of people experience various problems such as diabetes or alcoholism, when these characteristics are not cultural (Reimer-Kirkham et al., 2012). In postcolonial theory, there is an assumption that all descriptions of culture are only partial, constantly changing, and determined by the location from which they are viewed (Mohammed, 2006).

Postcolonial theory explicitly acknowledges the impact of colonialism as an important determinant of health (Durey et al., 2012) and provides an opportunity to view health disparities within a context of historical, political, and economic influences (Mohammed, 2006). Everyday interactions can be analyzed with a postcolonial lens to understand how race, class and gender are intersecting to oppress certain groups (Mohammed, 2006). It is argued that any analysis of Aboriginal health issues is incomplete if there is no discussion of the legacy of colonialism and its policies (Browne et al., 2005). New versions of inequities have emerged, and old inequities such as controlling and marginalizing policies like those in the *Indian Act* have continued (Browne et al.). Postcolonial theory is useful for developing a critical perspective that includes an examination of issues such as poverty as being a legacy of colonial policies (Browne et al.). Postcolonial theory fits well in the discussion of cultural safety as other cultural theories may not address the relationship between colonialism and the current domination of certain ideologies, or contain any theorizing about power and oppression (Racine, 2003).

3 METHODS AND PROCEDURES

This study was conducted using an interpretive description approach that was informed by a postcolonial lens. Interpretive description is a qualitative methodology first described in the late 1990s (Thorne, 2008). Other qualitative methodologies originate with various other academic disciplines and may contain aspects that do not align well with nursing's perspective (Thorne, Reimer Kirkham, & MacDonald-Emes, 1997). Interpretive description was intended as an alternative approach that would reflect nursing's theoretical underpinnings and contribute to the understanding of how people experience health and illness (Thorne et al., 1997).

The purpose of an interpretive description study is to capture themes and patterns of subjective descriptions as a way to inform clinical understanding about a phenomenon of interest (Thorne et al., 1997). To accomplish this intent, interpretive description aims to include two dimensions described as "knowing that which is shared by persons in similar situations and knowing that which is particular to the lived experience of an individual person," (Thorne et al. p. 170). Reality is viewed as both inseparable from its specific context and as having shared characteristics amongst people with similar experiences (Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004).

In contrast to the phenomenological tradition, an interpretive description study should be located within existing knowledge on a subject, and the study should allow for meaningful linkages to previous knowledge (Thorne, 2008). Morse (1994) cited in Thorne et al. (1997) agreed that "going in blind" can be counterproductive to nursing's scientific knowledge development (p. 173). Due to the existing body of literature on the phenomenon of cultural safety for Aboriginal people, it was more appropriate to aim to build on this body of knowledge as opposed to conducting a very exploratory study as if nothing is known about the phenomenon.

Interpretive description uses similar methods of data collection to other qualitative methods, such as in depth interviewing and participant observation as well as the collection of relevant data that may be found in lay media, clinical case studies and/or reports (Thorne et al., 1997). These methods are congruent with the belief that the best source of expert knowledge on an experience is someone living with that experience (Thorne, 2008).

3.1 Setting and Sample

The setting for this study was Regina, Saskatchewan with participants recruited from the Four Directions Community Health Centre (Four Directions). Four Directions provided

convenient access to potential participants as it provides prenatal and postnatal health services to many Aboriginal women in Regina (Regina Qu'Appelle Health Region (RQHR), 2014). After harmonized ethical approval from the University of Saskatchewan and the RQHR, and in consultation with the Primary Health Care Supervisor, the student researcher met with the staff at Four Directions to provide them with an overview of the purpose and intent of the study, and to ask for feedback about relevance to their clientele. The staff was supportive and welcomed the idea of this research, agreeing to assist the researcher with recruitment of participants.

The researcher observed at Four Directions programming aimed at care for pregnant women and women with young children, including a moss bag class for prenatal and postnatal mothers involved in the health region's Healthiest Babies Possible program and a prenatal class open to all women. Part way through the regular programming, the researcher provided an introduction and a brief explanation of the study. Women were invited to participate in the study and an information pamphlet was provided to take home to learn more about the study while considering whether or not to participate.

Informational posters were also distributed to other community agencies and locations frequented by potential participants including: the two major hospitals in Regina, the Regina Food Bank, the North Central Family Centre, the Regina Early Years Family Centre (Scott Collegiate location), the Albert-Scott Community Centre, as well as the downtown Fieldhouse and Aquatic Centre.

To be eligible to participate, the women had to self-identify as an Aboriginal woman, be over the age of 18, be able to speak and read in English, have the ability to provide informed consent and either be pregnant or have a child that is younger than two years of age at the time of acceptance into the study, as the focus of this study was the critical time period of the first thousand days of child development. Involvement with child protection and/or losing custody of some or all of her children was not an excluding factor. It was felt that women without custody of their infants would also have valuable insights to share regarding their treatment in the health care system.

Six women agreed to participate in this study. A seventh woman indicated an intention to participate but then did not meet with the researcher at the time planned for the interview. This sample size was appropriate for a qualitative study aimed at exploring participants' experiences in-depth (Sandelowski, 1995). A number of factors were considered when deciding that the study

had an adequate number of participants. As well as balancing the factors of reasonable time and resources required for graduate student enquiry, an important factor was some prevalent characteristics of the desired sample, including that they are often difficult to reach for practical reasons such as no home telephone and a lack of transportation to attend programming. As well, they are more likely to be experiencing challenges that make them less likely to spend time participating in research, especially research from which they are not likely to directly benefit (Adler & Adler, 2012). Another factor was that background literature and experiential knowledge suggested the experience of culturally unsafe care was a common phenomenon experienced by the target population; therefore a small number of participants would have significant experiences to share (Thorne, 2008). The researcher makes no claim that theoretical saturation was achieved, but instead acknowledges that from a disciplinary perspective, there are theoretically infinite variations in Aboriginal women's experiences with health care (Thorne, 2008). The conclusions are from the data and were not made beyond what the data could support (Becker, 2012).

Five of the six participants were recruited after their attendance at the Four Directions programming, and introduction to the study by the researcher. A public health nurse at the clinic directly recruited one additional participant to the study. No one contacted the researcher to participate based on the posters.

3.2 Data Collection

Participation in the study involved three optional parts: one or two in-depth semi-structured interviews and the completion of a diary. Each woman was invited to complete all three parts of data collection, but had the option to choose to complete only the first interview or a combination of the first interview and either the diary or second interview. At the time of the initial interview, four participants agreed to take home the diary and meet the researcher in two weeks to give back the diaries and answer questions relating to them. Two participants only wanted to do the first interview. All participants were aware that if they chose not to follow-up with the second interview, the researcher would still include data gathered from the first interview unless they requested to be withdrawn from the study. The plans for follow-up with the four women who agreed to the second part of the study involved meeting in two weeks at the health centre during the programming they usually attend. This was intended to be the most convenient for the women because they were planning to come to the programming at that time

regardless. However, when the researcher returned to programming at the planned time, none of the participants were in attendance. The researcher attempted to reconnect with participants by attending programming in person three additional times. One of the women provided her phone number for the researcher to follow up in two weeks, but this number was no longer in service at the time of the phone call and one of the women stated she would phone the researcher in two-three weeks, but no phone call was ever received. After one month, these attempts did not lead to follow-up with any of the four women, and no diaries were returned to the researcher.

The individual interviews were between thirty and sixty minutes long, and occurred in quiet, private meeting spaces at the health centre. The interviews were conducted by the student researcher and were audio-recorded so that they could be transcribed for data analysis. Benefits of conducting the interviews at the health centre included convenience for the participants, the ability to have their children in the childcare space during the interview, the participants' high level of comfort with the setting, and the ability to conduct the interviews on the same day as recruitment to the study, minimizing the risk of not being able to locate the participant after they initially agree to meet. Potential limitations included the risk of distractions and interruptions because of the busy environment, and the potential for staff to make assumptions about who was participating in the study. In appreciation for attending one interview, participants were provided with a \$25 grocery card. If the participants consented to the second interview, they were to be provided with another \$25 grocery card.

Demographic data (Appendix C) was collected at the interview. Current literature provided guidance on the creation of open-ended interview questions (Appendix C) that enabled the researcher and the participants to explore the topic. When planning the interview questions, the researcher also sought the guidance of a female Elder. The Elder was employed by the University of Saskatchewan and was present on campus a few times throughout the school year. The researcher met with her on two occasions in the fall of 2014. She was asked to provide feedback and guidance regarding the topic of study and the interview questions. She was able to help the researcher word some of the questions in a more open-ended, less directive way and provided her own stories about giving birth and raising children. She also agreed to act as a support person for participants if they felt they needed someone to talk to following participation in the study. She provided her contact information to the researcher and asked that participants be given this information if they wished to reach out to her. She was a former practical nurse and

although her work was primarily with home care for Elders, conveyed to the researcher an appreciation of the value of the inquiry to nursing.

The interview guide was useful and provided the basis of questioning, but other unplanned questions and probes were also used in each individual interview as they developed. The first three interviews all occurred on the same date. Following these first interviews, the researcher reflected on her own strengths and weaknesses in interviewing techniques, as well as the strengths and weaknesses of particular questions in discovering the nature of the phenomenon of study. Due to this reflection, a few new questions were added to the existing ones for the remaining interviews. Added questions and probes included: “Tell me about how health care providers behave towards you” and “From your experience, what parts of the health system really work for you? What does not?”

This method of data collection was appropriate to help with framing the discussion based on what was known about the topic, while also taking care to avoid preemptively determining everything that was discussed by sticking too closely to questions prepared in advance (Richards & Morse, 2013). Attempting to pre-determine the course of discussion could have limited the discovery of new insight and undermined the postcolonial intent of the study, which was hearing the participants’ true voices (Racine, 2003).

As discussed above, four participants were provided with a small diary and asked to keep a record of some thoughts related to their health care experiences for a few weeks before the second interview. The diary included a short list of prompts (Appendix C) to assist participants who may have had difficulty deciding what to write, but participants were encouraged to freely include thoughts in whatever form they wished. Participants were told that diary entries in the form of sketches, photos, or other medias such as newspaper articles would also be accepted. There was no minimum requirement for number of diary entries; participants were told to include as many or as few entries as they wished. A copy was to be made of what participants included in the diary and then the diary would be given back to them to keep for their personal use. As stated previously, completion of the diary was optional, and although four women agreed to take home the diary, no diaries were returned to the researcher.

3.3 Data Analysis

The main tasks of data analysis were to fully understand the data, synthesize, and theorize about meanings and relationships and then recontextualize those meanings into findings (Thorne

et al., 2004). Data analysis was an iterative process, occurring concurrently with data collection, and required the researcher to explore, confirm, or explain any themes that are noticed right from the beginning (Thorne, 2008). In interpretive description, the data analysis process should be inductive. Therefore, the researcher followed Thorne et al.'s (1997) recommendations to avoid analysis techniques that might make inductive thinking difficult, such as premature coding which can cause the researcher to arrive at superficial understandings and overly complex coding which can cause the researcher to feel overwhelmed with detail and therefore unable to discover a truly inductive interpretation. The researcher transcribing the interviews line by line resulted in repeated immersion in the data. The resulting familiarity helped the researcher to synthesize findings (Thorne, 2008). Categories were renamed and rearranged several times and sorted into five main headings and eventually into three themes. The researcher was cautious about jumping to the most easily visible conclusions and attempted to seek out data that could challenge early interpretations. This involved going back to the data several times to confirm or discredit early categorizations and critically analyze potential patterns. This decision-making was documented in a research journal and reflections were shared and discussed with the research supervisor throughout the process. It was important to alternate attention between the individual cases and the data as a whole to avoid making links that were overly superficial (Thorne, 2008). Other techniques used in data analysis besides coding included writing down "marginal memos" as reminders about similarities or ideas of significance (Thorne).

3.4 Data Trustworthiness

In qualitative research, it is important to acknowledge the researcher maintains ultimate control about what constitutes data, which data is relevant, and how the data will be conceptualized, with such decisions receiving careful attention to the researcher's biases and positioning (Thorne et al., 2004). Along with personal biases, potential bias may also exist in approaching the particular study with a nursing perspective. Thorne et al. (1997) list such potential biases as including "convictions about the value of a common social good, the belief that suffering can be ameliorated and the view that all people are deserving of the resources for health," (p. 175) which the authors argue are integral to nursing philosophy and therefore influential in the interpretation of research.

A reflective journal was kept as a way to make visible these biases and attempts to interpret and/or minimize their effects on the data analysis process (Richards & Morse, 2013). As

part of the journal, the researcher made field notes immediately following each interview. These notes included impressions of the interviews, reflections on phrases and discourse, and memos about patterns and themes as they emerged (Richards & Morse, 2013). The research journal also included decisions about which categories to re-name, merge together, or discard. It was a valuable tool for reflecting on the researcher's contribution to the data, with regards to her personal biases and individual research skills (Grove, Burns, & Gray, 2013).

Conducting more than one interview with participants was intended to increase the trustworthiness of the findings. The second interview was to provide an opportunity for challenging the initial conceptualizations of the data, which leads to increased confidence in the final interpretation (Thorne et al., 1997). Although there was no opportunity to interview any of the participants a second time, the researcher was still able to explore some of the common ideas and patterns brought up in the first few interviews with later participants. Incorporating the very initial interpretations into the discussions with the second set of participants, helped the researcher search for common experiences and clarify their significance (Wilson & Neville, 2009).

Throughout the process, the researcher made efforts to increase the dependability of the data by asking for the independent review of the initial impressions, initial categories, and developing themes by the research supervisor. Her agreement with conclusions at various stages enhances the trustworthiness overall (Cope, 2014). Another strategy to demonstrate the trustworthiness of the data is the inclusion of rich direct quotes from participants wherever possible in this report. The purpose of the quotations is to demonstrate for the reader how the findings come from the data and are not only reflections of the researcher's viewpoints (Cope, 2014).

3.5 Ethical Considerations

This study was submitted for ethical approval to the University of Saskatchewan Behavioral Research Ethics Board and the RQHR Ethics Board through a harmonized process. Participants recruited through Four Directions programming received an explanation of the study through a brief presentation and an information pamphlet. All participants had the opportunity to ask questions before they were asked to sign a consent to participate in the study. The consent form (Appendix B) followed the guidelines provided by the University of Saskatchewan Behavioral Research Ethics Board and included written information related to their participation,

risks and benefits, confidentiality, storage of data and the right to withdraw. All participants were provided with a copy of their consent and were provided with contact information for the principal investigators and the ethics office in case they had any further questions.

All data obtained from this study, including transcripts, and demographic data collection forms will be kept in a secure locked cabinet, in the office of the researcher's supervisor, at the University of Saskatchewan, College of Nursing, Regina campus. These documents will be kept for a period of five years at which time they will be destroyed. The researcher's journaling and other field notes are stored electronically on the University of Saskatchewan's secure network and password protected. Confidentiality of all information was maintained. The researcher did not share any personal information obtained with anyone outside of the researcher's thesis committee, including information about who participated in the study to anyone at the health centre. Direct quotes are used in the findings, but all identifying characteristics were separated from the data when it was transcribed and results are reported in a way that maintains the confidentiality of the participants. Participants were asked to indicate on the consent form if they would like the opportunity to review their interview transcripts. A transcript release form (Appendix D) was prepared; however, no participants indicated they wanted this opportunity.

Participants were reassured that their participation was completely voluntary and they could withdraw from the study at any time without any negative consequences. It was made clear to participants that they would likely not benefit directly from their participation in this research. However, it was hoped that the women participating would feel a sense of satisfaction in being able to share their personal stories, with the knowledge that their sharing would result in an increased understanding of the significance of cultural safety in health care encounters. The findings provide insight for future research regarding health issues pertinent to First Peoples' and the First Thousand Days. The potential risk of participating in this research was that participants might have felt anxious or uncomfortable, as it involved reflecting on personal experiences, both positive and negative. All of the participants were offered the contact information of the female Elder who had agreed to act as a support person if needed. No participants accepted the offer of her contact information. The Primary Health Care Supervisor at the health centre also recommended the researcher tell all participants that if they felt negatively impacted by the interview that they could seek the support of their individual support worker at the health centre. This information was provided to participants.

3.6 Research with Aboriginal People

Historically, research with Aboriginal people in Canada has not adequately reflected Aboriginal worldviews or resulted in benefit to Aboriginal populations (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada (TCPS), 2014). This has resulted in distrust among some Aboriginal people towards researchers (Campbell, 2014). The Canadian Institute for Health Research (CIHR) has developed guidelines for carrying out research with Aboriginal people that aim to balance the desire for good health research with the responsibility to take into account differing worldviews and ensure actual benefits to the subjects of the research (Campbell, 2014).

When engaging in research with Aboriginal people, showing respect requires an awareness of any traditions and protocols that may influence the research (TCPS, 2014). As well, the research findings need to accurately reflect the voices of the participant group and care should be taken to avoid portraying the results in a way that might reinforce negative stereotypes or minimize the value of Aboriginal ways of knowing (Wilson & Neville, 2009).

To work towards cultural safety in research, Wilson and Neville (2009) recommend the researcher: possess humility, listen and observe before speaking, demonstrate a recognition of the expertise of participants and show a willingness to observe participants' protocols, needs and priorities throughout the research project. Cultural safety in research occurs when researchers focus on the right of participants to be heard and treated with dignity and respect. In this study, participants were asked to provide their recommendations for the improvement of health services. The implications of the results are presented with the participant's recommendations in mind, so that they are relevant and reflective of the realities of participants (Getty, 2010).

The researcher strived to develop trust with potential participants through face-to-face engagement with them in a place they were comfortable. The terms for participating, such as where the interviews should take place, and which parts of data collection participants would like to do were negotiated as a way to increase the participants' control over the process. The location of the interviews ensured that transportation and childcare would not cause unnecessary strain on participants, and compensation for participation was provided as a sign of respect. During data collection, steps to involve participants included allowing participants to ask questions of the researcher and the provision of a few interview questions in a list on the pamphlet (Appendix F)

to assist the women in informing their decision whether or not to participate. As well, a summary of the study will be provided to all participants that indicated a wish to receive one. There was a place on the consent form for participants to indicate their interest in receiving a summary of the results and to provide either an email or mailing address where this can be forwarded. Several participants requested to receive the summary.

3.7 Personal Lens

Prior to commencing this study, it was important to reflect on my personal positioning and its potential relevance. Cultural safety requires an honest reflection on the impact of our personal cultural attitudes and life experiences in our interactions with others (Woods, 2010). I came into this study as a Caucasian, female, nurse and mother, and all of these characteristics had the potential to influence my interactions with participants and with the data.

I personally value gender equality and I believe promoting the health of women improves the health of our communities as a whole. These beliefs contribute to my passion for this research topic and influence my view of issues affecting women and their families.

My values as a mother, including things such as the role of extended family, and norms of discipline are a reflection of the style of parenting I absorbed through my personal experience and societal influences such as the media. I believe good parents make their children feel loved. In my career as a public health nurse, I have seen parents show children love in a wide variety of ways; some parents obsess about providing organic food, some parents enroll their children in several activities, some parents buy their children brand name clothes. My personal belief is that none of these ways make one parent better than another parent and my openness to different parenting styles, as long as children know love, has been beneficial to me when working with all types of families.

I spent two years working directly with Aboriginal women in a Cree community in Western Saskatchewan as a community health nurse and observed what I perceived to be instances of discrimination by health care providers. I acknowledge that this was my personal perception of the experience and have sought to actively ensure that I was not looking for validation of this perception in my interactions with the participants of this study. Although this provides a starting point, continual self-reflection throughout the research process is important when striving to conduct research in a culturally safe way (Wilson & Neville, 2009).

As a non-Aboriginal researcher approaching this topic, I hoped to share Aboriginal women's stories with health care providers in a way that could create more understanding towards Aboriginal women as patients. I believe understanding creates bridges between people, on which they can meet, and provides the place from which to move forward together. The words of a Mi'kmaw spiritual leader, Charles Labrador, were especially meaningful to me as I pursued this topic: "Go into a forest, you see the birch, maple, pine. Look underground and all those trees are holding hands. We as people must do the same" (as cited in Greenwood, deLeeuw, Lindsay, & Reading, p. 17, 2015).

4 FINDINGS

4.1 Participants

Demographic information requested prior to each interview included the women's age, marital status, the number of children at home, the ages of other children and the number of weeks gestation of pregnancy or weeks/ months postpartum. The results of these questions are described below and listed in a table (Appendix E). Of the six participants, two women were in their thirties, the other women were all in their twenties. The age range was 20-38 years. Three of the women were pregnant (one primiparous) and three were postpartum (one primiparous). All of the babies were under one year of age. The multiparous women had delivered between four and seven children. All the women described stable relationships with their current partners with four describing their relationships as common-law. A few of the women reported abusive and negative past spousal relationships. None of the women was currently parenting alone.

Other descriptions of the sample group come from information provided by participants during the interviews. All six women had numerous difficulties relating to the social determinants of health, and importantly, all of them relied on social assistance. They had similar issues of housing, food security, and transportation. Five of the women reported that they use the Food Bank from time to time. Only one woman had any post-secondary education and only one was currently employed. Three of the women had been or were currently involved with child protection. Two of the women did not have all of their children currently living with them. Two of the women disclosed a history of addiction and involvement with the methadone program. These circumstantial and relational descriptions provide important context when situating the interview data.

The perspectives the participants shared during the interviews were grouped into four main categories: Personal Circumstances and Struggles, Influence of the Social Determinants of Health, Identity, and Positive/Negative Experiences with Health Care.

4.2 Personal Circumstances and Struggles

The participants were very open about their lives and talked freely about their past and current situations. Understanding the context in which they live their pregnancies and parent their children is important to understanding their perspectives on cultural safety and their experiences with health care. Although not all the women shared the same challenges, the

number and interplay of challenges described by a very small sample of participants is worth noting.

4.2.1 Substance Abuse. A few of the women revealed that they had issues with substance abuse in the past. One participant continues to participate in the Methadone program and has used this program to help manage her addiction for several years. Another participant had been in the Methadone program but recently chose to discontinue. She talked about how addiction became an issue for her:

And because I was still around other family members that were drinking, or using, and that's how I ended up using, starting like with the Morphine and stuff. My auntie used to get it from the Doctor and then she'd sell them. (P2)

I lived in (another town) for 10 years. And then got into some bad drugs. And ended up pregnant. And I wanted out so I came to Regina to detox. (P1)

4.2.2 Violence. Violence was mentioned by a few of the participants. Types of violence included intimate partner violence experienced by them personally, witnessing violence at home as children, and violence occurring in their neighborhood that affected people they knew.

I'm not with my previous kids' Dad. I was with him for 16 years, um but we were in an abusive relationship. (P2)

4.2.3 Involvement with Child Protection. Involvement with child protection was brought up in the context of having children removed from their custody and also as having been a child placed in foster care. A few of the women talked about how at different times, they did not have all of their children living with them. One participant recently regained custody of her children and credits health care providers with assisting her in the process of reuniting with her children. The prospect of having their children taken away or being deemed an incapable mother was something almost all of the women worried about.

Yeah and then I started going to programs here, when I found out I was pregnant and that's what I was worried about, because my other kids, my last three youngest were taken right from the hospital when they were born. (P2)

Because that's where, if you freak out on them, they say "well is this woman capable of having a baby? If she's just going to freak out on us? Is she just going to freak out on that baby?" (P3)

Only one participant brought up being in foster care as a child, and described how it continues to have an impact on her today. She explained that she had a difficult experience in the care of her family member, and because of this, made the decision to not have her own children placed with family. She plans to do whatever she can to retain custody of her expected baby.

And yeah so I just think that I had the opportunity to put my kids with my family, but I was like no, I wouldn't. I wouldn't ever do that to my kids, because I know how it was for myself. (P2)

4.2.4 Mental Health. Mental health issues such as postpartum depression, and other mental illness diagnoses, affected some of the participants in significant ways. Their comments illuminate how mental health can become even more complicated during the first thousand days, as they struggled with caring for newborns and decisions about whether to continue medications.

(About having postpartum depression) That was really hard. Cause she like was in the hospital and like I was in there for I think about a week after, and then two days before I was released I was crying-... all day. Yeah. And just crying for nothing. Yeah and they knew that I was having trouble. (P1)

So that was something I struggled with was just my medication and deciding if I wanted to carry on with it or not or just whatever was best for the baby. That was something I struggled with and just always meeting with my psychiatrist like every month just to make sure, check in and make sure that I wasn't falling into depression because I opted to stop the medication. (P6)

4.3 Influence of Social Determinants of Health

The social determinants of health are factors influencing personal health exclusive of medical treatments or lifestyle choices and include living conditions such as housing and employment (Mikkonen & Raphael, 2010). In providing context to their experiences, the participants were asked to talk about what things made it difficult to have a healthy pregnancy or to be a healthy mother raising healthy children. The most common responses related to challenges common to those living in poverty and included: safe housing, food security, adequate income and transportation. A common narrative was that pregnancy and being a parent of young children intensifies the influence that the social determinants have on the women's day-to-day lives.

4.3.1 Housing. All of the participants currently lived in an inner-city neighborhood and safe housing was frequently a concern. The prospect of raising children caused a few of the

participants to feel less willing to continue living in the neighborhood, but there are many barriers, including lack of other affordable options, and proximity to resources and support that prevented them from leaving the area.

I'm trying to get my own house for my baby. I live in the hood. Here, not a good place for kids. But just, I need my own space. And a safe environment for my daughter. (P3)

We did not want to be in this area, just, we've always lived in this area. (P5)

4.3.2 Food Security. Women are more vulnerable to food insecurity during the first thousand days. Not only are there more mouths to feed, but this time period also creates added pressure to have a nutritious diet. Several of the participants spoke about trying to eat healthier while they were pregnant or breastfeeding because of the potential benefits to their babies, but struggling with the affordability and accessibility of healthier food.

So food was very hard. Like paydays, we would spend \$200 and it would last.. not a week. Not even close to a week, like 4 days. So we always kept a little extra to top it up at the end, but then between paydays, it would be hard. So when I was pregnant, food was very hard. (P5)

Some participants talked about how it is difficult to admit to needing the help of the food bank or other sources of food, or to discuss their issues of food insecurity with a health care professional.

And then they all like help you out if you are running low on food and stuff you just have to come and ask. But I don't know, I don't like asking for food and stuff because I don't know I've never really asked anyone for help I just got it on my own. Now it's hard while you're pregnant. I don't really know what to do. (P3)

4.3.3 Income. Income directly affects the other issues that the women brought up: housing, food security, and transportation. A few of the women shared how it is difficult to pay their bills. They talked about how they have little to no disposable income, and every dollar must be carefully allocated. The women, excluding one participant, completely relied on a fixed income from social services and child benefit payments. Therefore, additional support through charity or special programming is both essential and appreciated.

Um well, with the prenatal program it helped with having the milk vouchers and then there's the transportation, that helps, and childcare to come to programming and you can come like everyday if you need to or if you want to. (P6)

Well it was at the time, it was at the time, because I wasn't receiving my kids' family allowance or nothing. So there was a big chunk of time there where I was like really struggling. Yeah it was pretty hard. (P6)

4.3.4 Transportation. Although transportation is not an official social determinant of health and is likely a result of low income, the participants all highlighted transportation to and from health services as a major potential barrier to access. Only one of the participants had access to her own vehicle to drive where they needed to go to seek health care. Others relied on taxis and bus services, both of which are expensive to people living on a fixed income. When transportation was provided, a major barrier to attending health programming and healthcare appointments was removed.

They help me with transportation a lot here, and they help with like rides to doctors and stuff like that. Yeah yeah, the transportation is really helpful. (P6)

Or like you ask your worker here and your worker will fit it into her schedule and drive you there and wait for you, pick you up, (P3)

4.4 Identity

Participants reflected on several things that were important in shaping their identities. These included reflections about appearance, sameness, culture, health, motherhood, self-esteem and the legacy of residential schools.

4.4.1 Appearance – How I Appear to Others. Several times participants reinforced that one should not assume that people identify themselves based on their skin color. Some of the women felt that people made judgments about them or people they knew, based on their appearance, even if their appearance did not necessarily match their personal identity. Especially when it comes to Métis or other mixed race people, it was pointed out that a person might identify more with the group in which they were raised, as opposed what is assumed based on how they appear.

They probably don't see me as Métis. They probably think, "Oh that's just a little white girl coming in" Because I don't really look like I'm Métis. You wouldn't say, "Oh my god there's a Métis girl there!" (P3)

4.4.2 Sameness – We Are All The Same. Some women felt that they wanted to be seen as unique individuals, and not grouped together with others of similar ethnicity or culture. This was mostly based on the fear of being associated with negative stereotypes assigned to particular

groups. There was also the view that instead of making assumptions due to ethnicity or culture, everyone should be seen as the same based on shared humanity and common basic needs for respect and acceptance.

You know, First Nations women, they're just like any white person, or any immigrant that comes here, they're all the same. They're all women. You know they all need help. (P3)

Like I don't know, just because I'm a different color than him doesn't mean I'm not the same as him or the same human as him. Yeah he's a guy and I'm a girl. We're different like just because I'm a woman and he's a man, but doesn't mean we're different because I'm white and he's brown. (P3)

4.4.3 Perspectives on Culture. When asked about the influence of culture, the participants' stories highlighted the complex and dynamic mixing of cultures that has occurred and continues to occur for Aboriginal people. They talked about religious influences passed down as a legacy of residential schools, and the influences of urban living and assimilation versus influences of isolation and living on reserve. They also reflected on the choice to incorporate traditional ceremonies and ways of life or create their own way forward. In this young, female population, culture appeared to be fluid and something negotiated and adjusted with life experience.

I didn't really think about it or realize it until her baby baptism came up and how he didn't want it or you know, so we kind of had to compromise on that. Just because in his side of the family, like what he didn't like about being baptized is on his side of the family they are very into their culture, like pow wows and he feels that the church took us down kind of thing and he feels, or felt that my family is very, what is that word, what is that word when they tried to, assimilate! Like very assimilated, because we, my family are very, like goes to church and that type of stuff so. (P5)

Because, I'm more of an urban Aboriginal person. Like I wasn't in the reserve a lot or not brought up in a racist way at all. Even though my mother went through the whole boarding school era and everything but I'm just kind of a trying to break the cycle of things I guess. (P6)

4.4.4 Perspectives on Health. When talking about their health care experiences, the women revealed thoughts about being healthy. Being healthy included things like managing health problems, going for ultrasounds, seeing the doctor regularly, eating healthy and quitting smoking. They attributed being healthy to personal motivation, knowledge about healthy choices, and support from various professionals.

It was pretty hard this one. It was a challenge. Yeah because I was diagnosed with type 2 diabetes, and I had to take insulin four times a day and check my sugars and it was pretty hard...I was like what's going on? And I'm thinking maybe because of my age, and then diabetes runs in the family too, and it's along with Aboriginals, Aboriginal people so. I was alright with it (being diagnosed with diabetes) because I knew it could be managed with proper diet (P1).

I'm just taking my vitamins every day. Making sure I'm eating healthy and not all crazy. I try not to eat too much sugar and stuff. I'm trying to quit smoking. (P3)

4.4.5 Perspectives on Motherhood. The women presented several perspectives on motherhood and discussed both their hopes and their fears. The hopes revealed included finding a safe home, and being allowed to take their babies home to raise them without the threat of apprehension. For some, these hopes were motivation to carefully prepare to take on the responsibility of motherhood either for the first time, or this time around.

I'm trying to be independent. I'm trying to, you know, I made her. She's mine. She's my responsibility. (P5)

And I prepared, like last time too I didn't prepare I didn't get um like a car seat, stroller, playpen or anything, like they didn't have baby clothes or nothing. And this time I got like all prepared, make sure I have everything for her. (P2)

Fear, worry, and uncertainty were common for the women in the first thousand days. The worries included worry about the actual birth experience and complications, worry about partner reactions to news of pregnancy, worry about the reactions and judgment of health care providers, worry about raising a new baby, and worry about being seen as incompetent and subsequent apprehension. To describe this, they used words like “scared”, “panicked” and “freaked out.” Sometimes they were worried because of what had happened to them in the past and sometimes they were worried because of the uncertainty of their situations.

It made me scared to like come to Regina and be in a new city and not know the whole health care system in Saskatchewan like when it came to having a baby. It just made me scared of everything. (P6)

It just made it worse, because like you start panicking, like oh my god, are you going to have a miscarriage. Am I going to have this baby, is baby going to die, like you don't know. And they should be there to tell you. (P3)

*So I guess it is a lot of, worrying about judgment so I don't say it at the other places. Yeah I think having, now that I have a daughter, I guess I would be worried that they think I can't provide for her kind of thing you know?
I just worry about what they think about me kind of thing. (P5)*

4.4.6 Self-Esteem/ Self-Worth. Some participants mentioned feeling good about oneself. One participant said that she felt so much better about herself since she was able to tell people that she is no longer on methadone. Attending health programming was another reason to feel good because it was something productive to do. Another participant talked about the importance of self-esteem when interacting with health care providers (HCPs). For her, self-worth came from being able to talk about her post-secondary education. She seemed to feel because of her Aboriginality, she was entering relationships with HCPs with a disadvantage, for which she felt she had to compensate.

Yes. I do always bring up that I'm a (health care role) now. I casually always bring it up, like even my midwives, I let them know. Just I guess to bring me on the same level or make it feel like I'm on the same level kind of thing so. (P5)

4.4.7 Impact of Residential Schools. Although none of the participants were questioned about residential schools or their legacy, more than one participant talked about it. Those who did, spoke about the residential school system in terms of shaping Aboriginal peoples' identities and the extent they carried that forward. Although they shared the belief that it was important in shaping their pasts, they differed in how they wanted to address it in the future. One woman was interested in telling others about the legacy to her people, and felt that Truth and Reconciliation¹ was an important step to increase understanding between people. She felt there was a general lack of awareness that she could be a part of decreasing.

Um, I think the residential school system needs to be, like what they're doing with the truth and reconciliation. Just the truth being out there. Like we're not the way we are because we want to. You know. It was all we were taught kind of thing. So I think that's the very first step. Is knowing why we're like that. So I do always try and tell like one story, two stories you know. Just so they understand like oh she went through a lot of stuff and she's doing good. A lot of people went through a lot of stuff and aren't doing good, but there's a reason for that. (P5)

¹ The Truth and Reconciliation Commission of Canada was set up with the purpose of informing all Canadians about what happened at residential schools for Indian children. It serves to gather stories from survivors and others affected, and has provided public education, commemoration and recommendations to the Government of Canada based on the policy's legacies (Truth and Reconciliation Commission of Canada, 2015).

Conversely, another woman felt that she coped by finding her own way and creating a new version of herself, not connected to her upbringing or the impact of residential schooling on her family.

The way she raised me I don't want to raise my kids and put them through what she put me through. And all the, I don't know if you know about the whole boarding school era, and everything, all the issues that come along with it and the abuse and everything. So I kind of just cut my ties to that and I'm just kind of going my own way and every different program I go to, I pick up more knowledge and I'm forever learning. (P6)

Figure 4.1. Participant Factors Described: Shaping Women's Perspectives

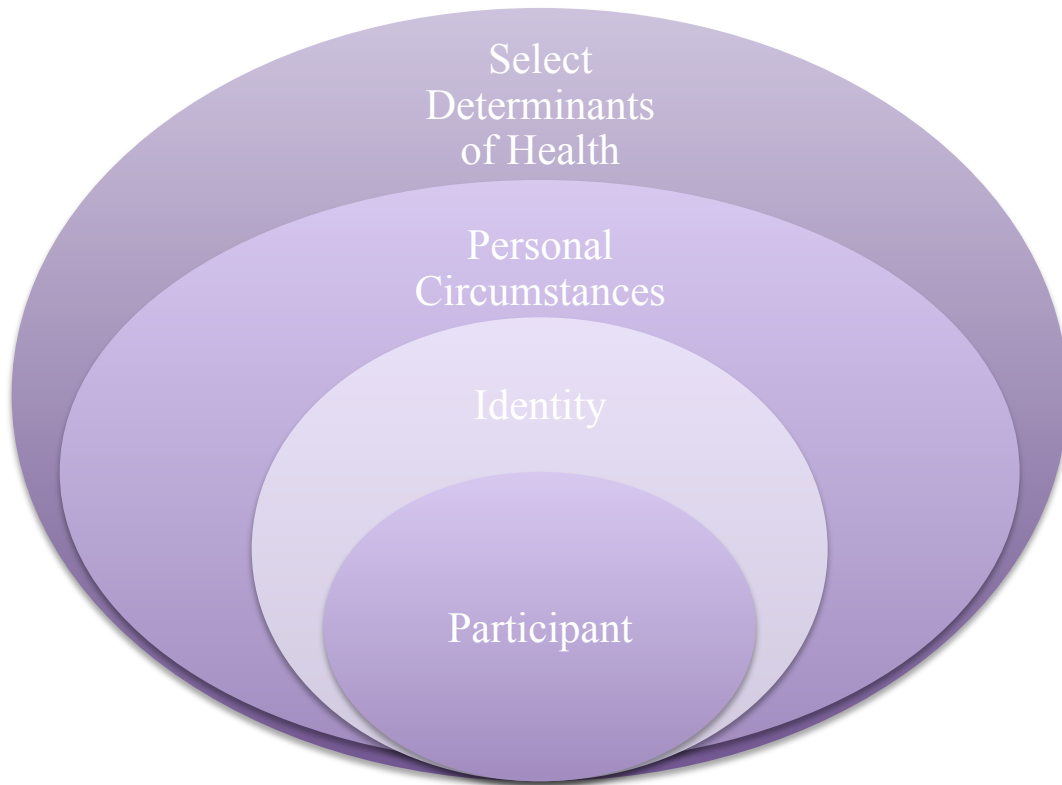


Figure 1 depicts how the participants are affected by their ideas about identity, their personal circumstances and some or many of the social determinants of health. When each woman interacts with the health care system she is influenced by all of these parts. Although these “background rings” are not easily visible to the health care provider, they play an important role shaping the woman’s experiences.

4.5 Positive Experiences with Health Care

The women's health care experiences in the first thousand days were broken down into positive descriptions and negative descriptions. Several positive experiences were described and each participant reflected on culturally safe environments and staff.

4.5.1 Familiar/ Relationship. Several participants discussed how it was important to them to get to know a health care provider and to develop a personal relationship with them. Providers that reached out to them if they were shy were seen as caring and led to the women returning to that care environment.

It felt like really warm and welcoming and I noticed that each and every time I came back like the staff remembered my name and were like "oh how is baby" and you know "how's the boys" and like "how's things going?" and just slowly just developed a relationship I guess. (P6)

They talked to me, but I was shy so I didn't really talk as much, I just said yeah or no. Actually I liked the first time I came so I decided to keep on coming. (P4)

Along with getting to know the staff in a place, it also helped to know other people that attended services there. They could feel more comfortable when the people sitting in the waiting room and going to the programs were familiar to them either because they knew each other personally or because they came from similar situations and environments.

I think it's because I know a lot of my peers come here. I know like, I guess it is because I know a lot of people who are worse off than me come here and you know enjoy coming here. (P5)

4.5.2 Information. The participants described feeling well cared for when they were able to have all their questions answered. It was important that staff asked the women if they had any questions or concerns and then were willing to respond. The staff showed caring by being thorough in their assessments and in their explanations.

He's a really good doctor. Like he'll check baby, check baby's heartbeat, tell me what's going on. He asks me how I feel, he um, if I ask him, um, he does the check up more better, like he checks more thoroughly, and he does the things that he says he's going to. Yeah and he asks me if I have any concerns. He'll go over it with me. (P2)

She asked us, they have to ask us, they have these forms and she made sure, you know? It's like some of the other, in comparison, like if you were to compare, some of the other nurses wanted, like they'd just hand you the papers. Yeah and then some others would make sure that you actually understand what's going on. (P5)

4.5.3 Reassurance and Support. As mentioned previously, the participants described the first thousand days as a time filled with uncertainty. There were several situations where the women needed reassurance that they were doing okay. Reassurance was provided in the form of a supportive presence from a caring person. It was reassuring to know that they had somewhere to go and someone to trust if they had any problems especially with their new babies.

Sometimes the women were afraid because of something they did not understand or lacked knowledge about, and so correct information about what was happening provided reassurance and alleviated their anxieties. HCPs provided the women support with skills like learning to breastfeed, assistance with practical tasks like moving and getting to health appointments, and emotional support when needed such as during their infant's immunizations.

Once I started coming here. They said Oh there's nothing to be scared about, don't stress. You know, they're here to help me and everything so that's good. (P3)

So it was just nice to know that if you, didn't know what to do, they were there. (P5)

They helped me lots.....They're out there to help and yeah that's something that I want to get into too is helping the Aboriginal women or just women in general. (P1)

It's really good. She's totally, she seemed like really understanding about everything. Because when my first appointment with her, you know that whole process, and they were like, I don't know, no judgment or nothing like that. I didn't feel uncomfortable at all. Everything was just fine. (P6)

4.5.4 Advocate. Some of the women were dealing with social services either in relation to social assistance payments or with child protection. HCPs at the community health centre provided advocacy for participants in their interactions with these other agencies and this was important to the participants and to their relationships with HCPs.

She said that if child protections, because I've been coming to the programs and they see that I'm doing good, she's like a support for me like when, because there will, because of my previous history dealing with child protections, they will come and talk to me after baby is born and that's what she said, she'll like help me, to make sure I understand, that I'm not just signing random papers, that I know what's going on and like if there's no reason for them to take baby then she'll make sure she'll speak up for me, and like help me. (P2)

Another participant talked about how, in the hospital environment, she felt secure knowing that if she had problems that Aboriginal Health Services would be able to advocate on

her behalf. Even if she did not need an advocate, it was beneficial to her to know one was available.

And then I also read up on the, at the hospital they have that cultural thing downstairs and I read that if you need help explaining, like I know one thing he mentioned, because he came and did a presentation, was that if you don't feel like you're being respected enough that you can go to them and they'll advocate for you. So that made me feel, like the hospital was a really good experience. (P5)

4.5.5 Able to Be My Honest Self. Along with wanting to feel comfortable, some participants described wanting to be able to talk truthfully with HCPs without having to feel like they have to hide what might be interpreted as inadequacies or present themselves in a particular way. For example, they might feel comfortable at a clinic, but when questioned about their current living situation, they might feel like they have to answer in a certain way to continue to feel comfortable there.

Like I have to act like.. are you eating right and I'm just like answering the questions "yes yes" you know, and they don't really ask further. But here its like, "oh no, I don't have any money." So I guess it is a lot of, worrying about judgment so I don't say it at the other places. (P5)

I can be more open and honest and before like I would lie about things.. yeah like cover up things and not tell the full truth. (P2)

4.5.6 Trust. It was important that HCPs did what they said they were going to do. For example, if they said they were going to send a referral or if they said they were going to come see them in the hospital. Another participant brought up trust in a different way, which was the importance of trusting that the staff was going to act in her best interest and take good care of you.

He does the things that he says he's going to. (P2)

It's just the staff and the whole environment. I don't know, like when I walk in, I know they are going to do their best to take care of me. (P6)

4.5.7 Respect. Several of the participants talked about being treated with respect by HCPs. At times, it was difficult for them to describe how respect was demonstrated. It included: smiling, being friendly, asking if they are okay, and showing that they are interested in them.

Respectful. Tells you what's wrong with you. Asks, like are you okay? Do you need water, are you hungry. Don't just sit there and like you know go run to the next person. (P3)

I would just say um, just keep a smile on your face, and just, not to try and, honestly, not to like be nosy about things, like not to “dig” but to just always, I don’t know, just try to be open to communication. Instead of, okay I always, there’s some nurses where they just don’t even talk and just do what they are supposed to and then leave, but just like show your personality too! (P6)

4.5.8 Recommended by Others – Positive Reputation. For a health care environment to be seen as safe enough to try, most of the women relied on the reputation of the place or the staff as shared by someone they know such as family members. Several of the women talked about sharing both their positive and negative experiences for the benefit of other women. These participants reported that it could be difficult to find out about available resources. “Word of mouth” sharing is especially important when one is new to town, and/or has limited access to phone, or internet communication.

She told me, my sister-in-law told me, because my sister-in-law went through this since she had her first baby. And she was like 15 when she had her first baby. So she told me, “Oh come here” and they’ll help me out and sure enough they did. They got me into this program right away. (P3)

4.6 Negative Experiences with Health Care

Each of the women had experienced culturally unsafe care. Culturally unsafe care occurred in a variety of settings, from hospital to community and was perpetrated by HCPs and health care support staff. Their negative experiences were described in the following ways:

4.6.1 Have To Put On Act To Gain Approval. The opposite of being able to be one’s true self, is feeling the need to act a certain way and or hide things about oneself. This was discussed in terms of either hiding or downplaying issues with things like food security and substance abuse. For some of the participants, there seemed to be a lot of thought put into what they could say that would help them gain acceptance, and what they should avoid saying to avoid poor treatment.

I was still using and I was still like hiding things and yeah sneaking around like I would lie to the workers here. (P2)

I’ve always acted like very proper around Caucasian people I guess. I’m not sure why. (P5)

And I always say, well my partner can’t come, can I book the appointment some other time so he can come? You know what I mean, make it noticeable kind of thing. (P5)

4.6.2 Lack of Trust/ Suspicion. Some women described having difficulty trusting HCPs. Sometimes this difficulty trusting was because that particular provider had let them down, but usually it was because other providers had let them down in the past either by treating them poorly or by not keeping their word.

He does the things that he says he's going to. Like he doesn't just say things and not do it. That's what I felt like my other doctor was doing. (P2)

One participant reflected on feeling suspicious about whether HCPs were being genuine in their concern. She described a situation where she felt that a physician was only apologizing to her because he was worried about how she might react and not because of actually feeling bad. Her suspicion existed because of previous negative experiences.

It was awkward. But then we told him like no we're dating. We're together. And the doctor said "OH sorry sorry sorry!" Yeah right, you're sorry. You just said sorry because you thought oh maybe they'll be rude. (P3)

4.6.3 Disrespect. The feeling of disrespect was common in descriptions of negative health care experiences. It was described in several different ways: including condescending looks, being grouchy or rude, and handling someone roughly. More than one participant stressed that all HCPs should be treating others the way they want to be treated. A few participants also mentioned respect as being something that is earned and not a given based on someone's positioning.

Then the looks you'd get from them or they'd be so ignorant, like they wouldn't talk to you, the way you should be talked to. (P1)

They're not just going to get respect just because "oh I'm your nurse" or "Oh I'm your doctor" Like no, you want to get respect from me then you gonna give me respect and I'll give you respect back. (P3)

4.6.4 Unequal/ Differential Treatment. A few participants described occasions when they felt like they received different treatment than other patients. They perceived these differences to be because they were Aboriginal, because they abused drugs, or because of their age. They felt stereotypes and assumptions caused some HCPs to behave differently towards them.

The women that had abused drugs in the past spoke about how they often wonder if people will treat them differently when they find out that they have an addiction. One woman's

biggest worry was that every time she went to a clinic or hospital, the staff would think she was there to get more drugs. Another participant talked about how she felt that HCPs were quick to jump to the conclusion that her family member had been using drugs during pregnancy instead of investigating other potential causes of the newborn's symptoms.

Oh yeah because they're on drugs, they might need help to get off that drug while they're pregnant. They don't get that help because nobody wants to help them because they're First Nation. Like I don't know, I think they're just too quick to judge. (P3)

More than one participant had experienced a time when they felt health care providers did not spend as much time with them, or asked them different questions than they would ask a Caucasian person in the same situation. As well, it was a worry for some women that they would be grouped together with others because of their race. They felt that HCPs sometimes think that all Aboriginal people are the same.

I don't know, being Aboriginal I see the bottom. Like I see people sitting on the streets and I see you know, that type of stuff. And I don't want to be, I don't want people to think ... you know, I work hard. (P5)

Another mother mentioned that she felt that she was treated differently because she was young at the time she had her first child. She was conscious of judgmental looks and questions. She assumed HCPs judged her negatively.

Well it was just always comments about my age, because I was a young mother. I was 16 when I had my first son That was always a major factor is just being judged about my age and getting looks and whatever like if I was there, if I had my kids with me, then it was worse. Just like, are those your kids? Or are you a teenage mother? (P6)

4.6.5 Punishment/ Shaming. In some of the negative experiences, the women felt like they were being punished for not meeting a certain standard and were made to feel bad about themselves. In all of the examples, the women felt confused about the treatment they received and unsure of how to respond.

He said I missed the two appointments, and I was like I didn't even know I had those appointments. So then ... he's like well if anything happens, like if you go into labor, if you go to the hospital, I'm just going to tell them I'm not your doctor he said. And I was like really?..., I didn't know what to say to him. (P2)

4.6.6 No Time for You. It was common that the women perceived a negative experience to be one in which the HCPs were either unable or unwilling to spend enough time with them.

They talked about feeling rushed, feeling like they were making work for staff, and feeling like staff wanted to be done interacting with them as soon as possible.

Like they didn't want to deal with you. Yeah and you see it with other people before you even get to you. You just feel like you are making too much work for them or something. (P1)

4.6.7 Gaps in Care. Although the specific circumstances were different in each case, several of the participants had similar issues that prevented them from receiving consistent prenatal care that meets recommendations. The women who already had children reported having a regular care provider, while the women pregnant for the first time reported going to walk-in clinics. The participants without a regular family doctor reported more difficulties connecting with an obstetrician and experienced delays in receiving care from someone able to manage their pregnancies. One participant that had a regular care provider also had issues with a delayed referral to a delivery physician.

I was seeing my doctor, Dr. A, he's just the methadone doctor, and I was really not happy with him, because he was supposed to refer me to another doctor, Dr. B, and then he kept putting it off and putting it off and then finally just last week, or on Friday actually, just this past Friday, she had called me and she said "oh I just got your paperwork now" and here he was supposed to send it like 6 months ago. (P2)

4.6.8 Not Being Informed. In one instance, the woman felt that information was being intentionally withheld. In another, a participant explained that the situation changed over time but that she was not kept informed about the change. It caused feelings of frustration about not being told and anxiety about not knowing what was going to happen.

Just not knowing what was wrong. Nobody told me like if I was going to be okay, if my baby was going to be okay. Them not telling me. They knew, they obviously had to know what was wrong, and them just not telling me. (P3)

4.6.9 Needs Not Met. The women described several situations they felt negatively about in which their needs had not been met. This feeling grows when they had to wait too long to access care, not being given antibiotics, and not having their questions answered. In some cases, the women's comments revealed the misunderstanding that occurs when patients are not provided explanations for HCPs decisions. For example, one woman was upset about the way she was treated when she was having prenatal bleeding:

Like if you're gonna have a miscarriage, or something like that, they should take you right away and treat you. Because they could prevent that from happening. (P3)

Another woman was upset by the physician's decision not to treat her child with antibiotics:

Well I told her that she was crying non-stop. And she was a bit feverish the first night. And so yeah, she thought she didn't need it but I thought she did. (P4)

4.6.10 Lack of Socio-Cultural Awareness. More than one of the women brought up the legacy of residential schools as shaping part of their identities. One participant perceived a general lack of awareness on the part of HCPs, which made her feel less confident that they are able to understand her fully.

Participant: She had no idea. And she was like "really, really?" Because my family had some pretty tough times in residential school so I just told her like a couple stories about what happened to my aunty

Researcher: Yeah. Do you feel like health care workers, like the average nurse or the average doctor, do you think they know enough stories?

Participant: No. I don't think so. I think what they know is what they see on the streets. (P5)

4.6.11 Negative Reputation. There were mixed reviews on whether a health care environment's negative reputation had an influence on the participant's decision to go somewhere. As mentioned previously, it was very important to hear of a positive reputation as opposed to not knowing anything about a place or a program. However, it seemed less important if a place had a negative reputation, and most of the women talked about being willing to go and see what it was like for them, before making a decision to not go somewhere. This could mean that the true anxiety is in not knowing how a situation will go. At least if you are prepared that it may go poorly, you can get your defenses ready.

Anyways, yeah she's like telling me "oh" like trying to warn me for the whole experience here, and she's like "oh its horrible, and this and that and they won't let you leave and blah blah blah" and I'm like what. But here the whole thing was, because she wasn't allowed to leave the unit to go downstairs and have a smoke. And I was like oh well that's, that's whatever. I knew, like I'm already at that age where I think well I gotta go see for myself. And I did and it was good. (P6)

Figure 4.2. Interactions With Health Care: Descriptions Across A Spectrum

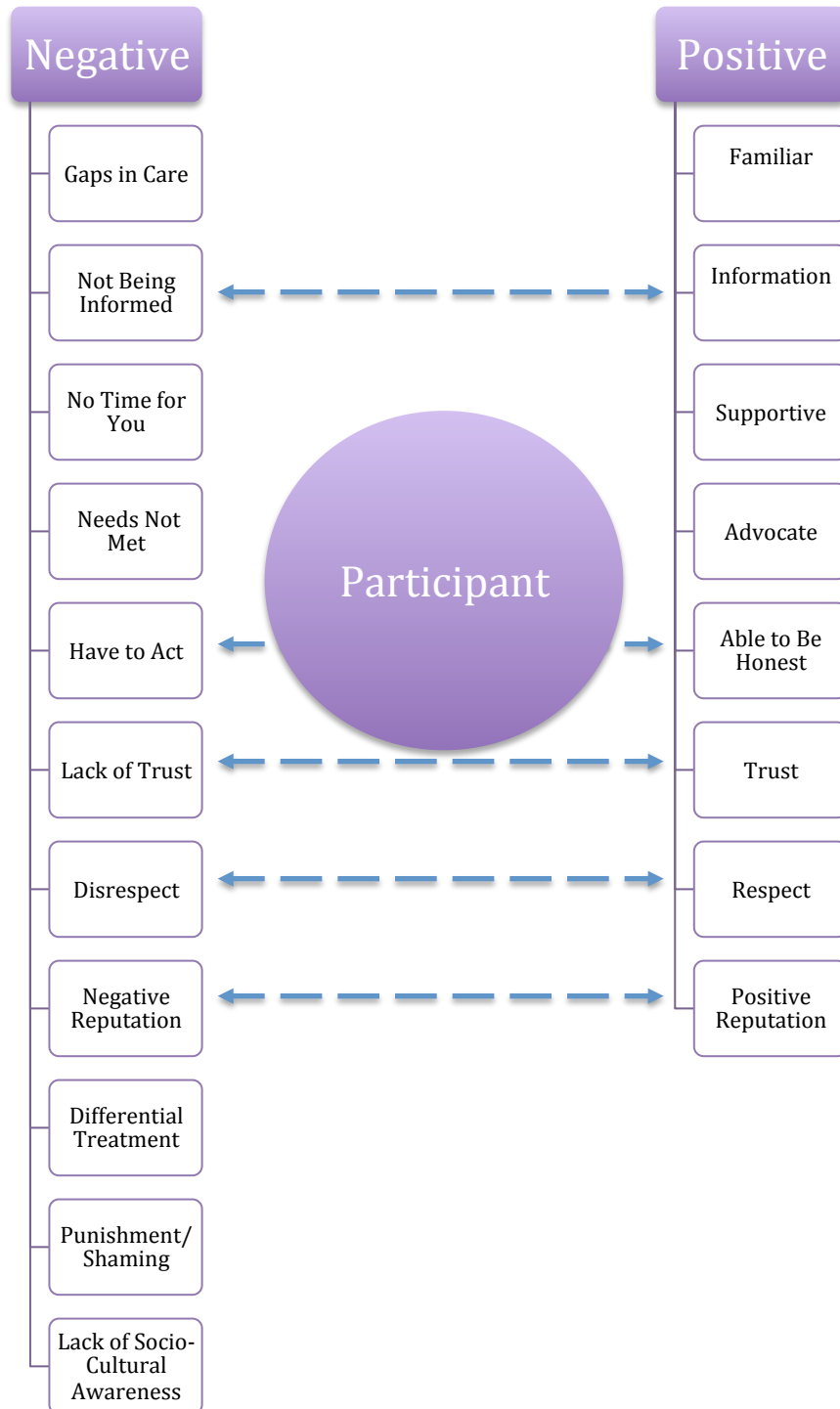


Figure 2. The participants bring with them all of their unique factors (as shown in fig. 1) to each interaction with the health care system. Their experience is positive, negative or somewhere in

between based on their particular perspective. Many of their experiences are presented in terms of contrasts such as trust/mistrust, and respect/disrespect, which are portrayed in this figure.

4.7 Responses to Culturally Unsafe Care

There were two main responses described by the participants who experienced culturally unsafe care: anger and avoidance. Some of the women used both responses, meaning they talked about feeling angry and ultimately ended up avoiding care.

4.7.1 Anger. It was common to feel angry in response to poor treatment, but none of the participants described any actions because of their anger other than avoidance. One participant in particular talked at length about wanting to “yell” or “freak out” but ultimately decided otherwise with the encouragement of family. She was upset about the way her sister was treated in hospital. The HCPs suspected her sister of substance abuse during pregnancy even though her sister denied this accusation.

Well I would have been freaking out. I would have been yelling around. I was going to yell around, but my sister (said) “No, no no, don’t do that.” All right, I won’t do that.
(P3)

4.7.2 Avoidance. Every participant said that if they had a bad experience with a HCP or in a care environment, that they would avoid going back in the future. Most women had actually experienced avoiding a HCP or environment in the past, while others knew that hypothetically that was what she would do. One participant said that when she was struggling with her drug addiction, there were times when she would rather suffer at home than face going to the hospital.

I probably wouldn’t stick around if I didn’t feel comfortable. (P4)

So then after that I just really didn’t want to see him anymore. (P2 – After incident with physician)

One participant described a particularly traumatic experience after childbirth that occurred several years earlier. She reflected that at the time, even though she knew something wasn’t right about how she was treated, she didn’t know what she should do or how to respond. If she would have had more power in that situation or felt more worthy of better treatment, she expressed that she realizes now that she could have responded differently.

I didn’t know at the time I was so much younger, and inexperienced, like I didn’t know what he should have done was a D&C right? Like instead of just doing it manually,

especially after I just had a baby and I had stitches and he just goes and does that. I was just insane. (P6)

In summary, the participants described both positive and negative health care experiences. Positive experiences were those where the women were able to develop a trusting personal relationship with care providers, in which HCPs provided them with reassurance, information, advocacy, and respect. Negative experiences were those in which the women felt suspicious of the motives of HCPs, felt that they had to hide their true selves, were disrespected, and had their needs ignored. The most common response to culturally unsafe care was to avoid a similar situation in the future. Although some women talked about feeling angry and hurt, avoidance was still their most common way of responding. Along with reflections on their experiences with culturally safe and unsafe care, the participants reflected on the realities of their lives and what they need from HCPs to achieve their best health.

5 DISCUSSION

Three themes emerged as common to several of the categories: Trusting I'm Safe, Struggle and Resilience, and Feeling Worried/Feeling Worthy. All three of these themes are relevant to the experience of cultural safety as lived by this group of women.

5.1 Trusting I'm Safe

Trust, or its opposite lack of trust, is a common theme throughout recent literature about Aboriginal women's health (Denison, Varcoe, & Browne, 2014; Health Council of Canada, 2011; McCall & Pauly, 2012; Van Herk et al., 2012). Much of what the women related was about either trusting the health care providers in a particular setting or not. Although trust and mistrust are their own categories, several of the other categories can also be related to trust in the provider or system. For example, the women needed to trust that it was "okay to be as I am" however that was at the time. They needed to trust that they could talk honestly about the realities of their lives; for example, that they were having difficulties with providing food or that they needed help with recovery from addictions. Trust was about believing that if they were honest they would still receive respectful care that met their needs. Many of the women felt like they had to hide aspects of their lives in interactions with health care providers in order to be treated nicely or be seen as worthy of respectful care.

In their responses to negative experiences, all participants showed a lack of trust because none felt able to verbalize to the care provider what they thought or how they felt about a situation. All but one participant either said that when they experienced a culturally unsafe situation, they "didn't know how to respond" or that they simply did not or would not go back to that provider or environment. This sentiment is consistent with other studies about cultural safety from the perspective of Aboriginal women (Browne & Fiske, 2001; Denison et al., 2014; McCall & Pauly, 2012). When trust is broken, as in a negative encounter, the response is overwhelmingly to avoid that person or setting in the future. Many of the women were very blunt about the fact that if an experience was negative, there would be no next experience. There was little room for giving a person the benefit of the doubt. If the experience was uncomfortable, or negative, that relationship was most likely over.

Trust is also the reason why categories like "familiar relationships" exist. In a long-term relationship, one develops a sense of how that relationship is going to exist or function and trusts that it will continue in a similar way to the way it has in the past. Trust can be linked to the

categories about reputation as well. Importantly, all the participants came to programming at their community health centre because somebody recommended it, demonstrating the importance of a positive reputation. In general, one might attend a program after reading about it and deciding it sounds interesting or useful, or if it is conveniently scheduled. The reputation of that program may or may not be included in the decision. Aboriginal women, even if they do not have a personal reason to lack trust in the system, have significant political and historical rationale based on the historical and present day failures of government and government agencies to act in their best interests and therefore a positive reputation is very important in their decision making (Hole, Evans, Berg, Botoroff, Dingwall, Alexis et al., 2015).

In this group of women, trust is experienced and important on numerous levels. It involves developing trust in the individual practitioner, as well as trust in the environment or the setting in which the care is delivered and the providers there as a group. On a more abstract level, trust in the system as a whole, which may be consciously or unconsciously known or experienced, is also important (Hole et al., 2015).

5.2 Struggle “*Life is Hard*” and Resilience

One participant said, “Being a mom is easy, is the easy part. Its just doing everything else is hard...life is hard.” All of the women talked about significant challenges related to necessities of life, especially life as a mother. Things like putting food on the table for their families, providing safe housing, paying bills, and finding transportation provide significant day-to-day challenges for the women. In addition, several of the women spoke about overcoming difficult situations, including addictions, partner violence, mental illness and unstable childhoods. Often these personal situations had negative effects on the women’s families and three of the women had not maintained custody of all of their children. A few of the participants reflected that these challenges are intensified during pregnancy or with a new baby.

Although each of the women had a unique story with unique challenges, the fact that Aboriginal women experience economic and social disadvantage at rates much higher than non-Aboriginal women has been well documented in other Canadian research (Adelson, 2005; Allen & Smylie, 2015; Denison et al., 2014; Mikkonen & Raphael, 2010; Reading & Wien, 2009). As an example, in this study, all talked about food security as being a concern and potential barrier to health in the first thousand days. Although this should be alarming, it is consistent with reports about food security in Aboriginal communities. A report conducted in 2004, found that

nationally, 33% of Aboriginal households off-reserve experienced moderate or severe food insecurity (Mikkonen & Raphael, 2010), and a food bank report from Regina, showed a 15% increase in the number of people relying on the food bank between 2009 and 2010, with 63% of all food bank clients being Aboriginal (Food Banks of Saskatchewan, 2010).

The struggles the women described relating to poverty, impacted the women's utilization of health services on a practical level, such as inability to get transportation, and accessibility to affordable childcare when needed. As well, the women felt HCP's made judgments related to their struggles with poverty and addictions, and therefore, these struggles also impacted their experiences of accessing health care on an emotional or psychological level. This finding is consistent with other studies that have demonstrated the significance of both structural barriers and psychosocial barriers to care for disadvantaged women (Browne & Fiske, 2001; Heaman et al., 2014). The women spoke of experiencing or being worried about experiencing discrimination in many forms. Pregnancy and raising young children is challenging for everyone, but adding on challenges associated with poverty, substance abuse and mental illness puts the women at higher risk for encountering discrimination when accessing health services (Heaman et al., 2014; Denison et al., 2014).

All of the women demonstrated resilience in overcoming these significant obstacles. The participants spoke about how some health services were there to support them through challenging times; however, it is the women who choose whether or not to attend programming or continue to meet with professionals who want to assist them. Caring staff is able to provide encouragement, but the motivation comes from within the women. One participant mentioned that she was aware of the help available to her at the community health centre a few years earlier, but she was not ready at that time to really engage in the programming or take steps towards a healthier life. The staff remained open and willing to assist her when she was ready and she is now making many positive changes.

5.3 Feeling Worried and Feeling Worthy

The first thousand days are filled with many uncertainties, and the participants expressed lots of worry and fear. Throughout many of the women's narratives, is the worry that they will not be seen as worthy and valued in the relationship with each health provider they meet. Several participants revealed that HCPs had shamed them in the past for various reasons including substance abuse, mental illness, missing appointments, and being young mothers. Past negative

experiences resulted in worry about future health care experiences and particularly if they would experience judgment. This worry about negative judgment is described in a number of studies focused on Aboriginal patients' perspectives (Browne et al., 2011; Denison et al., 2014; Hole et al., 2015; McCall & Pauly, 2012), which creates sensitivity towards both verbal and non-verbal communication of HCPs (Browne et al.; Hole et al.). The participants in this study talked about noticing facial expressions and body language to get a feeling about the health provider's attitude towards them.

Aboriginal identity and identity as mothers were sources of worry, but also sources of strength and pride when some of the participants talked about mothering well through obstacles and hardships. The women's identities, both imposed and self-determined, were seen as important to the health care encounter, which is consistent with other studies by Van Herk et al., (2011) which found that how Aboriginal women perceived their identities were evaluated by HCPs affected whether or not their relationship with them was positive. This particular finding highlights the role of identity in the interaction between Aboriginal women and HCPs. The value system, and social positioning of both parties in each interaction needs to be critically examined in a way that affirms the woman's identity rather than supposing superiority of the HCP (Van Herk et al., 2011).

When talking about feeling worried, participants expressed that HCPs could be quick to negatively judge Aboriginal people, but felt if they possessed more awareness about the multi-generational consequences of colonial policies such as residential schooling, HCPs would be more understanding. One participant questioned whether the researcher was aware of what had happened at residential schools, to see if she needed to explain that context. She seemed concerned that without that context, it wouldn't be possible for the researcher to understand her. This concern is common in other literature about Aboriginal women's health care experiences (Hole et al., 2015; Varcoe, Brown, Calam, Harvey, & Tallio, 2013) and Aboriginal women in other studies have also said that their experiences would be improved if HCPs demonstrated an understanding of historical and present-day influences of colonization and how that can affect health (Varcoe et al., 2013).

Several of the women talked about how HCPs' positive beliefs in them were important. They described times throughout pregnancy and the postpartum period when they needed to be reassured that they were going to be okay. This reassurance came in the form of information,

such as information about a medical condition and how to cope with it, and in the form of emotional support. The participants know they are worthy and valued when they feel they are heard, and that their opinions matter. In health care experiences, it matters that the provider is friendly to them, acts interested in getting to know them, spends time with them and attempts to understand what they want and need (Hole et al., 2015, Van Herk et al., 2012; Varcoe et al., 2013).

5.4 Implications for Nursing Practice

This study highlights the significance of access to culturally safe care for Aboriginal women. There are implications to nursing practice at the level of individual practitioners and implications for policies at the systems level.

5.4.1 Implications for Practitioners

Pregnancy is a time that presents significant opportunities for HCPs to positively influence women and their families' lives, because of the number of potential encounters between women and the health system during this time (Birch et al., 2009; Health Council of Canada, 2011; Petrucka, 2014; Van Herk et al., 2012). However, it is known that vulnerable women are not accessing regular preventative care for a variety of reasons (Denison et al., 2014; Heaman et al., 2014). When they present during pregnancy, nurses need to create a relationship with them that makes it not only possible, but likely that they will continue to come for services throughout the pregnancy and potentially beyond. The findings reinforce that this relationship starts at the first encounter, in which the HCP needs to demonstrate a friendly attitude, genuine interest and an open, non-judgmental style of communication (Van Herk et al., 2012). The women in this study provided examples showing that although trust in HCPs and the health care system is of utmost importance, it is not a guarantee, and therefore HCPs need to actively create opportunities to establish and maintain trust with Aboriginal women at each care encounter. Previous research suggests that from Aboriginal patients' perspectives, small gestures, such as remembering their children's names, or asking if they need a drink of water, can make a significant impact in the perception of the experience as positive (Browne et al., 2011). Therefore, even in very busy work environments, there are steps individual nurses can take to improve the care experience for Aboriginal women.

The findings from this study show that women are potentially hiding their struggles in order to protect themselves from judgment. When assessing the health of the woman and her family, it

is up to the health care provider to assess all women's current situations with regards to the social determinants of health. It cannot be assumed that someone does or does not need any assistance. It is always important to talk to the woman about why such information is being obtained, and that the same questions are asked of every mother, so that they do not feel the questioning is targeted or feel suspicious of the motives (Health Council of Canada, 2011).

In a large quantitative study about prenatal care utilization amongst inner-city women in Winnipeg, the most significant motivation for seeking adequate prenatal care was belief that prenatal care would help them to have a healthy baby (Heaman et al., 2014). HCPs need to develop a relationship with all women that specifically addresses what assistance they need to have a healthy pregnancy and healthy baby. When the women in this study were questioned about what makes it easier to have a healthy baby, they responded that having access to programming that provides them with food vouchers, emotional and social support, transportation, childcare, and that increases their useable skills in areas such as cooking and parenting was very important in helping them be healthy. Care that does not meet some of these needs, may not be seen as contributing to a healthy pregnancy and therefore may be deemed unnecessary or not worth the trouble. All women need to see the benefit in establishing and maintaining frequent health care visits throughout pregnancy and early childhood, and should not simply be told when and where to be (Health Council of Canada, 2011). The paternalistic attitude of "we know what is best for you" is often not effective and health professionals need to reevaluate how this attitude creeps into their practice (Hole et al., 2015; Van Herk et al., 2011). Contrary to the western medical model, the women's beliefs about healthy pregnancy were consistent with a worldview that health is a balance between the physical, spiritual, emotional and mental domains which is common in Aboriginal belief systems (Health Council of Canada, 2011; Greenwood et al., 2015).

5.4.2 Implications for Policy: Connecting Social Determinants of Health and Cultural Safety

As discussed, the women that participated in this study spoke at length about the difficulties of maintaining optimal health while living in poverty. It is argued that determinants of Aboriginal peoples' health in Canada are not purely "social" in nature but are in fact structural and therefore shaped by the historical, and existing, political and economic structures present in Canadian society (Greenwood, de Leeuw, Lindsay, & Reading, 2015). For Aboriginal peoples

of Canada, the social determinants of health have been categorized to include: proximal determinants such as health behaviors and physical environment, intermediate determinants such as health systems, and community resources, and distal determinants including colonization, racism and social exclusion (Reading & Wien, 2009). It is these distal determinants that act as the context within which all other health determinants are constructed (Reading & Wien). The metaphor of the tree has been used to describe the relatedness of the determinants with the proximal determinants being the branches, the intermediate determinants as the trunk and the distal determinants as the roots (Greenwood et al., 2015). The roots of any tree are sometimes deeply embedded and not easily visible but essential for the health of the tree. For Aboriginal people, as an example, the issue of overcrowded housing cannot be separated from the issue of historical and contemporary colonial policies that have created and maintained disadvantages for them (Denison et al., 2014; Reading & Wien, 2009).

The findings of this study demonstrate how important the social determinants of health are in shaping the abilities of Aboriginal women to create healthy lives for themselves and their young children. They provide a clear example of how health inequities are most frequently described in current literature: not as a result of lifestyle, behavioral or cultural factors, but instead of social, political and economic disadvantage (Browne, Smye, Rodney, Tang, Mussell, & O'Neil, 2011). For the Aboriginal women in this study, it is the intersection of the phenomena of race, poverty and gender that compound their effects on health (Browne et al., 2011). Health care policy and practice needs to continue to more strongly reflect the importance of the root causes of inequities for Aboriginal women as opposed to focusing on individual lifestyle factors (Reading, 2015; Varcoe et al., 2013). By maintaining ignorance to the conditions in which these women live, we ensure that the maternal-child health disparities will be maintained as well (Health Council of Canada, 2011; Varcoe et al., 2013).

From the postcolonial perspective, poverty is seen as a result of historical trauma, forced assimilation policies and systemic discrimination (Browne et al., 2011; Denison et al., 2014). This dynamic interplay is less like a neat cycle in which factor A leads to factor B, and more like a tangled web. Within this web, “synergies of advantage and/or disadvantage” can exist (Reading, 2015). Poverty compounds social exclusion, which then leads back to compounding poverty, which reinforces negative stereotypes and individual racism, which then leads women to avoid health services, thereby increasing their social exclusion (Hole et al., 2015).

Although the prospects of decreasing racism and social exclusion, and increasing self-determination sound daunting, cultural safety is a mechanism to disrupt the processes that negatively affect health, first by making these processes visible and then by renegotiating power and privilege in health care encounters (Allen & Smylie, 2015; Brascoupé & Waters, 2009). By making Aboriginal women serious partners in their own health care, by working with Aboriginal women to find their personal power, and by requiring health care providers to critically reflect on their values and assumptions, cultural safety can untangle the web of factors that create health disparities for Aboriginal women (Allen & Smylie, 2015; Health Council of Canada, 2012).

5.4.3 Implications for Research

The findings from this research provide direction for further study around culturally safe health care experiences. In this study, the experience of trusting the care provider, and building relationships with the providers and the environment over time were key to a culturally safe experience. There are many lessons to be learned from the relationship building that takes place in local community clinics, where effort is put into developing trust with each new client. However, in consultation with Aboriginal women, further research could explore how these principles may be transferred to acute care environments or walk-in clinics where there is less time to get to know the clients and meet their needs (Browne et al., 2009).

Another avenue to explore is the developing area of professionals, such as nurses or social workers, in the role of patient advocate or patient navigator. The women in this study talked about the wonderful support offered by the nurses and social workers at their community health clinic that included accompanying them to appointments. Once a positive, trusting relationship has been created between a professional and a vulnerable woman, there could be a great benefit to accompanying that woman through the system. The viability of this model for enhancing cultural safety at the systemic level should be explored in greater detail (Health Council of Canada, 2012). There is emerging evidence that patient navigators are beneficial, including case studies in Manitoba and British Columbia (Health Council of Canada, 2012). Future research could examine how the presence of a navigator could increase the power of a vulnerable woman in an unfamiliar setting, such as an ultrasound clinic or an acute care setting, and what Aboriginal patients perceive are the characteristics of an effective navigator.

Additional research into the understanding of nurses regarding the intersection of race, poverty and gender, would also be appropriate (Van Herk et al., 2011). This research could

investigate how nurses form their assumptions, and how those assumptions can be mediated through educational opportunities and experiences (Browne, 2009). Uncovering this requires more rigorous and academic evaluation of interventions to address racism and health inequities (Allen & Smylie, 2015). Despite investment by health regions in the training of HCPs to improve the care of Aboriginal people, there are few evaluations of the impact of these programs beyond pre and post surveys by participants (Allen & Smylie, 2015). More in-depth evaluation by both participants and recipients of care should be undertaken.

5.5 Limitations of Methodology

A potential limitation of this study is that although supervision and guidance was provided by an experienced group of researchers, a novice researcher performed all of the data collection. This inexperience with interviewing techniques for research purposes may have affected the overall richness of data collected. As an outsider to the community health centre, the researcher was unknown to all the participants. Although the researcher spent time interacting with the participants at health programming prior to the interviews, there was limited time to develop rapport and establish trust with each participant and therefore they may have held back some more sensitive stories. As well, it is possible that because the researcher is non-Aboriginal that the participants did not disclose all of the same information they would have shared with an Aboriginal researcher, although all of the women appeared comfortable during the interviews. Some of this could be attributed to the fact that interviews were all conducted at the community health centre where the women were comfortable. In an effort to establish cultural safety by decreasing the inherent power differential between researcher and participant, the participants were able to ask questions about the researcher and the interviews used a very conversational style to enhance the women's comfort.

Another limitation of this research involved the difficulty with recruiting participants. All of the participants were recruited through existing health programming, so it is possible that the perspectives of women who do not currently utilize health services or do not find the existing health services acceptable were not identified. Although effort was made to recruit others through invitation posters distributed to other community agencies, no women were recruited to the study from the community posters.

The inability to maintain contact with the participants after the initial interview was another limitation of this study. The researcher made several follow-up visits to the community

health centre to attempt to contact the participants who had agreed to complete a diary. Although efforts were made to follow-up with the participants over the course of one month, no participants brought back their diaries or presented for a second interview. This meant that the researcher was unable to ask questions that were formed because of the initial interviews, which would have allowed for deeper exploration of some ideas. The researcher made every attempt to balance the desire for depth in study results with the need to respect the wishes of participants. After attempting to follow-up in the previously agreed upon manner (either meeting at the health centre or calling the provided number), the researcher was confident that the women knew how to be in touch if they wished to do so.

5.6 Conclusion

This study focused on obtaining the perspectives of Aboriginal women in Regina, Saskatchewan about the significance of cultural safety in their health care experiences during the first thousand days (from conception of their child to the time they were two years of age). Using a postcolonial perspective, one aim of this study was to recognize and value Aboriginal women's voices. The methodology used aligned with really hearing the participants' stories and allowing the women to present what they felt was important. As expected, the participants in this study had experienced culturally unsafe healthcare on several occasions, resulting in avoidance of care, frustration, shame and fear. Although all the experiences were different, similar elements of trust in the system, the struggle of poverty and feeling worried and unworthy were identified, and several recommendations for policy and practice were linked to each theme. However, this study also illuminated many positive efforts on behalf of community agencies and professionals in Regina that are having a positive impact on the health of Aboriginal women in the first thousand days. It was encouraging that all of the women had positive stories to tell and that they were remaining resilient in their desires to raise healthy children with bright futures. One participant said that she was having her healthiest pregnancy ever and her comment really highlighted the value of investing in culturally safe health care. Making the health system work better for Aboriginal people is not only important in regards to improving their health, but is also poignantly described as "a concrete way to show respect and work towards reconciliation and justice" (Health Council of Canada, 2012, p. 15). In order to practice with cultural safety, health care providers must understand the tree metaphor of Aboriginal peoples' determinants of health and attend to the roots of health inequalities. To examine the roots is to acknowledge harmful

colonial structures, including the *Indian Act*, the legacy of residential schools, discrimination in the labor market, and policies of economic oppression, that continue to be linked to current health issues facing Aboriginal women and children (Reading, 2015). Nurses must consider this work integral to their social justice practice, and urge system change whenever opportunities present.

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Appendix A: Terminology

Aboriginal Peoples: A collective name for the original peoples of North America and their descendants. The Canadian constitution recognizes three groups of Aboriginal people: Indians (commonly referred to as First Nations), Métis and Inuit. These are distinct groups with unique histories, languages, cultural practices and spiritual beliefs (University of British Columbia, 2009).

First Nations People: Both Status and non-Status Indians in Canada are frequently referred to as 'First Nations people(s)'. It is also commonly used to replace the word 'Band' in the name of a First Nation community (Government of Canada, Aboriginal Affairs and Northern Development Canada, 2013).

Indigenous Peoples: An official definition of the word presents challenges due to the diversity of the world's indigenous peoples. However, several commonalities exist and together create a common understanding of what it means to be "indigenous". The World Health Organization, 2007, lists Indigenous people as peoples who:

- Identify themselves and are recognized and accepted by their community as Indigenous.
- Demonstrate historical continuity with pre-colonial and/or pre-settler societies.
- Have strong links to territories and surrounding natural resources.
- Have distinct social, economic or political systems.
- Maintain distinct languages, cultures and beliefs.
- Form non-dominant groups of society.
- Resolve to maintain and reproduce their ancestral environments and systems as distinctive peoples and communities (World Health Organization, 2007).

Inuit People: The Aboriginal people of Arctic Canada. The word "Inuit" means "the people" in the Inuit language called, Inuktitut and is the term by which Inuit refer to themselves (Government of Canada, Aboriginal Affairs and Northern Development Canada, 2010).

Métis People: The term Métis refers to a collective of cultures and ethnic identities that resulted from unions between Aboriginal and European people, in what is now Canada. The word initially referred to the children of these relationships, but over generations it came to refer to the distinct cultural identities these communities developed (University of British Columbia, 2009).

Appendix B: Consent Form



Consent Form: Focus on First Peoples First Thousand Days: Cultural Safety from the Perspective of Select Aboriginal Women in Regina Saskatchewan

Please read this form carefully, and feel free to ask questions you might have.

Principal Investigators:

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Purpose and Procedure: Cultural safety is about a respectful relationship between patients and health care professionals, where patients of different cultural backgrounds feel respected and do not fear judgment. We want to know what Aboriginal women in Regina experience when getting health care while pregnant or raising children under the age of two.

To participate in this study you need to be:

- At least 18 years of age
- An Aboriginal woman
- Be pregnant or be raising a child less than two years of age.

Your participation is voluntary. If you decide to participate, you will be asked to sign this form. If you do decide to take part in this study, you are still free to withdraw at any time and without giving any reasons for your decision. Please take time to read the following information carefully. You may ask as many questions as you need to.

Participation in the study involves:

- At least one interview, less than an hour long
- Optional second interview a month later
- Optional diary to record your thoughts for a few weeks

First, you are invited to take part in a one-on-one interview that will last around 30-60 minutes. With your permission, this interview will be tape-recorded. The interview will be at a location and time that is convenient to you. If needed, the costs of your transportation will be provided and you are welcome to bring your children with you. To thank you, you will be given a \$25 grocery card to a grocery store of your choice when you come for the interview. If you would like to stop part-way through the interview, you will be able to keep the gift card. If you are willing to do a second interview, you will be given another \$25 grocery card.

If you are willing, you will be given a diary to record your thoughts about your healthcare experiences for a few weeks. You can include stories, drawings, photographs or poems. A copy will be made of the diary contents and then the diary will be yours to keep. If you choose to include photos, please don't include a photo of any other person in case they do not wish to be a part of this study.

Potential Benefits: Your participation may increase our understanding of how the healthcare system can better meet the needs of Aboriginal women. It is likely that you will not benefit directly by participating in this study.

Potential Risks: If you find it upsetting to talk about past healthcare experiences, you can discuss these feelings afterwards with a female Elder who has agreed to speak with anyone who would like to talk with her. Her contact information will be provided to you at the interview. You can also call the Mobile Crisis line in Regina at 306-757-0127 if you need to talk to someone right away. Your decision to participate will not affect the health care services you receive in any way and your health care providers will never know whether or not you participated in this study.

Confidentiality: The information that you provide will only be shared with the student's supervisor and thesis committee. Although direct quotations from your interview may be used when this research is published and/or presented, no identifying characteristics such as your name or other specific details about you will be included in the findings to make sure no one will be able to identify you by your responses. You will have the chance to review the transcript from your interview to make sure it is accurate. There is a spot at the end of this form to indicate whether or not you wish to do this. If you wish to review your transcript, you will be contacted and given two weeks to provide a response.

Storage of Data: The interviews will be audiotaped and transcribed into written form. Any diary entries provided will be photocopied and the original diary will be returned to you. All of the information you share for the study including the audiotapes, diary entries and any written notes will be kept separate from your name and other identifying information. Information stored on the researcher's computer will be securely password protected. Other data from the study, including a copy of this consent form, will remain in a locked cabinet in the supervisor's office at the College of Nursing, Regina Campus for five years at which time the paper data will be shredded and any electronic information will be deleted.

Right to Withdraw: You do not have to participate and you can answer only those questions that you are comfortable with. You may withdraw from the research project for any reason, at any time, without any consequences. Up until the time that all the interviews are complete and data analysis begins, your information can be removed from the study and destroyed at your request.

Questions: If you have any questions concerning this research project, please feel free to contact the student or the principle investigator whose contact information is provided at the top of the page. This research project was reviewed and approved on ethical grounds through a harmonized

review process by the University of Saskatchewan and Regina Qu'Appelle Health Region Research Ethics Boards. Any questions regarding your rights as a participant may be addressed to that committee through the U of S Research Ethics Office at ethics.office@usask.ca or (306) 966-2975. Out of town participants may call toll-free at 1-888-966-2975.

Consent to Participate:

I have read and understood the description provided. I have had an opportunity to ask questions and my questions have been answered. I consent to participate in the research project, understanding that I may withdraw my consent at any time. A copy of this consent form has been given to me for my records.

(Name of Participant)

(Date)

(Signature of Participant)

(Signature of Researcher)

OR:

Verbal Consent:

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.

(Date)

(Signature of Researcher)

If you would like to go over the transcripts from your interview, to add to or change anything that you said, please circle yes and a time for that will be arranged with you. If you choose to review your transcript, you will have two weeks to provide your response. If I do not hear back from you, I will assume you are okay with the contents of your transcript.

I would like the opportunity to review the transcript from my interview before any of my quotes are used in this study: **Yes No**

I would like to receive a summary of the results of the study when it is complete: Yes No

Please send it to my mailing address:

OR my email address:

Appendix C: Data Collection Tools

Demographic Data:

Age:

Marital Status:

Number of Children at Home:

Ages of Children:

Pregnant: Yes or No

Interview Guide:

How did you hear about this study?

Do you have a family Dr.? If not, why not?

Where do you go for health care? Why did you choose this place/ doctor?

What kinds of health services have you used in your pregnancy? For example, prenatal class, family dr., health nurse, ultrasounds, other programs?

Can you tell me about your pregnancy so far? OR Tell me how you finding being a mother?

Tell me about what things or people help you during your pregnancy/ with being a mother?

Tell me about anything that makes it hard to have a healthy pregnancy/ healthy child?

Tell me about the place where you feel most comfortable going for health care.

Tell me about a place or a situation where you felt uncomfortable getting health care.

Do you know someone who experienced unfair treatment by a health care provider? Can you tell me about what happened to them?

Tell me about a time that you or someone you know felt misunderstood by a health care provider.

How could health care providers make women feel more safe and welcomed?

What makes you feel respected? How do you know if a health care provider respects you?

What does cultural safety in health care look like to you?

Is there anything you want to ask me?

Diary Prompts: Suggestions will be provided to help you think of things to write about, but you can write about whatever is important to you, including things you thought about after our interview. You don't have to write, you can draw a picture, or include a photo of something meaningful to you. You can make one entry or lots of entries – it is up to you. I will take a copy of whatever you include in your diary at our second meeting and then you can have the diary back to keep for yourself to use however you like.

1) When I went to the clinic today (Dr.'s office, hospital), I felt.....

I noticed.....

2) In this pregnancy it is important to me to

Or: When raising my baby it is important to me that

3) I wish my Doctor or Nurse (was more... , asked me about...., made me feel.....)

4) Being a pregnant or parenting as an Aboriginal woman is

Appendix D: Transcript Release Form

(To be used if Participant indicated on consent form that they would like the opportunity to review their transcripts)

I, _____, have reviewed the complete transcript of my personal interview/s in this study, and have been provided 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/s with Dana Laczko.

I hereby authorize the release of this transcript to Dana Laczko to be used in the manner described in the consent form. I have received a copy of this Data/Transcript Release Form for my own records.

Participant _____

Date _____

Researcher _____

Date _____

Appendix E: Table of Sample Demographics

Characteristic (N=6)	Frequency
<i>Age</i>	
20-24	2
25-29	2
>30	2
<i>Marital Status</i>	
Common-law/Married	6
Single	0
<i>Stage of First Thousand Days</i>	
Pregnant	3
1 st Trimester	0
2 nd Trimester	1
3 rd Trimester	2
Postpartum	3

Appendix F: Recruitment Poster

Cultural Safety: Perspectives of Select Aboriginal Women in Regina Saskatchewan



A research project by Dana Laczko, Masters Student,
College of Nursing, University of Saskatchewan

I would like to hear about your experiences accessing health care and your advice for improving health services.

WHO?

Aboriginal women who are 18 or older and are either pregnant or have a child aged 2 or younger.

HOW?

By participating in one or two face-to-face interviews (your choice) and writing in a diary (optional).

TO THANK YOU:

You will be given a \$25 grocery card (store of your choice) for each interview.

QUESTIONS?

If you have any questions or would like to participate, please contact Dana Laczko at 306-216-5824 or

dan772@mail.usask.ca

This study has been approved by the University of Saskatchewan and Regina Qu'Appelle Health Region Research Ethics Boards



Appendix G: Information Pamphlet




The Kind of Questions That You Will be Asked:

- Where do you go for health care? Why did you choose to go there?
- What makes you feel respected by a health care provider?
- Have you ever felt misunderstood by a health care provider?

All participants will be given a grocery card of \$25 to the grocery store that you shop at. If you would like to do two interviews, you will receive \$50 in grocery cards.

If you have any questions or would like to participate please contact:

Dana Laczko 306-216-5824
 dan772@mail.usask.ca or
 Marie Dietrich Leurer 306-337-3816
 marie.dietrichleurer@usask.ca

Cultural Safety: Perspectives of Select Aboriginal Women in Regina

A Masters of Nursing research project by Dana Laczko, RN



UNIVERSITY OF SASKATCHEWAN



What is this study about?

Cultural safety is about a respectful relationship between patients and health care professionals, where patients of different cultural backgrounds feel respected and do not fear judgment. In this study, we want to know what Aboriginal women in Regina experience when seeking health care while pregnant or raising children under the age of two and what culturally safe care means to them. This study has been approved by the University of Saskatchewan and Regina Qu'Appelle Health Region Research Ethics Boards.



Who Can Participate?

Any woman aged 18 or older who is currently pregnant or who is parenting a child under the age of 2.

What Does Participation Involve?

- One face to face interview lasting about one hour
 - Optional completion of a diary about your health care experiences
 - Optional second interview, one month after the first one
- The interview will be at a location that is convenient to you
- Transportation costs and childcare will be provided for you if necessary.