

Indigenous Mothers' Perspectives for Culturally Safe Birth in a Hospital Setting

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By

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Abstract

Background: There is a resurgence of traditional and cultural birth practices in Saskatchewan, which involves Indigenous women reclaiming their rights to choose and to have greater freedom in the birth of their children. Traditionally, western medical approaches to childbirth were designed for physical safety, but do not address the cultural safety for Indigenous mothers. The goal of this study is to gain an understanding about Indigenous women's birth experiences in hospitals and to improve culturally safe maternal health care in Saskatchewan hospitals.

Providing culturally safe care for Indigenous mothers in Saskatchewan hospitals helps protect their mental health and wellness, strengthens the relationship between the infant, mother and her community, and provides a foundation for the child to begin their life immersed in their culture.

Methods: This study uses participatory action and patient-oriented research as a theoretical and research framework to hear the stories of 24 Indigenous women's experiences of giving birth in a Saskatchewan hospital. Narrative inquiry was used to guide data collection and analysis. Semi-structured individual interviews and a collective consensual data analytic procedure (CCDAP) were used to collect and analyze data.

Results: Five overarching themes arose from the mothers' stories. The five themes were: Culture, Relationships, Access, Choice, and Resilience. The mothers' stories revealed their cultural practices were important to them during pregnancy and during birth, and they would like access to culturally safe care when they are in hospital to give birth.

Conclusion: The findings support the need for culturally safe care from early pregnancy to the period following the birth of the baby, which may provide protective health factors for Indigenous women and their infants. Health care providers have an opportunity to provide and advocate for improved cultural care for Indigenous mothers. The mothers in our study spoke of the value of culture to them, and their desire to reclaim traditional and cultural birth practices.

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I have an immense amount of gratitude for the mothers who graciously shared their stories with me; I hope I honour their voices. To Janice and Jessica especially, thank you for your dedication and commitment to this initiative, for your kindness, and for your wisdom. I am forever grateful and changed by my interactions with you and the rest of the mothers who so generously contributed to this project. Thank you to the project Elders, Eileen Thomas and Alice Pahtayken, for their guidance, prayers and wisdom throughout the duration of the project.

I pay acknowledgment to the Treaty Six territory and the homeland of the Metis, the land where I live and study; I am grateful for the privileges afforded to me as a treaty person. I acknowledge my ancestors by thanking and loving them. I ask them to walk with me and keep me safe; I know they love me and are proud of me. I know I am never alone.

Thank you to my supervisor, Dr. Angela Bowen, who has provided me an abundance of rich opportunities and has helped me in my intellectual, mental, and spiritual development. I am immensely thankful for her time and dedication to my learning and development as we progressed through this project together. Dr. Bowen's dedication to her work and her students is inspiring and unparalleled; she has helped me to become a better nurse, academic, and person, and I am privileged and blessed for this experience with her.

My sincerest gratitude goes to Dr. Holly Graham, who was a member of this thesis committee, for her meaningful support and expertise. Dr. Graham introduced me to the collective consensual data analytic procedure (CCDAP) methodology and was pivotal in facilitating the data analysis. I would like to acknowledge Dr. Graham for her extensive experience as a Registered Nurse and Registered Doctoral Psychologist; she is an expert in both mental health and Indigenous research methodologies, and her guidance has been crucial to the success of the project. Dr. Graham was able to answer many of my questions and has been a great academic and cultural mentor to me. I thank her for inviting me to her home community, and for sharing her experience and knowledge. This project could not be what it is without her guidance.

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Thank you to my parents Ralph and Merle Lee Ann Pratt for your love, for teaching me the value of education and for always supporting me. Thank you to Tyler for all the support and encouragement you have given me over the last three years, for your patience with me, and your endlessly good advice.

And finally, I would like to thank the reader for joining me thus far. I hope you find the reading both enjoyable and enlightening, and that the knowledge you gain might help you or someone you know in some way.

Dedication

This thesis is dedicated to:

The mothers who participated in this study, and all of their children. Thank you.

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List of Acronyms

JPCHF – Jim Pattison Children’s Hospital Foundation

NACM – National Aboriginal Council of Midwives

NI – Narrative Inquiry

PFA – Patient Family Advisor

POR – Patient-Oriented Research

PTSD – Post traumatic stress disorder

SCPOR – Saskatchewan Centre for Patient-Oriented Research

SHRF – Saskatchewan Health Research Foundation

TRC – Truth and Reconciliation Commission

UNDRIP – United Nations Declaration for the Rights of Indigenous Peoples

Prologue

When engaging in narrative inquiry (NI), researchers must attend to their personal justification of the research study, and clarify why the research is important and matters to them personally (Kim, 2016). This personal justification of the research can be done by situating oneself within the research through writing a section called “narrative beginnings” (Clandinin, Pushor, & Orr, 2007, p. 25), which I will provide in this prologue.

Situating Thesis within the Body of Indigenous Birth Research in Saskatchewan

Through my work as a Registered Nurse and graduate student, an opportunity arose to become involved in the project “Culturally Safe Birth” under the supervision of Dr. Angela Bowen at the College of Nursing, University of Saskatchewan. Dr. Bowen directs a body of research with various First Nation community partners, where the goal is to return cultural birth practices to Indigenous communities and includes two research grants: Culturally Safe Birth, and Bringing Birth Back. This research is funded by the Jim Pattison Children’s Hospital Foundation (JPCHF), the Saskatchewan Health Research Foundation (SHRF) and the Saskatchewan Centre for Patient-Oriented Research (SCPOR). Dr. Bowen serves as supervisor for this thesis project “Indigenous Mother’s Perspectives for Culturally Safe Birth in a Hospital Setting”, which is a component of the larger body of Indigenous birth research in Saskatchewan.

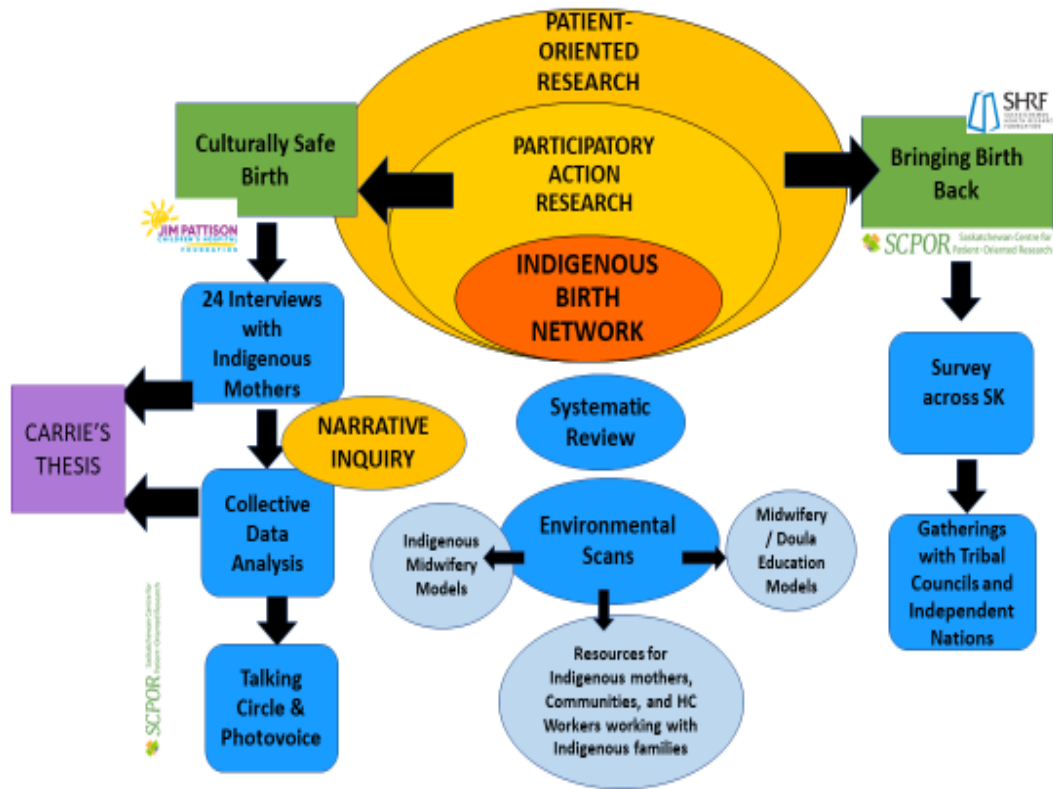


Figure 1. Thesis work within greater context of Indigenous Birth Research in Saskatchewan

I began working for Dr. Bowen as a research assistant in May 2017 and started the Master of Nursing Thesis Program at the University of Saskatchewan in September 2017. This thesis project was derived from Dr. Bowen’s research grants, which use participatory approaches to improve the cultural safety of Indigenous women giving birth and to increase the cultural humility of the health care professionals caring for them. One objective of the Culturally Safe Birth grant was to conduct individual interviews with Indigenous women to share their stories of giving birth, and this is the objective that I chose as the focus for this thesis. The Bringing Birth Back research uses a patient-oriented research (POR) approach; as a trainee who received funding from the SCPOR, I incorporated elements of POR into this project.

Another objective of the Culturally Safe Birth research grant was to hold talking circles and a photovoice project with the mothers. While this thesis focuses solely on the individual interviews with the mothers, I was involved in facilitating the talking circles and photovoice components of the larger grant. The primary method of knowledge translation for this research

will be the photovoice. I would also like to note that the talking circle and photovoice, while not included as data in this document, deepened my relationships with the mothers.

Self and Cultural Awareness

I am a Métis woman. I was born in Prince Albert, Saskatchewan and was raised thirty kilometers south in Birch Hills. Our family lived on ten acres of land with many big trees; it is quiet and peaceful. You can hear the songs the spruce trees sing with the wind. This piece of land raised me and is an essential part of who I am. I am grounded and feel peace when I am home.

My Grandma Gertrude Pratt is 96 years old; she is a pillar in my life. Grandma is status Cree and likely the oldest Aboriginal woman veteran in Saskatchewan; her mother was Marie “Minnie” Fraser, who was a community midwife and brought dozens of babies into the world. According to my Grandma, her mother Minnie was a good student and writer; I feel connected to her, and I feel that I honour my grandmothers through this work. My paternal great-grandmother is Carrie Pratt, who is my namesake; Carrie died in childbirth at the age of 24. My grandmothers are a great source of inspiration and motivation in the work I do.

My mother’s parents are of mostly European descent; my Granny did have French-Métis ancestors, several of those great-great aunts cooked at camps for the Red River Rebellion, an ancestral thread of resistance that inspires me in this work. My blood, as I know it, is a mix of Cree, Metis, English, Scottish, Irish, Polish, and French. I strive to take the best teachings from all sides of my ancestry, as I believe there is value in different worldviews and paradigms.

My mother is Merle Lee Ann Pratt, and my father is Ralph Pratt; I love them very much. My little brother and older sister and I are close in age; they are my protectors. Another brother came into our lives a bit later; he was a child from my mother’s teen years and was raised by his adoptive family. I have learned important lessons about the trauma and legacy left when babies are not raised knowing who they are, and also the effect on the mother. This brother is in our lives now, and he has two daughters who are gifts to our family.

Birch Hills, my hometown, is a rural farming town with a small mostly Caucasian population. I had every privilege and was able to move freely through borders of all kinds; I have never had a concern because of my physical appearance or last name. I am pale-skinned and move with ease and security through colonial systems in Canada and around the world. Thus, it took me a long time to understand the history of colonization and the devastation it creates for Indigenous families across Canada and the globe.

As an adolescent, I began to learn about the world outside my home, about issues in “third world countries,” environmental destruction, and social issues in Canada. I started to notice these issues in my environment. I thought about the comments relatives and schoolmates made about people who aren’t white skin. Racist jokes were normal and common, and no one questioned the stereotypes that develop in small towns like mine. Around that same time, I witnessed the physical assault of my younger brother; I heard the victimizers brag about “the Indian they beat up.” In school the next week, fellow students asked about “the Indians that beat up your brother.” I began to understand the ease of my life afforded by the privilege of my light skin and how my own brother would be treated differently at times because he is darker than I am.

Around then I was learning the Canadian history that was common high school curriculum in 2006. This was the first time we learned about topics like residential schools and the Sixties scoop – the first time a narrative was provided that showed Canadian history in a less-than-ideal light. I wanted to learn more, and eventually my path brought me to nursing at the University of Saskatchewan. Nursing school is when I found many opportunities to learn more about traditional Indigenous ways of knowing, the Treaties, and the ongoing process of colonization. I have completed Cree culture and language courses, participated in activism training for Indigenous youth, and attended my first powwow, sweat, round dance, and feast. I fell in love with Cree culture and Indigenous teachings from around the world. I grew up knowing that I was Métis, but did not receive cultural teachings; nursing school gave me the tools and opportunities to discover more about who I was, and the true history of Indigenous people and Indigenous-Settler relations in Canada.

Nursing also brought me to Africa where I spent time in remote Tanzania with a Maasai community. The Maasai are another example of an Indigenous society plagued by colonialist practices which forced them from their homelands. After working with the mothers in that community, I was reminded that my life is privileged and this experience cemented the understanding that I must be acutely aware of my position in this world. I felt a great duty to work towards rectifying these injustices experienced by so many across the earth.

In 2016, I graduated and became a Registered Nurse; my first job was on a surgical ward, and now I work as a rural homecare nurse. In my short time working as a nurse, I have witnessed discriminatory and racist incidents from clients and from other nurses. I cannot imagine the

experience of visibly Indigenous nurses, and how difficult it would be to keep going to work when you face that racism. Altogether, these experiences gave me a deeper understanding of the complex issues Indigenous people have to face and I felt a sense of duty to advocate for the improved health and wellness of Indigenous peoples in Canada. Although my families' traditional and cultural knowledge did not survive to be passed to me, I am trying to reclaim my culture and share it with them.

I was named after my fathers' paternal grandmother Carrie Johnstone, whose mother is Caroline Belanger; through them, I am a seventh-generation descendant of Chief Mistawasis and Chief Ahtakakoop, both signatories of Treaty Six. I am a seventh-generation direct descendant of Askenootow, who is known more commonly by the English name, Charles Pratt, an interpreter of the Treaty Four negotiations. I take my right to education very seriously as it is my claim to the Treaty rights my ancestors negotiated.

Choosing Birth Research and Personal Benefits of the Research

I chose to pursue a Masters' degree to do research that improves Indigenous family health and wellness. The opportunity presented to work with Dr. Bowen on her project "Indigenous Women's Perspectives for Culturally Safe Birth" funded by JPCHF and SHRF, and thus I based my thesis work on this grant. Dr. Bowen used participatory action research (PAR) for "Culturally Safe Birth," and as such, I have used PAR as a framework to guide my thesis. Also, as a SCPOR trainee, I chose to use elements of POR in my research framework. Under this umbrella of PAR and POR, a narrative inquiry (NI) approach was used to guide data collection and analysis. According to Kovach (2009), "narrative is the primary means for passing knowledge within tribal traditions" (p. 94), and storytelling has always been an integral part of Indigenous knowledge and epistemologies. As part of NI, I utilized a collective consensual data analytic procedure (CCDAP) that included a team of Indigenous mothers, Elder, researchers, and health care providers.

As I engaged in research to support the return of traditional and cultural birth practices for First Nation and Métis mothers, I began to understand my own family and my ancestors better. Through the interviews with the mothers, teachings from Elders and through ceremonies and gatherings, I discovered much about myself as well as the topics I was researching. I have experienced intellectual, cultural and spiritual growth; the research has been transformative on a personal level, and I am overwhelmed with emotion to think of my journey. Although I have not

been blessed with the gift of children at this time, I am more confident in my role as a woman through the teachings I have received from the mothers and Elders I learned from. I also understand that, while I am not a mother myself, I have a duty to care for the children and mothers in our communities. I hope this research contributes to a culture that celebrates birth, motherhood, and the roles we all have in ensuring that mothers and their babies are safe.

Mentorship is another important benefit I gained through this research, and the growth I have experienced through this work can be owed to the relationships I developed. The profound learning and mentorship opportunities I received were an unexpected but much appreciated benefit of the methodologies, and I am grateful for the impact of these relationships on my personal development. The nature of the research, including the people, the communities, and the methods, have allowed for bi-directional learning and reciprocity. The mothers, through the interviews, taught me so much about culture and motherhood. As part of the POR methodology, it is necessary to include patient family advisors (PFAs) in the research project. The PFAs for this project were two mothers, Janice Osecap and Jessica Dieter; these two First Nation women have helped me immensely along this journey in terms of guidance and advice, and through sharing their life experience.

Dr. Angela Bowen is my supervisor and has provided teaching and support to me through my journey in graduate studies. Through Dr. Bowen's mentorship and incredible support, I have been able to grow and develop my capabilities as a researcher and begin to establish myself within the academic community. Dr. Holly Graham, a member of my committee, provided invaluable guidance and mentorship to me through her expertise in Indigenous research methodologies and mental health, especially related to trauma and post-traumatic stress disorder (PTSD). Dr. Graham invited me to attend cultural experiences in her home community, Thunderchild First Nation; I cannot underestimate the importance of her guidance and direction through all stages of the research process.

As a means of gratitude for what I have received, I hope the contributions from this research creates meaningful change and improved cultural care for Indigenous mothers. This research project could not be possible without the mothers who volunteered their time and willingly told their stories. Through their vulnerability, they are strong and have helped create a movement for birth rights for Indigenous mothers. Furthermore, this study is a collaboration of academics, health care leaders and decision makers, community organizations, knowledge

keepers and Elders, and Indigenous mothers. It is this collaboration that made the project a success. Listening to and sharing these mothers' experiences reveals gaps in Indigenous maternal health care with an opportunity for care providers to improve cultural care for Indigenous mothers who deliver their babies in Saskatchewan hospital.

Chapter 1: Introduction

At one time, Indigenous pregnancy and birth was a joyous event, celebrated with ceremonies and rituals that involved all members of the community (Anderson, 2011; Bruyere, 2012). A decrease in midwifery services in Canada over the last several decades, along with a lack of maternity services in rural and remote communities, has resulted in a decline of cultural influence in birth with subsequent negative impacts on Indigenous maternal newborn health outcomes (National Aboriginal Council of Midwives [NACM], 2016; Tarlier, Johnson Brown, & Sheps, 2013). Indigenous maternal and infant health inequities are a consequence of colonization processes that attempted to systematically destroy Indigenous systems and ways of being (Bourassa, 2018; Daschuk, 2013; Kelm, 1999; Truth and Reconciliation Commission [TRC], 2016). Colonization processes (for example, residential schools), led to the breakdown of Indigenous family and community structures, and the interruption of traditional parenting and birthing knowledge (Aboriginal Healing Foundation [AHF], 2007; Kelm, 1999; TRC, 2016). The drastically disproportionate number of Indigenous children in foster care - a rate sixteen times greater than that of non-Indigenous children (Statistics Canada, 2016) - is an example of the Canadian Government's continued interference with Indigenous peoples' families and culture.

There are several documents that were created in response to the devastation of Indigenous peoples' ways of life as a result of colonialism. One is the United Nations Declaration for the Rights of Indigenous Peoples (UNDRIP), and another is the Truth and Reconciliation Commission of Canada (TRC) Calls to Action. The UNDRIP and TRC Calls to Action state the rights of Indigenous people and give clear direction on how to reconcile authentically so the rights of Indigenous people are honoured and meaningful action is taken to repair past harms.

The United Nations Declaration for the Rights of Indigenous Peoples

In 2007, the United Nations Declaration on the Rights of Indigenous Peoples [UNDRIP] (United Nations, 2007) was adopted by the General Assembly; the Declaration is the most comprehensive international document on the rights of Indigenous people. Articles relevant to this study are:

Article 8:

1. Indigenous peoples and individuals have the right not to be subjected to forced assimilation or destruction of their culture.
2. States shall provide effective mechanisms for prevention of, and redress for:
 - a. Any actions which has the aim or effect of depriving them of their integrity as distinct peoples, or of their cultural values or ethnic identities

Article 11:

1. Indigenous peoples have the right to practice and revitalize their cultural traditions and customs. This includes the right to maintain, protect and develop the past, present, and future manifestations of their cultures, such as archaeological and historical sites, artefacts, designs, ceremonies, technologies and visual and performing arts and literature.

Article 15:

1. Indigenous peoples have the right to the dignity and diversity of their cultures, traditions, histories and aspirations which shall be appropriately reflected in education and public information.

Article 24:

1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservations of their vital medicinal plants, animals, and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services. (United Nations, 2007).

The Truth and Reconciliation Commission Calls to Action

In 2015, the Truth and Reconciliation Commission of Canada released a publication of its inquiry into the residential schools that heard testimony from over 6,000 witnesses. One outcome of the TRC report were the 94 Calls to Action, which are directions to reconcile the harm rendered to Indigenous people (TRC, 2015). Calls to Action that are pertinent to this study are:

18. We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize

and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.

22. We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

23. We call upon all levels of government to:

- i. Increase the number of Aboriginal professionals working in the health-care field.
- ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.
- iii. Provide cultural competency training for all health-care professionals.

24. We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the *United Nations Declaration on the Rights of Indigenous Peoples*, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism. (TRC, 2015).

Together, these two documents give rationale to support cultural birth practices for Indigenous mothers and their babies, and for health care providers and researchers to implement culturally safe care for Indigenous mothers.

1.1. Purpose of the Study

The introduction of western medical systems led to the cessation of traditional birth knowledge and Indigenous midwifery, and fragmented maternity care for Indigenous women in Canada (NACM, 2016; Tarlier et al., 2013). Indigenous women currently experience health inequities compared to non-Indigenous populations and those inequities extend to their babies. For example, in Canada, perinatal and neonatal death rates were higher in Indigenous than in non-Indigenous populations in urban, rural and northern settings (Luo et al., 2009; Tarlier et al., 2013). Rates of high birth weights and large for gestational age are more than double in northern First Nation populations compared to Inuit and non-Indigenous populations in Quebec (Luo et al., 2009). According to Tarlier et al. (2013), “the possibility that the most basic of maternal-

child health outcomes remain in jeopardy in a developed and wealthy nation such as Canada raises serious concerns” (p. 90). Similarly, the Society of Obstetricians and Gynecologists (SOGC) acknowledges gaps between birth outcomes for Indigenous and non-Indigenous women and advocate for models of care in Canada that are unique to Indigenous mothers (SOGC, 2010). According to Smith (2003), “improving perinatal health outcomes could significantly reduce the disparities in health status between Aboriginal and non-Aboriginal people” (p. 143). Furthermore, ensuring optimal maternal infant health outcomes is critical to decreasing risk factors for health challenges later in life (Tarlier et al., 2013). Rates of chronic diseases, such as cancer, cardiovascular disease, diabetes and mental illness disproportionately affect Indigenous people, who also experience reduced life expectancy and higher mortality rates (AHF, 2007; Reading, 2018; Wright, Wahoush, Ballantyne, Gabel, & Jack, 2016), and many of these diseases have their beginnings in pregnancy and birth (Bowen et al., 2014).

Returning birth to home communities to support cultural practices and traditions is one solution to improve maternal health outcomes (NACM, 2016; SOGC, 2010); however, it is not possible for all women to have their babies in community, for accessibility and medical reasons, or by the mother’s own choice. When women leave their communities and support systems to birth in unfamiliar environments, childbirth can become stressful, and lead to adverse events such as preterm delivery (Brown, Varcoe, & Calam, 2011; Kornelson, Stoll, & Grzybowski, 2011; Tarlier et al., 2013). Therefore, there is an urgent need to address the cultural safety of Indigenous women who birth in hospitals. Improving the cultural safety of Indigenous mothers has the potential to improve health outcomes for the mother and her child and restores kinship between the child and its community (SOGC, 2010). As one Elder states, “there is a breakdown in traditional family structure...family is excluded from the joy of being at birth – this is important to our community, to our families” (Brown et al., 2011, p. 110).

While there is evidence in Canada of the success of returning birth to communities (SOGC 2010; Wagner, Osepchook, Harney, Crosbie, & Tulugak, 2012), there is little published data on the experiences and outcomes of Indigenous mothers who birth in Canadian hospitals. The intent of this research is to gain insight into the experiences of Indigenous mothers who give birth in a Saskatchewan hospital. By listening to and sharing the mother’s stories, we hope to reveal solutions to improve the cultural care they receive and ultimately improve maternal and infant health outcomes.

1.2. Research Question and Objectives

Semi-guided individual interviews were conducted with Indigenous mothers in Saskatchewan to answer the research question: What are the experiences and stories of Saskatchewan Indigenous women who have gave birth in a hospital between January 2017 and September 2018?

The research objectives are:

1. Understand Indigenous women's experience of birth in Saskatchewan hospitals:
 - a. What do women expect from health care providers when they give birth?
 - b. What cultural practices do Indigenous women find comforting during birth?
 - c. How do rural Indigenous women experience birth? How do urban Indigenous women experience birth?
2. Develop policy recommendations to improve the cultural safety of women giving birth
3. Explore Indigenous birth practices and ceremonies that can be integrated into the delivery room

1.3. Key Concepts and Terms

1.3.1 Indigenous. Indigenous people is a collective term for the original inhabitants of North America and their descendants (Government of Canada, 2017). The Canadian Constitution recognizes three groups of Indigenous people: First Nations, Inuit, and Métis; each Indigenous group has their own culture (Government of Canada, 2017). More than 1.67 million people in Canada are Indigenous; they are both the fastest growing population and youngest population in Canada (Government of Canada, 2017). Indigenous people have cultural and social identities, as well as social, economic, and political systems separate from the dominant society, and live within traditional habitats or ancestral territories (World Health Organization [WHO], 2020).

1.3.2. First Nation. First Nation people historically lived in North America, from the Atlantic to Pacific, below the Arctic. There are more than 630 First Nation communities in Canada, representing more than 50 nations and 50 Indigenous languages (Government of Canada, 2017). The First Nation population includes people who are members of a First Nation/Indian Band and those who are not members, as well as those with and without registered Treaty status under the Indian Act (Statistics Canada, 2019). Other terms for First Nation include Indian and Native.

1.3.3. Inuit. The Inuit are the Indigenous people of Canada's Arctic; there are approximately 64,235 Inuit people in Canada (Government of Canada, 2017).

1.3.4. Métis. The Métis emerged as a distinct people during the 18th and 19th centuries in the Canadian Northwest. The initial offspring were unions of First Nation and European settlers; overtime, the gradual establishment of Métis communities grew as a distinct Indigenous people (Métis Nation Saskatchewan, n.d.). Saskatchewan has the highest percentage of Métis children in Canada (Tait, 2008).

1.3.5. Culture. The term culture refers to a way of living, which includes components such as food, languages, and belief systems (Government of Canada, 2011). Culture includes a value system “that relate strongly to religious beliefs, kinship patterns, social arrangements, communication and networks” (Aboriginal Healing Foundation [AHF], 2005).

1.3.6. Cultural Safety. Cultural safety addresses inequities arising from sociocultural factors and power differentials between service providers and those they care for and clinical practice without cultural safety contributes to the continued oppression of Indigenous peoples (Roy, 2014).

1.4. Outline for Thesis

The next chapter reviews relevant literature to provide a background and temporal context (Clandinin & Connelly, 2000) required to locate the mothers’ stories and examine cultural safety related to Indigenous birth in Canada. The third chapter describes and provides rationale for the chosen methodologies used in this research. The fourth and fifth chapters are manuscripts to be submitted for publication, with the fourth chapter describing the research teams’ experience with the chosen methodology, and the fifth presenting the results of the research. The sixth and final chapter discusses the main findings of the thesis, strengths and limitations, implications for health care providers and considerations for future research.

As discussed in the prologue, this thesis is one component of a more extensive research project that addresses cultural safety and Indigenous birth. Themes from the individual interviews discussed within this thesis were later used to inform talking circles and a photovoice project with the participants. The talking circles and photovoice, while not presented in this thesis, strengthened the relationship of the author with the participants, and will play a large role in knowledge dissemination.

Chapter 2: Background

2.1. Colonization

Before exploring Indigenous maternal health and birth outcomes, and the experiences Indigenous mothers have when they access pregnancy and birth health services, it is vital to examine the processes that have led to the continued oppression of Indigenous people today. To fully appreciate the current health inequities that Indigenous peoples face (Reading, 2018), this background will discuss the impact of colonization on which our current health systems operate. Current health care services often alienate Indigenous peoples as a direct outcome of these colonial processes; health care providers must understand the impacts of colonization in order to provide culturally safe services (Gerlach, 2012).

Colonization occurs when one group of people takes control of another, including their land and resources, and is an ongoing process (Czyzewski, 2011). Colonization processes in Canada happened over several hundred years and continue today; as a result, most Indigenous groups have faced extreme alterations in their economic, political, and social systems (Reading, 2018). In this case, the colonizers refer to settlers, and the colonized are the Indigenous people of Turtle Island, now referred to as North America (Robinson & Filice, 2019). Although there is immense diversity amongst Indigenous peoples in every province, for ease of reading, the term Indigenous is used in the article to describe First Nation, Métis, and Inuit peoples (Government of Canada, 2017).

Colonization processes caused tragic and massive losses of the North American Indigenous population (Daschuk, 2013; Geddes, 2017). Government policies harmed Indigenous populations through means of disease, violence, and suppression of their cultures and identities, and geographic and economic dispossession further compromised Indigenous people's health (Kelm, 1999; Tait, 2009). While the precise number of Indigenous people who died is unknown and indeterminable because of loss of records (Daschuk, 2013), it is generally accepted the population loss of Indigenous peoples occurred at a rate of 90% from pre-contact to the late 1800s (First Nations Health Council [FNHC], 2011).

2.1.1. Early Contact and Relationships

Before the arrival of the Europeans, the people of Turtle Island (North America) had complex societies, created through kinship and trade relationships (Aguilar & Halseth, 2015).

Indigenous nations had advanced government, education, health, and economic systems; they were self-sufficient and sophisticated people (Daschuk, 2013; Geddes, 2017; Venne, 2006). European colonizers began to make their way to Turtle Island in the interest of extracting resources for economic gain, by taking raw materials, such as animal fur, to their homelands to be manufactured and sold (Daschuk, 2013). During the early time of the trade, there was a mutually beneficial exchange of technology and knowledge (Dickason & Newbigging, 2015; Dolin, 2011). The fur trade initially benefited Indigenous people, as they had access to new technologies and tools that made life more efficient (Dickason & Newbigging, 2015; Government of Canada, 2017). Europeans benefited from the Indigenous people's expert knowledge of the land, without which the newcomers would not have survived, and the fur trade would not have existed (Daschuk, 2013; Kelm 1999). Economic development and European-Indigenous relationships centered around the fur trade for roughly 250 years until the 1800s when animal resources began to decline.

2.1.2. Shifts in Power

At first, the relationship between the newcomers and Indigenous people was mutually beneficial, but soon the balance in power began to shift, disrupting traditional ways of life (Daschuk, 2013; Dickason & Newbigging, 2015; FNHC, 2011). Indigenous communities grew increasingly reliant on European goods, and the colonial presence gradually influenced Indigenous societies (Dickason & Newbigging, 2015). Also, the influx of diseases, such as smallpox epidemics, decimated Indigenous populations; in one instance in the 1770s, smallpox eliminated several Indigenous groups on the plains provinces of Canada (Daschuk, 2013). After the Confederation of Canada in 1867, the Government began its pursuit of western expansion, with visions to build a railroad and occupy the land with Europeans who would raise crops and cattle (Daschuk, 2013). The conversion of Indigenous hunting territories into pasture lands and the decline in animals for hunting further restricted access to traditional food resources. In their ongoing pursuit of manufacturing, the Government banned many forms of fishing and hunting, which robbed Indigenous people of their self-sufficiency (Reading, 2018).

Towards the late 1800s, the Government considered the Indigenous people to be barriers to their goals of railway construction and agricultural settlement and consequently developed strategies to eliminate Indigenous identities from Turtle Island (Daschuk, 2013; Dickason & Newbigging, 2015). Strategies to assimilate or eliminate Indigenous people include the Indian

Act, which legally allowed the removal of Indigenous children into residential schools and non-Indigenous homes, and tactics of starvation by purposeful attempts to decimate the bison and restricting food rations entitled to Indigenous people (Daschuk, 2013).

Along with death by starvation, the Indigenous people began to die in epidemics of flu, polio, smallpox, and tuberculosis (Daschuk, 2013; FNHC, 2011; Geddes, 2017). The viruses the newcomers carried from Europe had not previously existed on Turtle Island; Indigenous communities faced alarming rates of disease and mortality over the centuries (AHF, 2007; Daschuk, 2013; Dickason & Newbigging, 2015; Geddes, 2017). The loss of Indigenous lands and resources to the Government further resulted in poor living conditions, compounding the sickness and death of many Indigenous people (Daschuk, 2013; Geddes, 2017; Kelm, 1999). The ongoing erosion of Indigenous people's way of life created opportunity for the Government to roll out harsher interventions to eliminate Indigenous people from their goals of expansion (Daschuk, 2013; Reading, 2018).

2.1.3. The Indian Act

Canadian authorities issued a legislation called the Indian Act in 1867 intended to systematically erase Indigenous identities, called the Indian Act (Marenko, 2008). The Indian Act stripped Indigenous people of their rights and dignity (Geddes, 2017); they were no longer considered sovereign people and became wards of the Government (Marenko, 2008). This racist legislation abolished Indigenous systems of governance and imposed patriarchal elective systems, to be overseen by the Government, where they could remove Indigenous leaders at any time for any reason (Marenko, 2008). Low ranking officials of the Department of Indian Affairs, called Indian Agents, were tasked to oversee the reserves and there are many reports of their abuse and exploitation of Indigenous people exist (AHF, 2005; Daschuk, 2013).

The Indian Act gave the Government, not Indigenous people themselves, the power to determine who met the definition of Indian Status, and Indigenous women were not allowed to maintain their identity if they married a "non-Indian" (Marenko, 2008). Amendments to the Indian Act continued until the 1950s and the following examples elucidate the Governments' intentions of disappearing Indigenous people:

- Indigenous people faced imprisonment if caught holding spiritual ceremonies; sacred ceremonial pieces and garments were destroyed or sold for profit or to museums.

- Canadian Government had the power to remove people from reserves near towns with populations over 8,000, and power to take land from reserves for roads, railways, and other public works, and power to remove reserves entirely.
- Treaties were meant to support Indigenous people in agriculture, but the Government provided them with equipment that was inferior to what new settlers were given and Indigenous people were also forbidden from selling their produce without the Indian Agent's approval (Marenko, 2008).

The Indian Act debilitated the autonomy of Indigenous people, and ultimately resulted in poor living conditions and endemic poverty for Indigenous people (Geddes, 2017).

2.1.4. The Numbered Treaties

Indigenous people of Turtle Island were familiar with treaty-making before the arrival of the colonizers; when Europeans arrived, the Indigenous people extended similar negotiations, for example, the Peace and Friendship Treaties of 1725-1779 (Government of Canada, 2018). However, with the collapse of their traditional ways of life and the oppressive forces of western expansion, many Indigenous leaders had no choice but to enter into what we refer to today as the Numbered Treaties with the Government (Daschuk, 2013). The Numbered Treaties, signed between 1871 and 1921, outlined the rights of Indigenous and Settler people, with the intent of peaceful coexistence; there were eleven treaties signed altogether (Government of Canada, 2018; Venne, 2007). Note all of North America is Indigenous land, and all Canadians are treaty people and have rights according to the Numbered Treaties. Without treaty rights, Settlers today have no law to legitimize their occupancy of Turtle Island (Venne, 2007).

Indigenous people understood the Treaties as shared use of land and responsibilities, in return for provisions such as protected lands (called reserves), hunting rights, food provisions, access to education, assistance to establish agriculture, and in the case of Treaty Six, the provision of medicine (Daschuk, 2013). When Indigenous nations agreed to the Treaties, they did so with the intent they would last forever (Venne, 2007).

On the other hand, the Government thought of the Treaties as massive land surrenders that put Indigenous people under their jurisdiction; they were ill-prepared and failed to deliver on the agreements that were made (Daschuk, 2013; TRC, 2015; Venne, 2007). For example, the Government initially assured the Indigenous people they would not take all the land, the land

they did take would be enough for farming purposes only, and that Indigenous leaders who signed treaty would choose the sects of land to occupy (called reserves) (Venne, 2006). However, with the Indian Act amendments, the reserve system became a tool to relegate Indigenous people to undesirable tracts of land, which they eventually required permission from the Indian Agent to leave, and could be claimed at any time by the Government for expansion interests (Daschuk, 2013; Marenko, 2008). The Indian Act and Numbered Treaties of the late 1800s resulted in harsh conditions for Indigenous people during the first half of the twentieth century (Daschuk, 2013; Kelm, 1999); according to Geddes (2017), “the great tribes who welcomed, fought alongside us, and shared their land...were to be starved, betrayed, displaced, infected, and humiliated” (p. 15).

2.1.5. Residential Schools and the “Sixties Scoop”

One of the most inhumane attempts of assimilation against Indigenous peoples as part of the plan to civilize targeted their children, who were removed from their homes and placed in Government operated schools, termed residential schools (Kelm, 1999; TRC, 2012). The Government handed control over Indigenous education to the churches in 1867, when residential schools became the primary method of assimilation (Reading, 2018). The children’s cultural teachings were replaced with Christian belief systems, with the intention of conditioning Indigenous children into western economic and social systems and dismantling Indigenous family and kinship structures and cultural learning (Kelm, 1999; Reading, 2018, TRC, 2012). Schools were often located far from Indigenous communities to ensure the children’s isolation (Reading, 2018; TRC, 2012) and in the 1920s, it became mandatory that parents must send their children to the schools; parents were threatened with the risk of imprisonment if they did not comply (Daschuk, 2013), and enrollment in residential schools increased dramatically (Kelm, 1999). Removing Indigenous children from their families to the schools was based on the premise that unassimilated Indigenous women were poor mothers, and children were best off raised away from them (Kelm, 1999).

Residential schools were underfunded and understaffed; many children lost their lives at the schools due to poor diets and poor sanitary conditions, overwork of the children, and widespread abuse (emotional, mental, spiritual, sexual and physical) (Geddes, 2017; Kelm, 1999; Reading, 2018; TRC, 2012). Children who survived the schools were often traumatized and suffered psychological damage that affected them, their children, and succeeding generations

(Aguiar & Halseth, 2015; Reading, 2018; TRC, 2012). Many children never saw their families again, and their families never knew what had happened to them (TRC, 2015).

Residential schools operated for 125 years, with the last school closing in 1996 in Saskatchewan (TRC, 2015). The loss of the children due to residential schools left Indigenous families and communities devastated and broken (Aguiar & Halseth, 2015; TRC, 2012). Although the majority of residential schools closed in the 1960s, the practice of apprehending Indigenous children and placing them in non-Indigenous homes continued with the "Sixties Scoop" (Daschuk, 2013; Reading, 2018). The "Sixties Scoop" refers to the mass removal of children of Indigenous children from their homes and communities and placing them into mostly non-Indigenous households, beginning in the 1960s (AHF, 2003; TRC, 2012). The removal of these children into foreign homes promoted the loss of their cultural identity, and the physical and emotional trauma of separation affects adoptees of the "Sixties Scoop" and their families today (TRC, 2012). As discussed in the next section, the continued impacts of residential schools and the "Sixties Scoop" are evident in the health inequities for Indigenous people compared to non-Indigenous people, and the disproportionate rate of Indigenous children in welfare.

2.1.6. Impacts of Colonization on Indigenous Health

Health disparities between Indigenous and non-Indigenous people in Canada are a result of colonization processes (Bourassa, 2018), where the exploitation of Indigenous people has created broken lives, families, and communities (Geddes, 2017). The sequelae of colonization include reduced life expectancy and higher mortality rates, and disproportionately higher rates of chronic and communicable disease, addictions, suicide, and social violence (Aboriginal Healing Foundation, 2007; Reading, 2018; Wright, Wahoush, Ballantyne, Gabel, & Jack, 2016). The impacts of residential schools and other assimilation tactics are generational; children who lived through the schools often faced challenges in their roles when they became parents (Aguiar & Halseth, 2015; TRC, 2012). Over time, the legacy of the schools led to poverty, family violence, sexual abuse, prostitution, and incarceration (Tait, Henry, & Walker, 2013; TRC, 2012). Christian Missionaries undermined the role of Elders in communities, and as residential schools continued, Elders passed on, which left leaving a gap in cultural knowledge and loss of wisdom and each succeeding generation had fewer resources to draw from (Kelm, 1999).

Another fallout of Government assimilation policies is evident in the disproportionate numbers of Indigenous children in child welfare (Tait, 2009). In 2011, Indigenous children

accounted for seven percent of the child population in Canada, but represented almost half of all foster children in Canada (Statistics Canada, 2016b). The disproportion is even more startling in the provinces of Saskatchewan and Manitoba, where 85% of children in foster care were Indigenous (Statistics Canada, 2016b). The legacy of removing children from their community continues, and more often than not, children are placed in non-Indigenous environments away from their families, culture, which weakens the entire community (Tait et al., 2013). Although Canada has entered what is considered a postcolonial era, government systems continue to negatively impact the health and wellbeing of Indigenous people, with the unequal rates of children in foster care being an example (Tait et al., 2013).

Colonization processes continue to impact Indigenous health and wellbeing negatively. These factors will continue to affect future generations, including pregnancy and offspring (Bowen et al., 2014), therefore addressing Indigenous maternal and infant health is crucial to mitigate the impacts of colonization on their wellness.

2.2 Indigenous Pregnancy and Birth

Children are highly valued in Indigenous cultures and are considered gifts from the Creator; women are connected to Mother Earth through the responsibility of reproduction, and thus childbirth is a sacred event (Bruyere, 2012). Elders taught pregnancy and birth ceremonies, and these teachings started when girls were young, to prepare them for motherhood (Anderson, 2011). Traditionally, Indigenous women birthed in their communities where cultural practices help connect the mother, infant, family, and community and help the infant develop a strong sense of identity (NACM, 2017; SOGC, 2012). There are many people involved in raising Indigenous children, including family members, Elders, and community members, and the birth of a baby is an important event that includes these people (Bruyere, 2012). Community midwives facilitated cultural practices related to childbirth, which “contributed to the early shaping of individual bodies” (Kelm, 1999, p. 169). Prayer, music, ceremonies, and involvement of family and community are essential parts of birth ceremonies - particular food or clothing might be as essential to the family as medical management is for health care professionals (Bruyere, 2012).

It is important to understand that Indigenous cultural practices are healing based (Bruyere, 2012). Indigenous people understand the importance of ceremony and prayer, as much as medical management, when welcoming a child (Bruyere, 2012; Olson, 2013).

2.2.1. Colonial Interference to Indigenous Birth Practices

Colonial forces imposed their medical systems, and therefore maternal care for Indigenous women has evolved in the context of western medicine that has mainly replaced Indigenous birth practices and midwifery (Brown et al., 2011; Kelm, 1999). Medical control is a form of power, which impedes Indigenous women's autonomy over their bodies (Brown et al., 2011; Simpson, 2006).

As one Elder states, "There is a breakdown in traditional family structure...family is excluded from the joy of being at birth – this is important to our community, to our families." (Brown et al., 2011, p. 110). This breakdown of family involvement with birth is a direct result of the imposition of western medical practices; modern science has women birthing in controlled, sterile environments with physicians and nurses, and disregards the expertise of Elders and traditional midwives (Bruyere, 2012). These hospital environments are designed for safety but do not meet the cultural and spiritual needs of Indigenous mothers (National Aboriginal Council of Midwives [NACM], 2016). The foundation of Indigenous midwifery in communities has declined over the last several decades, which has negative impacts on cultural preservation and for maternal/newborn health outcomes (NACM, 2016). Colonization and assimilation policies outlawed traditional midwifery practices, which has contributed to poor health outcomes, loss of power of pregnant women and their families, and removal of birth from Indigenous communities to hospitals (NACM, 2017).

In the first half of the twentieth century, there were conflicting obstetrical views on how to care for Indigenous women (Kelm, 1999). Propaganda heralded the safety of doctor-centered births to Indigenous women – the distribution of the Canadian Mothers Handguide to Indigenous communities enforced western medical ideologies related to childbirth and parenting (Kelm, 1999). Yet some colonial politics encouraged the restriction of hospital births for Indigenous women for fiscal restraint, while at the same time, some Indigenous politicians argued that Indigenous women should have the same rights as settler women (Kelm, 1999). Indigenous women maintained their birthing knowledge and traditions, but as new disease processes took effect, they began to seek western care if they feared a complicated pregnancy (Kelm, 1999).

In response to maternal mortality rates in the 1970s the Government enforced a policy that women in northern areas of Canada would be transferred out for delivery at approximately 37 weeks gestation (Chamberlain & Barclay, 2000; SOGC, 2010). Government expectations of a

safer hospital environment may not have considered the cultural and spiritual needs of Indigenous women and their families (Bruyere, 2012). According to Chamberlain and Barclay (2000), “the Government policy of transferring out all first-time mothers is not based on research evidence” (p. 121). Technological advances have taken priority over important traditions and devalue the sacred ceremony of birth (Bruyere, 2012). As Simpson (2006) states, “the western medicalization of birth replaced our ceremony...and mothering was replaced by the physical, psychological, sexual, and spiritual abuse of the residential school system” (p. 28). Now, Canada is beginning to question the practice of evacuating women from their home communities to urban centres for birth, including the cost to mothers and the impact on the Government’s healthcare budget (SOGC, 2010). Colonial interference has influenced Indigenous maternal health today, and it is timely for researchers and health care providers to address the needs of Indigenous women in Canada.

2.3. Indigenous Maternal Health

Indigenous women are the fastest growing population of women giving birth (Bowen et al., 2016), where the fertility rate is 2.2 children per woman compared to 1.5 children per non-Indigenous women (Statistics Canada, 2017). As well, Indigenous women in Canada are birthing in urban settings at increasing rates (Birch, Ruttan, Muth, & Baydala, 2009).

Indigenous mothers seem to experience stress at a higher rate than their mainstream counterparts (Kornelson, Stoll, & Gryzbowski, 2011; Parker, McKinnon, & Kruske, 2014; Tarlier, Joy, Browne, & Sheps, 2013). High levels of stress during pregnancy and birth is related to a lack of resources, and the need for women to leave their community and support systems for labour (Tarlier et al., 2013; Kornelson et al., 2011). High levels of stress could lead to adverse perinatal outcomes, such as preterm labour and low birth weight (Tarlier et al., 2013; Kornelson et al., 2011). In their systematic chart review of a primary health care facility servicing a First Nations population, mothers in Northern Canada showed preterm delivery rates three times the rate compared to the Canadian population overall (Tarlier et al., 2013). Indigenous women also showed higher rates of depression and increased risk for depression, compared to other populations (Bowen et al., 2014). Overall, Indigenous mothers are younger, less likely to be married or in a common-law union, less likely to have graduated from secondary school, and have had more previous births compared to non-Indigenous counterparts (Statistics Canada, 2017). One study found that fertility rates of Indigenous teenagers aged 15 to 19 were almost

five times higher than non-Indigenous teenagers, and therefore, Indigenous mothers account for a large share of early mothers in Canada (Statistics Canada, 2017). Indigenous mothers who give birth at an early age are less likely to complete high school (Statistics Canada, 2017).

2.3.1. Rural and Urban Experiences

Approximately half of the Indigenous population in Canada live in metropolitan areas, and the other half in rural, remote, and northern regions (Bourassa, 2018; Statistics Canada, 2019). Since the 1970s, women in rural or remote communities in Canada have been evacuated to urban centres for birth at approximately 37 weeks of gestation (Chamberlain & Barclay, 2000). Declining access to maternity care is a reality for many pregnant Indigenous women in rural areas (Graves, 2012), and the requirement to leave home communities for birth has been an issue for many years (Olson, 2013; SOGC, 2010). When women leave their communities to birth, they are in unfamiliar settings and are with strangers, and the birth becomes stressful rather than strengthening (NACM, 2017; SOGC, 2010); their social and kin networks are not available to them, and the infant misses the opportunity to establish a connection with their home community from the beginning of their life (Olson, 2013). Rural geography shapes the experience of birth, through availability of resources and the challenges of travelling outside the community for labour; further challenges include poverty, isolation, limited economic opportunities, and decreasing maternity services (Brown et al., 2011). Overall, women in rural communities are less likely to report satisfactory care than their urban counterparts (SOGC, 2010).

In Chamberlain and Barclay's (2000) comparative study of two communities - one that evacuated Indigenous women for birth and one that had a birth centre where women delivered - they found women who evacuated for birth experienced increased emotional, physical, and economic stress. Women who birthed in their community experienced far less stress, enjoyed having their families around them, and found the constant presence of a midwife very helpful, facilitating their ability to deliver how they wanted (Chamberlain & Barclay, 2000). Many women who delivered away from home experienced a traumatic event that was intensified by feelings of isolation from their families, with the additional worries around loss of income, and travel and accommodation costs (Bruyere, 2012; Graves, 2012). There are also social consequences for mothers who have to travel for birth, such as separation from their other children, partners, family, and friends (Graves, 2012). However, in their critical review, Bowen

et al. (2014) found that, regardless of their geographical location, Indigenous women felt disconnected from their culture, families, and friends.

A cohort study based on national data in Quebec found Indigenous mothers living in urban centers faced even worse outcomes than their rural counterparts (Luo et al., 2009), and a study in Australia showed the primary demographic variable that determined newborn mortality is Indigenous status, not remoteness (Coory, 2003). Sokoloski (1995) interviewed seven participants in a Canadian urban centre, who were familiar with and participated in Indigenous culture; results showed participants believed pregnant women are life carriers for the Creator, and pregnancy was considered a natural process that did not require interference. Participants believed it should be older, experienced women who attend to women during childbirth, and physicians should attend when there are complications or problems with the pregnancy or birth (Sokoloski, 1995). These findings indicate that, regardless of geographical residence, there is a need to improve outcomes for Indigenous mothers, for which culturally tailored interventions could be appropriate.

2.3.2. Choice

In their comparative study of two Inuit communities, Chamberlain and Barclay (2000) found the mothers who left the community for birth expressed a lack of choice regarding the place and type of delivery, as well as the amount and type of support they received. Parents reported they could make few choices for themselves, with most of the decisions made by health care professionals. For example, some mothers said they would have preferred to squat or kneel instead of being on their backs to deliver the baby, and that lying down made the delivery more difficult (Chamberlain & Barclay, 2000).

One study in Australia used secondary analysis to compare women's maternity care experiences according to different geographic locations; not surprisingly, women in rural areas has less choice in the gender of their healthcare provider than women in large urban centres (Hennegan, Kruske, & Redshaw, 2014). Another study in Australia with Aboriginal mothers of Queensland and Torres Strait Island showed one third of women could not choose the gender of their care provider, and one third were unaware if the choice was available to them (Parker et al., 2014). The same study showed two thirds of Aboriginal women did not have a choice where they would deliver their baby (Parker et al, 2014).

2.3.3. Indigenous Infant Health Outcomes

Health inequities posed to Indigenous mothers extend to their babies and can lead to a sequelae of chronic disease in children (Tarlier et al., 2013). Indigenous birth outcomes are consistently more adverse compared to non-Indigenous populations (Bruyere, 2012; Statistics Canada, 2017), for instance, Indigenous infants have higher rates of abnormal birth weights, which can be a predictor of Diabetes Mellitus II, lower hemoglobin, and lower rates of immunization than non-Indigenous populations (Baldwin et al., 2002; Tarlier et al., 2013). Perinatal death rates were higher in Indigenous populations in all urban, rural, and remote locations (Luo, et al., 2009), and infant mortality rates were more than twice as high in Indigenous populations than non-Indigenous populations in Canada, with sudden infant death syndrome being more than seven times higher in Indigenous populations (Statistics Canada, 2017). These inequitable outcomes are because Indigenous children have disadvantaged socio-economic and health profiles when compared to non-Indigenous children (Tait, 2009).

2.4. Culturally Safe Care

The principles of cultural safety were founded in the 1980s by Dr. Irihapeti Ramsden, a Maori nurse, where the primary tenant is that the health disparities experienced by the Maori people were a direct outcome of colonization (Gerlach, 2012). Culturally safe care enables the recipient to determine whether or not the service was safe (Ramsden, 1996) and requires the provider to examine deeply rooted assumptions of power (Browne et al., 2009; Gerlach, 2012). Health care providers are to take responsibility for a process of change and transformation by reflecting on their positions of power and privilege in society and transferring power to patients (Browne et al., 2009; Gerlach, 2012). In Canada, cultural safety means understanding how intergenerational trauma and other colonial impacts influence access to and relationships with health care providers (Bourassa, 2018; Gerlach, 2012). Culturally safe care is likely to be more effective in addressing health disparities, (Birch, et al., 2009), yet because of racism, oppression, historical and ongoing Government policies, Indigenous people in Canada lack culturally safe health care (Bourassa, 2018).

2.4.1. Culturally Safe Care in Maternal and Infant Health

In a survey with Indigenous mothers in Australia, another commonwealth country with similar colonization impacts, women commonly report that they are unable to carry out cultural

practices and often feel uncomfortable giving birth in the hospital (Parker et al., 2014). Another study in northern Australia found health care providers believed Aboriginal women lacked understanding of and were distressed by the hospital context; they identified communication as a barrier to providing quality psychosocial care (Watson, Hodson, Johnson, & Kemp, 2001). While Australia and New Zealand have models of care in place for Indigenous mothers, Canada and the circumpolar region lack such models (Rich, D'Hont, Linton, Murphy, Veillard, & Chatwood, 2016). Most urban and rural communities across Canada lack culturally safe health services, and especially culturally safe reproductive services (NACM, 2017).

As the 20th century progressed, there was an increase in complicated births for Indigenous women, possibly due to cultural changes, or to introduction of disease (Kelm, 1999). However, the Indigenous women did not abandon their midwives or birth practices. Instead, Indigenous women began to use traditional and western healing modalities when they feared complications in childbirth (Kelm, 1999). Today, maternity services in Canada focus mostly on the biophysical aspects of maternal and infant health (Chamberlain & Barclay, 2000) and tend to neglect the spiritual and emotional needs of Indigenous mothers (NACM, 2017). Providing culturally safe care for Indigenous birth practices may improve pregnancy and labour outcomes and reduce health disparities for Indigenous communities (NACM; 2016; Smith, 2003).

The revitalization of Indigenous midwifery is restoring traditional practices, along with western medical practices, to facilitate care that is clinically and culturally safe for Indigenous women (NACM, 2016). However, most mothers are required to leave their communities to give birth in hospitals (Birch et al., 2009), and Indigenous midwives are inaccessible to many regions in Canada (NACM, 2017). Therefore, delivery of culturally safe health care services is vital when Indigenous mothers come to the hospital to birth their babies, and health care providers and hospital administrators can address birthing disparities for Indigenous women by providing culturally safe maternal and infant care (Bruyere, 2012; Smith et al., 2006).

2.5. Resilience

Indigenous women are decolonizing their bodies by reclaiming birth as a ceremony and claiming their traditional cultural roles and as life-givers (NACM, 2017; Simpson, 2006). Birthplace in Canada has become a political issue for some Indigenous people (Olson, 2013) and in response to the removal of birth and lack of support for mothers who wanted to birth in community, some Indigenous women, families, and communities lobbied successfully to

established birth programs (SOGC, 2010). Residential schools sought to end Indigenous people as a distinct group in Canada and failed (TRC, 2012), and in a similar manner, we are witnessing a resistance to western medical birthing norms.

2.6. Summary

Some studies have explored the experiences of Indigenous women who gave birth in a hospital in Canada (Birch et al., 2009; Brown et al, 2011; Bruyere, 2012; Chamberlain & Barclay, 2000; Tarlier, et al., 2013), however there is a lack of understanding on behalf of care providers of the cultural needs of Indigenous mothers and their families. It is important to provide culturally safe care to support Indigenous mothers and their families in reclaiming their culture to promote optimal health outcomes. As the literature indicates, colonization processes have interfered with the traditional and cultural birthing practices of Indigenous communities, and these birthing practices are important for Indigenous identity, health, and wellness.

Chapter 3: Bridging Chapter - Methodologies

3.1. Participatory Action Research

Participatory action research (PAR) is can be considered a philosophy, theoretical framework, and methodology; it is grounded in critical theory and social constructionism (Chenail, St George, & Wulff, 2007; Ginn & Kulig, 2015). It is a process of critical and reflective inquiry that “gives voice to the silenced ...and aims to ensure the power balance between [researchers] and Aboriginal communities is equitable” (Vukic, Gregory, & Martin-Misenerre, 2012, p. 15). To this end, participants are to be equal partners throughout the research process (Castledon et al., 2008; Ginn & Kulig, 2015). PAR draws from an array of research methods, and brings researchers and participants together as partners to answer questions of relevance to the community (Gannan & Ciliska, 2016; McHugh & Kowalski, 2009; Vukic et al., 2012). Participants are considered experts due to their lived experience in the research topic (Reid, Greaves, & Kirby, 2017). PAR aligns with Indigenous knowledge values of reciprocity, community, and respect (Reid et al., 2017; McHugh & Kowalski, 2009). Overall, the goal of PAR is to use research findings to influence social change to benefit the community directly (Watters, Comeau, & Restall, 2010; McHugh & Kowalski, 2009). The main principles of PAR can be succinctly summarized as: participants are regarded as experts in lived experience, power is shared equally between team members, and there is mutual respect regarding team member’s knowledge (Watters et al., 2010).

3.2. Patient-Oriented Research

Research in the euro-western manner view patients as subjects, and, although this is the still the dominant practice, efforts have been introduced to empower patients to be active members of the research team (Johansson, 2014). POR is conducted in partnership with patients and their families, called patient family advisors (PFAs) where the goal is to answer research questions that matter to patients (SCPOR, 2019). This collaborative research method is an answer to unethical paternalistic research processes that exclude patients from research on the basis they are subjects, and not experts; on the contrary, patients have experiences and insights which academic and medical researchers lack (Johansson, 2014). The goal is to transform the role of a patient from passive into proactive partners in research, and as a result, transform health care (CIHR, 2019).

There are two key elements of POR: first is the inclusion of patients in grant writing and the research process; the second is the inclusion of decision makers and health care practitioners throughout the research process (SCPOR, 2019). Including patients and/or families results in more relevant research questions and more appropriate methods (SCPOR, 2019) and helps to transform the patient from a passive receiver to an active partner in research (CIHR, 2019). The involvement of decision makers serves to hasten the process of translation research into practice (SCPOR, 2019). POR is about bringing useful scientific research to communities and producing information that healthcare providers need to improve care (CIHR, 2019).

In the context of POR, a patient is someone with personal experience of a health issue, and as such can include the individual afflicted with the issue, as well as caregivers, community, and others who have experience with illness (SCPOR, 2019). Patients for this research study include the advising Elder for this project and four mothers who were interviewee participants. The POR method is ideally suited for this study that engages Indigenous mothers to understand their experiences of giving birth to more effectively translate knowledge into practice.

3.3. Intersection of PAR and POR

From the research teams' perspective there are a number of similarities of the two research methods, in that they both centre on meaningful inclusion of the community the research aims to benefit. PAR aims to involve communities in action to change community identified problems or issues (Gannan & Ciliska, 2016), and POR mandates that patients and health care leaders and decision makers direct the actual research question and grant development. PAR aligns with the critical social theory, "describing the reality of those who have traditionally been excluded as producers and consumers of research" (Reid et al., 2017, p. 6); PAR does offer benefits to the participants and researcher, but also uses a critical lens to examine society at large (Watters et al., 2010).

Both methodologies assume the patient as expert, but where PAR is concerned with giving voice to those unheard in society, a primary tenant of POR is the collaborative involvement of key stakeholders to hasten the translation of research into practice and effective solutions for patients, and the health care system

For our purposes, the grant was developed using a PAR framework and principles, where community groups supported the research question and design. The question did not come from mothers directly, rather, from community organizations in the province where the research is

based that have Indigenous mothers' interests at heart. As the research progressed, the team was able to secure funding through SCPOR to support the research. For this reason, we were able to incorporate elements of POR into the research design; for example, the inclusion of patients and health care leaders in the collective consensual data analytic procedure (CCDAP). PAR primarily aims to benefit community, while POR looks to benefit health systems and create effective practice solutions. There are elements of each methodological framework that suited our needs, and the research team feels the approach we adapted is appropriate for the research question with this community of First Nation and Métis mothers.

3.2. Narrative Inquiry

Under our theoretical and research framework combining PAR and POR, we chose a narrative inquiry method to guide the data collection and analysis. Relatively new to nursing research, narrative inquiry is a methodology that provides an in-depth description of the participants' point of view and "attempts to illuminate the meanings of personal stories and events" (Wang & Geale, 2015, p. 195). The term narrative inquiry arose in 1990 by Connelly and Clandinin, who developed their conceptualization from "a Deweyan notion that life is education" (Clandinin, Pushor, & Orr, 2007, p. 22). Narrative inquiry is a common practice in the sense that humans have lived out and told stories since we could speak, and these stories that are lived and told are a way we fill our world with meaning (Clandinin & Rosiek, 2007). Narrative researchers study stories or narrative descriptions of a series of events; what differs is the kinds of stories, and methods used to study that story (Pennegar & Daynes, 2007). Narrative inquiry is the study of experience, and honours lived experience as an important source of knowledge (Clandinin & Rosiek, 2007), through a "collaboration between researcher and participants, over time, in a place or series of places, and in social interaction with milieus" (Clandinin & Connelly, 2000, p. 20).

According to Clandinin and Rosiek (2007), "following Dewey, the narrative inquirer takes the sphere of immediate human experience as the first and most fundamental reality we have" (Clandinin & Rosiek, 2007, p. 54). Yet narrative inquiry does not only describe a feature of one's experience, it is also a description of and intervention into human experience, because the descriptions give meaning to the experience (Clandinin & Rosiek, 2007). Furthermore,

narrative inquiry gives voice to marginalized people and makes their experience visible, telling stories that may otherwise go untold (Happel-Parkins & Azim, 2015; Wang & Geale, 2015).

The focus on story helps researchers understand cultural and historical worlds of the narrators; they are interested not only in objective truth, but also in the meaning, and subjective truth conveyed through narratives (Wang & Geale, 2015). The theoretical and philosophical approaches to narrative inquiry all revolve around the narrative and stories of the participants (Kim, 2016).

In the following section the conceptual framework of narrative inquiry is discussed with examples from the research.

3.2.1. Common Dimensions of Narrative Inquiry

The boundaries of narrative inquiry are what distinguish it as separate from other qualitative research methods based in understanding (Pinnegar & Daynes, 2007). There are common dimensions of narrative inquiry that create a conceptual framework, which have come to be known as temporality, sociality, and place; narrative inquirers must simultaneously explore these narrative dimensions throughout their study (Clandinin & Connelly, 2000; Clandinin, et al., 2007; Kim 2016). Working continuously in these dimensions reiterates the importance of relation in narrative inquiry, as researchers must “find ways to inquire into participants’ experiences, their own experiences, as well as the co-constructed experiences developed through the relational inquiry process” (Clandinin, 2006, p. 47). The three common dimensions of narrative inquiry allow researchers to consider the complexity of individuals’ lived experiences, and future outcomes as well (Kim, 2016).

Temporality. When narrative inquirers consider temporality it includes the past, present, and future of the research interest, as “inquiry is an act within a stream of experience that generates new relations that then become a part of future experience” (Clandinin & Rosiek, 2007, p. 50). Narrative inquiry is concerned about the experience of life on a continuum (Clandinin & Connelly, 2000). The interest of research is described in relation to the past, present, and the future (if possible), and inquirers should consider events as happening over time (Clandinin & Rosiek, 2007; Kim, 2016).

Temporality pertained to the mothers’ stories as they moved back and forth between the births of their other children and their most recent, drawing on the past to make comparisons and using past knowledge to construct their stories of the birth they shared. For mothers who had

previous children, their birth stories included all of their births; the research team used the narratives that spoke to the most recent birth for data analysis to answer the research question.

Sociality. Sociality concerns personal conditions (feelings, hopes, desires) and social conditions (environment, surrounding factors and forces) that form each individual's context (Clandinin, Pushor, & Orr, 2007). This dimension also considers the relationship of the inquirer to the research and participant (Clandinin et al., 2007). Considering sociality in narrative inquiry is necessary because individuals' stories are "a confluence of social influences on a person's inner life, social influences on their environment, and their unique personal history" (Clandinin & Rosiek, 2007, p. 50).

The importance of sociality as a dimensional factor in the mothers' story is evidenced through the history of colonization and subsequent impacts on the participants' hospital and birth experiences. Regarding the social relationship between the researcher and participants, open forms of communication began when the research commenced and remain now that the research has concluded. The author participated in ceremony and circle with several of the mothers over the duration of the research study, reinforcing trust that allows relationships to develop.

Place. Narrative inquirers must consider the impact of place on the research, for example a school, home, or other environment (Kim, 2016). Connelly and Clandinin (2006) define place as "the specific concrete, physical and topological boundaries of place or sequences of places where the inquiry and events take place" (p. 480).

Place, in the context of geography, is highly important to this study as we consider the impacts of urban and remote/rural residences on the participants' experiences. The research question seeks to understand the experience of birth within a hospital, but given the temporality as discussed above, participants shared some experiences of birth outside the hospital which influenced their narrative.

3.2.2. Engaging in Narrative Inquiry

Narrative inquirers can begin their work either by engaging participants through telling their stories, or by being alongside participants as they live out their stories (Clandinin, 2006); "narrative inquiry begins in experience expressed in lived and told stories" (Pinnegar & Daynes, 2007, p. 4).

Participants' stories are a detailed organization of events arranged in a structure based on time, though not necessarily in chronological order (Kim, 2016), thus researchers much

collaborate and discuss the participants' stories with the participant (Wang & Geale, 2015). The process of narrative inquiry is described as a reoccurring process of being in the field, creating field texts (narrative inquirers term for data), and drafting and sharing the research text (narrative inquirers terms for final product) (Clandinin, 2006).

Data from the field can be gathered in multiple ways, and field texts can include transcripts of conversations, field notes, family stories, photos, and other texts composed by narrative inquirers and participants (Clandinin, 2006; Kim, 2016). As inquires compose their research texts from field texts, there may find a return to the field, for example to discuss or clarify texts with participants, or to gather more field notes (Clandinin, 2006). According to Pinnegar and Daynes (2007), narrative inquirers must “recognize and embrace the interactive quality of the researcher-researched relationship” (p. 6), understanding the need to move between field and research texts.

There is a number of ways to conduct a narrative inquiry study; the researcher determines the best narrative fit for their research puzzle (Kim, 2016). Clandinin et al. (2007) propose a list of eight elements to consider at each phase of the narrative inquiry. In this section, I will describe these eight elements as they relate to this thesis.

Justification.

Personal justification. Narrative inquirers begin their work with personal justification, that is, by justifying the inquiry in the context of their own life experiences, tensions and personal experiences (Clandinin, 2006). The prologue at the beginning of this thesis describes the authors' personal justification in the research.

Practical justification. The practical justification centers around how the research will inform the researchers' own and others' practices (Kim, 2016). The research team intends to create a unique education tool for health care providers as an outcome of this research.

Social justification. The social is considered with how the research will address larger social issues, considering the “so what and who cares” questions (Kim, 2016). According to Clandinin and Rosiek (2007), “the challenge for the narrative inquirer, therefore, is less one of achieving the highest possible grade of epistemic clarity and is instead how to integrate ethical and epistemic concerns – how to put knowledge in the service of enhancing human experience” (p. 56). Narrative inquiry intends not just to validate the participants' experience, but also to explore the social, cultural, and institutional narratives that shape the experience (Clandinin &

Rosiek, 2007). The research teams' intent in this narrative inquiry is to make visible the impacts of colonization and subsequent effects on the cultural birthing practices of Indigenous mothers, and ultimately how it impacts the health of them and their infants.

Naming the phenomenon. This narrative inquiry seeks to understand the experiences of Indigenous mothers with specific interest in their cultural practices related to pregnancy and birth. Naming the “what” that is being studied (Clandinin, 2006) was a collaboration between the research team. The emergence of the participants and their stories, and the ways we heard and analyzed their stories, was a fluid process influenced by the back and forth from field texts to research texts.

Describe methods to study phenomenon. Considering the particular method of inquiry entails considering the kind of field texts to be used (Clandinin, 2006). We considered individual interviews as the entry point into the data, which produced: field texts in the form of interview transcripts, the interviewers' field notes and research journal, the participants' additions (if they wished) to their transcripts upon participant transcript review, and field texts from a collective consensual data analytic procedure.

Describe analysis and interpretation processes. The individual, semi-guided interviews were transcribed by a professional transcriber; participants were offered the opportunity to review their transcripts to add or omit anything they felt pertinent. Transcripts from the individual interviews were prepared by the author and supervisor to be included for the collective consensual data analytic procedure (Barlett et al., 2007).

Position study within other research. This thesis a component of a larger body of research exploring the cultural safety of Indigenous mothers; results from the CCDAP, presented in this thesis, went on to inform two talking circles and a photovoice project with the mothers. Results from the interviews and talking circles/photovoice will be used to inform health care providers of providing culturally safe care for Indigenous mothers. Data shows poorer health outcomes for Indigenous mothers and their children, compared to non-Indigenous children, but there is a paucity of research in Canada exploring Indigenous mothers' birth experiences, and impact on health outcomes (Brown et al., 2011).

Uniqueness of study. This study is unique in that engages mothers directly in the research process to understand their experiences of giving birth in a hospital. This is the first

known study of this nature to be done in this Canadian province and as such will contribute to the health care and delivery of services to Indigenous mothers.

Ethical considerations. Because of the relational components of narrative inquiry, ethical considerations are guided by relationship, not required forms from institutional research boards (Clandinin, 2006). There is an ethics pertinent to narrative inquiry (Kim, 2016), which require negotiation, respect, mutuality and openness to multiples voices (Clandinin, 2006). Negotiating relationships in narrative inquiry, including research purposes, transitions, and how the researcher is going to be useful in those relationships occur spontaneously and intentionally and can occur in ways we are not aware of (Clandinin, 2006). Although data from the talking circles and photovoice are not included, these components of the project significantly influence the relationship between the author and the mothers.

Along with the research ethics of narrative inquiry are the research ethics of Indigenous communities. Story and storytelling methods are appropriate to use with this population of Indigenous mothers, as these methods allow for a more natural relationship to develop (Kovach, 2009). According to Wang and Geale (2015), "stories heal and soothe the body and spirits, provide hope and courage to explore and grow" (p. 198), and storytelling is fundamental in narrative inquiry; it is considered a culturally appropriate method for doing research with Indigenous communities (Graham & Martin, 2016).

Process of representation. Narrative inquires must consider different forms of texts than traditional research texts to share research findings (Clandinin et al., 2007). Two of the mothers were closely involved with the research and will be included in the publications. The author encouraged two mothers to attend a research gathering in Montreal, and these same mothers have co-presented with the author and her supervisor at conferences. Clandinin and Connelly (2000) discuss the importance of temporality in understanding the inquiry, including the personal and social aspects, and historical and institutional - historical influences are described in chapter two; chapter five, the results, examines the personal and social. In telling the stories, participants and narrative inquirers come together to co create meaning.

Research Relationships. Relationship is key to narrative inquiry (Clandinin & Connelly, 2000). Through the duration of the research project the author developed relationships with the mothers. Temporality of narrative inquiry indicates that the relationship should continue beyond the duration of the research (Clandinin, 2006), which is the case between the author and several

of the participants. The relationships the author formed with several of the mothers over the course of the research transcends the traditional outcomes of western research; both the researcher and the participant are changed in coming together over the research puzzle, learning from the other, in true reciprocity.

Chapter 4: Manuscript 1 (Methods)

This manuscript will be submitted to a relevant BMC journal. The first author, Carrie Pratt, reviewed the relevant literature to do the analysis, read and prepared the transcripts for the collaborative data analysis, and drafted the manuscript.

A Methodological Approach to Collaborative Research with Indigenous Mothers in
Saskatchewan

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Abstract

Background: Indigenous people have been excluded from western colonialist research practices, and there is little research in Canada about the experiences of Indigenous mothers who labour and give birth in hospitals. The goal of our study is to use research methods appropriate for Indigenous communities to explore the lived experiences related to culturally safe care of Indigenous mothers who gave birth in a Saskatchewan hospital. The aim of this paper is to elucidate the team's collaborative approach to research with Indigenous mothers.

Methods: The research team drew from patient-oriented research (POR) and participatory action research (PAR) methodologies as the guiding framework, and a narrative inquiry approach for data collection and analysis. The end result is a novel approach suitable for our goals and congruent with Indigenous research ethics and values. First, individual interviews occurred with 24 mothers who gave birth between January 2017 and September 2018 in urban and rural Saskatchewan. Second, the transcripts were analyzed using a collaborative team approach following a collective consensual data analytic procedure (CCDAP) (Bartlett, Iwasaki, Gottlieb, Hall, & Mannell, 2007).

Results: The CCDAP approach brought research participants, health care providers, researchers, and decision makers together to determine the outcomes of the interviews. Although the women who participated in this study come from diverse backgrounds within Saskatchewan, findings indicate that they desire support in accessing and practicing their cultural and traditional teachings.

Conclusion: We believe our chosen methodology proved effective as a culturally appropriate research strategy and achieved the goal of determining the experiences of this sample of Indigenous mothers giving birth in a hospital setting. Using methodologies that are appropriate for research with Indigenous communities is essential in finding effective solutions to implement health care that is culturally safe for Indigenous women in Canada.

4.1. Introduction

This article describes the data collection and analysis of a study of Indigenous mothers' experiences giving birth in Saskatchewan hospitals. We used two methodologies, participatory action research (PAR) (Ginn & Kulig, 2015) and patient-oriented research (POR) (SPOR, 2019) as our theoretical and research framework. First, we will discuss the context and importance of culturally safe care in the birth setting for First Nation and Métis mothers. Next we highlight the importance of understanding and following Indigenous research ethics, followed by a description of the chosen research methodologies and the specific methods of data collection and analysis. The outcomes of the data analysis process and our insights about research methods that can be used to improve culturally safe care practices are discussed. Results will inform care providers and communities and will promote research that is respectful and inclusive of First Nation and Métis communities.

4.1.1. Indigenous Maternal Health in Canada

Colonization processes in Canada influenced maternity care for Indigenous mothers; medical control over birth served as an expression of power over Indigenous women (Brown, et al., 2011). A long practice of gender subordination along with cultural and economic destruction silences and oppresses Aboriginal women in all regions of Canada (Tait, 2008). This subordination of Indigenous women extends to maternity care, and the subsequent cessation of traditional birth practices (Brown et al., 2011; Kelm, 1999)

Research indicates the impacts of colonization lead to health inequities on several indices between Indigenous and non-Indigenous women (Daschuk, 2013; Geddes, 2017; Kelm, 1999). When compared to other populations, the birth outcomes for First Nation women are poor, including higher risks for low birth weight, pre term labour, and infant death (Bruyere, 2012; Kornelson, et al., 2011; Tarlier et al., 2013). Indigenous infants have higher rates of abnormal birth weights, and Indigenous infant mortality rates are nearly double the rate of the general population (Statistics Canada, 2017).

While there is increasing evidence linking the health inequities Indigenous women experience to the impacts of the colonial context in Canada, there is little knowledge about the impacts on Indigenous women's experiences of maternity care and birthing (Brown et al., 2011).

Improving perinatal health outcomes could prove to reduce disparities in health status between Indigenous and non-Indigenous people (Smith, 2003).

According to the National Aboriginal Council of Midwives (NACM), historical and political issues in Canada have resulted in stories of negative birth experiences for Indigenous women (NACM, 2016). The Society of Obstetricians and Gynecologists (SOGC, 2010) advocate for models of care unique to Indigenous mothers in Canada, and they acknowledge gaps between birth outcomes for Indigenous and non-Indigenous women (SOGC, 2010). The Truth and Reconciliation Commission of Canada (TRC) developed Calls to Action which have been adopted by the government of Canada and are relevant to all Canadians (TRC, 2015). The Calls to Action most pertinent to this study are:

#22 We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients (TRC, 2015).

Given the harmful colonial research methods with Indigenous communities of the past (Vukic, Gregoy, & Martin-Misener, 2012), we employed a framework we believe is congruent with Indigenous research values and ethics, according to the guidelines of TCPS 2 Chapter 9. This paper describes a method of collective data analysis as part of a POR and PAR framework that professionals can use to conduct appropriate research with Indigenous communities.

The first phase of data collection began with semi-guided individual interviews with First Nation and Métis mothers in a Canadian province to answer the research question: What are the experiences and stories of Saskatchewan Indigenous women who have had birth in hospital between January 2017 and December 2018?

4.1.2. Ethical Considerations with Indigenous Research

Incorporating research methodologies that respect Indigenous knowledge systems and the communities who own them is imperative to implement appropriate solutions (Ball & Janlyst, 2008; Castledon, Garvin, & Huu-ay-aht First Nation, 2008). Colonialist research methods tend to result in negative experiences for Indigenous communities (Vukic et al., 2012), necessitating vigilance amongst non-Indigenous researchers to pursue ethical methodologies (Ball & Janlyst, 2008). For too long, colonialist research methods have exposed Indigenous struggles but lack tangible products for the communities (Ball & Janlyst, 2008). Research has historically been

done on - rather than with - Indigenous people, sometimes without consent or without sharing research findings with the community; this has led to a lack of trust in western researchers and their methodologies (Castledon et al., 2008).

In response to inappropriate research activities, ethical frameworks have been developed to guide research with Indigenous communities. One ethical framework used in this study is Ownership, Control, Access and Possession (OCAP), proclaimed as the de facto standard for Indigenous research by The First Nations Information Governance Center [FNIGC] (2017). OCAP ensures First Nations are in control of their information and compare the stewardship of their knowledge to their stewardship of the land; information is meant to benefit the community and reduce risks (FNIGC, 2017). Another framework we used is the Government of Canada Tri-Council Policy Statement 2 Chapter 9 [TCPS 2] (2014) that is a guideline for doing research with Indigenous communities. The TCPS Chapter 9 provides a foundation for researchers to engage in ethical research with Indigenous peoples.

We employed a method adapted by Bartlett et al. (2007), called the collective consensual data analytic procedure (CCDAP). The CCDAP is different from approaches that assume researchers and practitioners are the experts, and “involves local people as experts who bring forward Indigenous knowledge and help researchers by viewing the research through a decolonizing lens” (Bartlett et al, 2007, p. 2380). Despite academic researchers’ best efforts, their lens and worldview differ from the participants they work with; therefore, it is critical in decolonizing research that Indigenous individuals are directly involved in the research process (Bartlett et al., 2007). Analyzing data in this manner ensures reciprocal learning between researchers and community members (Bartlett et al., 2007). Overall, CCDAP aligns with the methodological framework and narrative inquiry approach to data collection.

Our research team used POR and PAR as methodological frameworks to facilitate meaningful relationships and engagement with community members. Throughout the study the research team were invited to participate in community events, such as cultural gatherings and ceremonies and treaty days; exposure and involvement to communities contributed to the richness of the study’s data and the researchers’ connection with study participants.

The First Nations Information Governance Center [FNIGC] (2017) proclaims the de facto standard for Indigenous research is OCAP: Ownership, Collaboration, Access, and Possession. OCAP, along with the Tri-Council Policy Chapter 9, are the guiding ethical frameworks of this

study. The University of Saskatchewan Research Ethics Board approved the study in October 2017. Participant consent forms and recruitment material was reviewed and approved by the project Elder.

4.1.3. Methodologies

Participatory action research. Participatory action research (PAR) is a philosophy, theoretical framework, and method all at once, grounded in critical theory and social constructionism (Ginn & Kulig, 2015; Chenail et al., 2007) that aims to ensure equitable power balances between researchers and Indigenous communities (Vukic et al., 2012). PAR draws from an array of research methods to answer questions of relevance to the community (Gannan & Ciliska, 2016; McHugh & Kowalski, 2009; Vukic et al., 2012). Participants are considered experts due to their lived experience in the research topic - meaning anyone can know anything (Reid et al., 2017). The main principles of PAR can be succinctly summarized as: participants are regarded as experts in lived experience, power is shared equally between team members, and there is mutual respect regarding team member's knowledge (Watters et al., 2010). PAR aligns with Indigenous knowledge values of reciprocity, community, and respect (Reid, Greaves, & Kirby, 2017; McHugh & Kowalski, 2009).

Patient-oriented research (POR). POR is a collaborative method that was introduced in answer to unethical paternalistic euro-western research processes that exclude patients from research on the basis they are subjects, and not experts; on the contrary, patients have experiences and insights which academic and medical researchers lack (Johansson, 2014). The goal of POR is to transform the role of a patient from passive into proactive partners in research, and as a result, transform health care (CIHR, 2019).

There are two key elements of POR: first is the inclusion of patients in grant writing and the research process; the second is the inclusion of decision makers and health care practitioners throughout the research process, which leads to more relevant research questions and appropriate methods (SCPOR, 2019). POR is about bringing useful scientific research to communities and producing information that healthcare providers need to improve care (CIHR, 2019).

In the context of POR, a patient advisor is someone with personal experience of a health issue (SCPOR, 2019). Patient advisors for this research study include the advising Elder for this project and four mothers who were interviewee participants.

Intersection of PAR and POR. While both methodologies focus on the meaningful inclusion of the community, the principle aim of PAR is to involve communities in identifying issues (Gannan & Ciliska, 2016), and the central principle of POR is that patients and health care leaders/decision makers direct the research. Both methodologies assume the patient as expert, but where PAR is concerned with giving voice to those unheard in society, a primary tenant of POR is the collaborative involvement of key stakeholders to hasten the translation of research into practice and effective solutions for patients, and the health care system. PAR primarily aims to benefit the community, and POR looks to benefit health systems and create effective practice solutions. There are elements of each methodological framework that suited our needs, and the research team feels the approach we adapted is appropriate for the research question with this community of First Nation and Métis mothers.

Narrative Inquiry. Under our theoretical and research framework combining PAR and POR, we chose a narrative inquiry method to guide the data collection and analysis. Relatively new to nursing research, narrative inquiry is a methodology that provides an in-depth description of the participants' point of view and "attempts to illuminate the meanings of personal stories and events" (Wang & Geale, 2015, p. 195). Narrative inquiry is a common practice in the sense that humans have lived out and told stories since we could speak, and as methodology it honours lived experience as an important source of knowledge (Clandinin & Rosiek, 2007). Narrative inquiry gives voice to marginalized people and makes their experience visible, telling stories that may otherwise go untold (Happel-Parkins & Azim, 2015; Wang & Geale, 2015). The focus on story helps researchers understand cultural and historical worlds of the narrators (Wang & Geale, 2015).

The common boundaries of narrative inquiry create a conceptual framework, and they are: temporality, sociality, and place, which narrative inquirers attend to throughout their study (Clandinin & Connelly, 2000; Clandinin et al., 2007; Kim 2016). These conceptual dimensions reiterate the importance of relation in narrative inquiry (Clandinin, 2006, p.47).

Narrative inquirers can begin their work either by engaging participants through telling their stories, or by being alongside participants as they live out their stories (Clandinin, 2006); "narrative inquiry begins in experience expressed in lived and told stories"(Pinnegar & Daynes, 2007, p. 4). The process of narrative inquiry is described as a reoccurring process of being in the

field, creating field texts (narrative inquirers term for data), and drafting and sharing the research text (narrative inquirers terms for final product) (Clandinin, 2006).

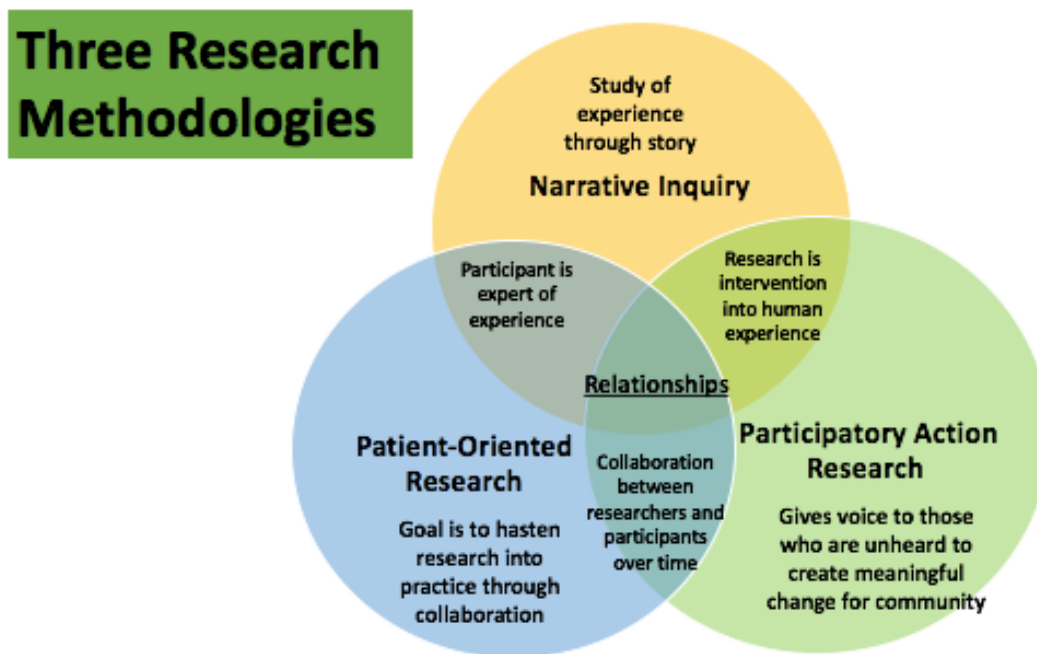


Figure 2. Three research methodologies

4.2. Methods

4.2.1. Sample

Researchers must remember that Indigenous people and communities are not homogenous in their cultural identity and expressions (Bruyere, 2012; Lavell-Harvard & Corbiere Lavell, 2006). Therefore, a sample of 24 self-identified Indigenous mothers who have had a birth between January 2017 and September 2018 was chosen to represent the population of Indigenous mothers from Saskatchewan. We attempted to attain an equal sample of mothers from urban and rural centres; in the end, fourteen mothers from urban cities and ten mothers from rural areas were interviewed to compare their experiences. Hearing stories of birth from mothers from both urban and rural areas allowed the research team to hear different lived experiences.

To be included, mothers had to be Indigenous (First Nation, Métis, or Inuit) and had a viable birth between January 2017 and September 2018 in a Saskatchewan hospital. We included mothers of any parity, who experienced vaginal or surgical births, and who experienced (or did

not experience) complications in labour and pregnancy. We excluded mothers who suffered pregnancy loss or neonatal death, due to the unique and sensitive nature of their experiences.

Purposive sampling was used to recruit interview participants. Community research partners helped circulate a recruitment poster with a brief explanation of the study and an offer of a \$50 honorarium. Snowball sampling was also used by asking participants to share the study information with other women who met the inclusion criteria and whom they believed would be interested.

4.2.2. Data Collection

Volunteers were asked to participate in an individual, semi-structured interview with the author in the location of their choice (i.e., participants' home, Gordon Oakes Red Bear Student Centre, or College of Nursing in Regina). Mothers had the option to interview over the phone if they were unavailable to meet in person. Interviews occurred between January 2018 and November 2018. The interview protocol was developed by the P.I., a Métis Research Assistant, and graduate student (see Appendix A).

Mothers who participated in the study had the opportunity to choose pseudonyms to maintain their anonymity, but were allowed to use their own name if they chose to. The mothers also had the option to provide oral and/or written consent (see Appendix B).

Interviews were audio recorded then transcribed into text by a trained transcriptionist. The author then shared the mothers' transcripts with them, so that they have a chance to review the script for accuracy (Appendix C). Following transcript review the first and second author read and re-read the transcripts to familiarize themselves with the text to prepare for the collaborative data analysis. The research team (including interview participants) used a collective consensual data analytic procedure (CCDAP) (Bartlett et al., 2007), discussed in further detail in the Data Analysis section.

The interviews were semi-structured and conversational. Each interview began with demographic questions, before the author would ask the open-ended question: *Can you please tell me about your story of giving birth?* This approach allowed mothers to share their stories freely as they were comfortable. The author focused on an open story approach, asking about experiences with health care providers and if any cultural practices or traditions were used. Each interview was unique, and the author let the participant lead the conversation, using broad conversational prompts as necessary to elicit details of the mother's experience of labour and

birth. The approach of respectfully listening to stories, using conversational prompts, helps to avoid western academic constructs and avoids imposing assumptions (Bartlett et al., 2007). The interviewer did use an interview guide to ensure every participant was asked the same questions, but in a more storied and natural manner. Interviews lasted anywhere from twenty minutes to an hour and a half, depending on the mother's story. See Appendix A for the full interview guide.

Demographic data was gathered on age, cultural background, and geographical residence. With consent, interviews were audio recorded and transcribed. Participants were given the opportunity to review (alter, add, or omit) their transcripts from the individual interviews; this was done in person or by email. The majority of participants left their transcripts unaltered, and changes that were made were mostly grammatical or an error in demographics (i.e., age or home residence was recorded incorrectly). Providing the opportunity to omit or add to their interview, and review for accuracy and clarity is known as "member checking" (Richard & Morse, 2013). After the women approved their transcripts the data was used in analysis.

4.2.3. Data Analysis

Qualitative data collection and analysis are an iterative process, that is, ongoing and concurrent and not a one-step process (Richard & Morse, 2013). The research team conducted Bartlett's (2007) collective consensual data analytic procedure (CCDAP). This collaborative data analysis method was developed by Judith Bartlett, and is an adaptation of the Institute of Cultural Affairs facilitation and organizational planning process (Bartlett et al., 2007). The CCDAP method aligns with "Indigenous thought and orientations" (Bartlett et al. 2007, p. 2378), because data is displayed to the team collectively, and verified collectively. CCDAP was developed in response to impacts of colonization and colonial systems of knowing.

In preparation for the group data analysis, the first and second authors prepared the data for the collaborative analysis by reading and re-reading the text to become familiar with the content, then identified phrases relevant to the research questions. Phrases were physically cut and pasted in easily readable large font onto cue cards; on the back of the card was the participant's confidential ID so that the code could be cross referenced to the original transcript.

The data analysis day occurred at an urban primary health centre in the Canadian prairies. The centre is mother and baby friendly and holds respect for Indigenous culture. Present for the data analysis day were: the project's advising Elder; four mothers who were interview participants; a physician; two community workers; two research assistants; and the graduate

student and her supervisor and committee member. All of the participants, except the graduate student, are mothers, and all participants, except the supervisor, are Indigenous. The entire CCDAP process occurred over one day from 8:30am to 4:30pm.

The day began with a meal, then the Elder led a prayer and smudge circle. An introduction and brief were given regarding CCDAP, and there was an opportunity to ask questions. Participants received a brief of the days' activities a week in advance (see Appendix D), so they had a chance to familiarize themselves with the process prior to the day of the event.

Before the team began the analysis process, the RAs and PFAs drew symbols onto cardstock that held no meaning to the research, and these cards were hung horizontally across the walls. These symbols would come to represent the various categories and resulting themes. The prepared data cards were aloud at random, according to the CCDAP method (Bartlett et al, 2007). The team discussed each phrase card and collectively decided which symbol the card belonged under. The first card was placed under the Circle - if the next card was similar, it was also placed under the Circle; if the next card read was something different, it was placed under the next symbol. This process was repeated until the team felt no new key phrases were being found from the key code cards. There were twelve categories in total, represented as twelve columns of cards, each headed with a random symbol. The final step in the CCDAP method was for the team to consider all the key code cards in each column, and as a group decide on a label that explains the theme of the cards. This process was repeated for each category/symbol. Effectively, the process of CCDAP is both a clustering and thematic analysis process (Bartlett et al., 2007). After further discussion and analysis, the group narrowed the data. Each of these themes, in turn, had subthemes – for example, value of culture and known traditions were subthemes under culture. See Chapter Five for further discussion of the findings of the individual interviews and CCDAP.

4.3. Discussion

4.3.1. Challenges and Limitations

POR and PAR present some challenges to the research team. First, colonialist and Indigenous research approaches can be at odds (Vukic et al., 2012) and there is tension between funding organizations' desires for expedient processes and the community's lengthy consultation process (Ball & Janlyst, 2008). Indigenous interests must take precedence over the researchers or funding agencies; to account for this, researchers should allow for extra time in research to build

relationships and negotiate agreements (Ball & Janlyst, 2008; Vukic et al. 2012). Secondly, despite best attempts to make relationships equal, “there is an inherently unequal relationship between researchers and research participants,” (Castledon et al., 2008, p. 1395). And, although PAR is collaborative, it is still a Western approach (Moffitt, 2012). Given this, academic and health researchers must be hyper vigilant of their research methods, and allow for flexibility and adaptability through the duration of the project.

Another limitation is that researchers using participatory methodologies assume that the population of interest feels a need for a problem or dilemma to be corrected (Chenail et al., 2007); therefore, engaging with community stakeholders should occur as early as possible to ensure research is relevant (Vukic et al., 2012). While our interview questions did not come from the interview participants themselves, the research goal was devised in collaboration with community organizations. In the future the team could address this challenge by adhering to POR principles and finding PFAs to develop both research questions and interview guides. Finally, PAR is criticized for lacking scientific merit and rigor and is considered more akin to community development and social activism than research (Vukic et al., 2012). Researchers can combat this by working with PFAs to disseminate results to a variety of communities.

4.4. Conclusion

Western and colonial ideologies drive Canadian research systems; participatory methodologies, where community expertise and collaboration are a must, can help to transform policy and practice (Ginn & Kulig, 2015; Moffitt, 2012). There are considerable challenges of community processes required with PAR and adhering to the principle of OCAP, but it is worth taking the time to address and to ensure the research is conducted in a “good way” (Ball & Janlyst, 2008). Of utmost importance is the realization that oppressive practices must be replaced with “relational and safe care” (Moffitt, 2012, p. 215). Whether formal PAR methodology is employed, there is an opportunity for consultation and collaboration in every research project (Reid et al., 2017), to ensure Indigenous research is done in "a good way" (Ball & Janlyst, 2008).

Engaging in research with Indigenous communities is warranted because of past and current legislation which has created factors that influence Indigenous mother’s birth experiences and their right to choose. There is a lack of research with Indigenous mothers in Saskatchewan which should be remediated to advocate for improved resources for Indigenous mothers and their

families. This research must be conducted collaboratively with those whom the research intends to benefit following methods acceptable to Indigenous communities.

Chapter 5: Manuscript 2 (Results)

This manuscript is prepared to be submitted to an appropriate BMC journal. The first author, Carrie Pratt, reviewed the relevant literature, synthesized data that emerged from the collective consensual data analytic procedure (CCDAP) and drafted the manuscript.

Indigenous Mothers' Perspectives for Culturally Safe Birth in a Hospital Setting: Results
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Abstract

Background: Evidence shows clear health disparities between Indigenous mothers and their infants and non-Indigenous populations. Part of these health disparities is related to a decline in midwifery services and maternity care services in the last several decades, which especially impacts the care for Indigenous mothers. There is little research to understand Indigenous mothers' experiences of birthing in a hospital in Canada and the cultural care they receive.

Methods: This study uses a narrative inquiry approach, under a participatory action and patient-oriented framework, to conduct semi-guided individual interviews with 24 Indigenous mothers from both rural and urban regions in Saskatchewan. A collective consensual data analytic procedure (CCDAP) was used to interpret results.

Results: There were five overarching themes that arose from the CCDAP. These are: Culture, Relationships, Access, Choice, and Resilience.

Conclusions: Results show the mothers desire a culturally safe approach to maternity care, and they believe this is an appropriate solution to help improve their in-hospital birth experiences.

5.1. Introduction

Research indicates health inequities exist between Indigenous and non-Indigenous populations in Canada on several indices (Aboriginal Healing Foundation, 2007; Statistics Canada, 2017) which extend to maternal health and care. Indigenous maternal health care has evolved in the context of colonialism where western colonialist standards of care have mainly replaced Indigenous reproductive practices (Brown et al., 2011; Happel-Parkins & Azim, 2015). Colonization impedes the self-sufficiency of Indigenous women, resulting in the loss of Indigenous midwifery and fragmented maternal care. Improving Indigenous maternal health outcomes could help reduce health inequities between Indigenous and non-Indigenous populations (Smith, 2003). And as one Elder states, “there is a breakdown in traditional family structure...family is excluded from the joy of being at birth – this is important to our community, to our families” (Brown et al., 2011, p. 110).

Indigenous mothers have their babies predominantly in hospitals, and historical and political issues in Canada have resulted in stories of negative birth experiences for them (NACM, 2016). The Society of Obstetricians and Gynecologists (SOGC, 2010) advocate for models of care unique to Indigenous mothers in Canada, and they acknowledge gaps between birth outcomes for Indigenous and non-Indigenous women (SOGC, 2010).

The Truth and Reconciliation Commission of Canada (TRC) developed the TRC Calls to Action to advance reconciliation (TRC, 2015). Most pertinent to this study are:

#22: We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

This paper describes Indigenous women’s birth experiences in hospitals to inform care providers and for communities to promote culturally safe birth practices.

5.2. Research Design

Using participatory action (Kemmis & McTaggart, 2005) and patient-oriented methodologies (SPOR, 2019) as a research framework, with a narrative inquiry (Clandinin & Connelly, 2000; Clandinin, 2006) approach to data collection and analysis, semi-guided

individual interviews and a group data analysis were conducted with Indigenous mothers in Saskatchewan to answer the research questions:

- a. What do women expect from health care providers when they give birth?
- b. What cultural practices do Indigenous women find comforting during birth?
- c. How do rural Indigenous women experience birth? How do urban Indigenous women experience birth?

5.3. Methodology

The research team adopted a unique approach to answer the research question, where we combined two methodologies, participatory and patient-oriented research, into one theoretical and research framework. To guide the data collection and analysis, a narrative inquiry approach was used. Together, these approaches facilitate meaningful participation of community members and decision makers in the aim of listening to the mothers stories of their lived experiences (Clandinin, 2006; Kemiss & McTaggart, 2005; SPOR, 2019). A sample of 24 Indigenous mothers was chosen to represent the population of Indigenous mothers from Saskatchewan. To be included, mothers must have had a viable birth in a Saskatchewan hospital between January 2017 and September 2018. Mothers who experienced pregnancy loss or neonatal death were not included due to the unique and sensitive nature of their experiences.

Purposive sampling was used to recruit interview participants via recruitment posters circulated through social media and community partners. The poster included a brief explanation of the purpose of the study and contact information. Snowball sampling was also used by asking participants to share the study information with other women who met the inclusion criteria. Mothers who participated in the study were asked to choose pseudonyms to maintain their anonymity, although many decided to use their own names. With informed consent, interviews were audio-recorded then transcribed to text by a trained transcriptionist. Transcripts were shared with the mothers and they were asked to review them for accuracy and provided the opportunity to add or omit information. Following the transcript review, the analysis involved a two-step process. First, the PI and author read and re-read the transcripts to familiarize themselves with the text before identifying key phrases related to the research questions. Second, the research team (including interview participants) used a collective consensual data analysis process (CCDAP) (Bartlett, et al., 2007) to determine the themes.

5.4. Ethical Considerations

Western research methods have taken advantage of Indigenous communities and often do not allow them to benefit from the research (Ball & Janlyst, 2008). For this reason, researchers must practice vigilance and pursue ethical methodologies when working with Indigenous communities (Vukic, Gregoy, & Martin-Misener, 2012). According to Wang & Geale (2015), "stories heal and soothe the body and spirits, provide hope and courage to explore and grow" (p. 198). Storytelling is fundamental in narrative inquiry and is considered a culturally appropriate method for research with Indigenous communities (Graham & Martin, 2016).

The First Nations Information Governance Center [FNIGC] (2017) proclaims the de facto standard for Indigenous research is OCAP: Ownership, Collaboration, Access, and Possession. OCAP, along with the Tri-Council Policy Chapter 9, are the guiding ethical frameworks of this study. The University of Saskatchewan Research Ethics Board approved the study in October 2017. Participant consent forms and recruitment material was reviewed and approved by the project Elder.

5.5. Results

Twenty-four Indigenous mothers participated in a semi-structured narrative interview. Of these mothers, 16 were Cree, three were Métis, two were Dené, and there was one each of Cree/Dakota, Dakota/Ojibwe, and Saulteaux women. Twenty-two of the participants originated from different communities, and the participants currently reside in a total of ten different communities. Fourteen mothers were married or in common-law relationships, and ten mothers were not. The mothers' levels of education ranged from currently completing grade twelve to the completion of a master's degree. The mothers were between 20 and 38 years of age (mean = 28.96), and parity ranged from first-time mothers (n=5) to mothers with their fifth child (average parity = 2.63). The mothers gave birth at a total of five hospitals in Canada between January 2017 and December 2018. The narrative themes and subthemes from the interviews that arose through the CCDAP include:

- Culture – Value of cultural practices in pregnancy and labour; some cultural practices in pregnancy and labour; reclaiming culture
- Relationships between Mothers and Health Care Providers – Empowerment; disempowerment

- Access – Access to Elders; services and programming
- Choice – care provider/birth support worker; birth site/location; birth process
- Resilience

5.5.1. Culture

Value of cultural practices in pregnancy and labour. Many of the mothers felt culture is part of the healthy development of their children and spoke of teaching their children culture, beginning from birth. Charlotte said that using culture in birth gives children pride, and Irene believed babies raised in culture are calmer than babies who are not. Janice said there is a difference when children are brought up culturally versus non-traditionally, that those children honour and respect themselves; this is why she raises her children in their culture from the beginning. Erin thought that children raised in their culture helps them not to be outcasts. Cindy said, "I think that's where culture has to be – with mothers and babies. You can't do it later; it has to be right from the beginning."

Mothers spoke of how culture helps them cope with hard times, and they thought cultural practices would be helpful during birth. Yvette felt if she would have had support to use culture and traditions in her birth, she would have been less scared for herself and her baby. Irene felt that when people were mindful of her culture, it made her feel safe because it feels more like home. Payton said her culture made her feel more relaxed and whole. Janice said she turns to her culture in times of turmoil, and Jessica stated that cultural teachings help her feel more grounded and confident in her role as a mother. Carrie said her culture was necessary to her in pregnancy and birth because "it just keeps our culture strong...we have to pass it onto our children."

Some cultural practices in pregnancy and labour. As the mothers spoke about their cultural practices, the following subthemes arose: family; naming; smudging and prayer; umbilical cord and placenta care; ceremony and song; moccasins and mossbags.

Family. The necessity of family involvement during labour and birth was evident through the mother's stories. Payton said the only part of her birth plan was to have her family there. Irene said she would like to have lots of her family there for her baby's birth, including the many Elders who are in her family; as she describes, "They all just show up and will just sit there, and one person will come in with you for the birth. And you just have a lot of family and it's just really good." Cindy expressed that family should be involved, that "it shouldn't have been an issue for my husband to be there - and I can't imagine like some people are farther away from the

city than me. And they are alone!" Nancy said that without family there, one's mental and emotional health suffers, and with family there, "You are happy after you have a kid, and everyone is celebrating, and it's just great."

The mothers also spoke about the importance of having their other children close to them for their baby's birth, a significant challenge for mothers who live in rural and remote areas. Jessica, who had to travel to an urban centre for her delivery because of labour complications, said, "I was lonely and missed my kids...I did get to see my kids for a few minutes at a time...whereas before, with my other birth, I was only away from my son for a few hours." Jenny felt similarly, and would have liked to have her other children with her.

Although the presence of family was necessary for some, one mother did say it could be overwhelming to have too much family, as they were more focused on holding the baby than respecting her healing process.

Naming. Giving the baby his or her name was an important cultural practice identified, and the importance of language, and food were common in some of the mothers' stories. Jenny was waiting for the proper ceremony and feast so her grandfather could give her baby his Cree name; she said the naming ceremony would help her baby know his culture. Kashina told of how she was grateful that her great-grandmother was able to visit her after she had her baby in the hospital and spoke of the experience: "She was 95 at the time – she is the one that gave him his last name in Cree. After colonization, our name got changed to a colonized name. And my mom picked his first name, and my grandmother his middle name." Mercedes spoke of the importance of having a Cree name for her and her children, "I wanted to get mine and my daughter's Indian names, but I don't have any information about how to go about that. I don't know what to do or where to go for that."

Smudging and prayer. In Indigenous culture, prayers are offered through an act called smudging, a cleansing ritual that uses burning sage (or other sacred plants) to remove bad energy and bad thoughts; coupled with prayer, the intention is to make the individual whole again (Bruyere, 2012; Cohen, 1998). Several mothers practiced smudging at home both before and after the birth of their baby. Brittany smudged her belly throughout her pregnancy, and Jessica smudged when she came home from the hospital, "to welcome the baby and remove any negativity that would have been in the house." Naomi smudged herself routinely when she was pregnant and after her baby was born; Irene also spoke of the importance of smudging with her

children. Charlotte spoke of the importance of prayer and smudge to her during her pregnancy and labour and how it helped her feel better after her delivery. Maya, who had her baby at a different hospital than Charlotte, expressed her desire to have smudging available at the hospital where she delivered her baby.

Umbilical cord and placenta care. The mothers told stories of keeping their baby's umbilical cord and putting it someplace special, and the meaning behind the act. Irene put her baby's cord at a clean place on the reserve; Jessica was hoping to put her baby's cord somewhere to help him become a good hunter. Kealy said an Elder told her to keep her children's cords together so the children will always remain together, and Kashina placed her baby's umbilical cord in a leather pouch and buried it by a tree.

Some of the mothers also discussed the placenta - Erin said, "I don't know if it's a tradition, but I wished that they would have left the placenta intact for at least an hour or so." Charlotte expressed similar thoughts that she would have liked to "wait until the placenta stops pulsating before you cut it ...that's something I would have liked." Kealy explained, "I just want to feel connected. I want to be able to hold my baby and be able to see the cord from both of us." Jessica was happy that she was able to fulfill her desire to delay cord clamping with her baby. Other mothers spoke of treating the placenta similar to the umbilical cord; Janice said - "You take it to where you want it to be home. You kind of have a tie to it, it's symbolic."

Song, ceremony, and other cultural practices. Madison told how her grandparents held a sweat while she was in labour, and how powerful that was for her - "After the sweat, they came from like two hours away, and when I saw them, I just started crying and they just came and prayed for me and stuff. They came at the perfect time really. I'll remember that forever...I named my baby after my Kokum [because of that]." Janice told of her how her family was in ceremony at the time of the child's birth - "So they're not like immediately right beside the child, but they give thanks." Maya spoke of other ways to use ceremony in pregnancy and labour - "praying and stuff helps. And even singing the songs... drums and stuff like that." Maya also told how she would go to sweats to help her relax during her pregnancy. Charlotte said she played round dance music in the hospital after she had her baby, and that she did this with her other children because the music helped them sleep. Nancy also spoke of the importance of singing lullabies to her baby, how they are part of teachings from the grandparents. For Jessica and her partner, "one of the first things we did with my baby is that we spoke to him in our languages."

Cultural foods were also important for Jessica, who intended to give pureed moose meat to this baby as she did her other children. Charlotte felt that eating traditional foods would have helped her pregnancy, but sourcing wild meat was challenging. She expressed the desire to have foods more for Indigenous women, as she "didn't get to eat wild meat at all." Several mothers expressed their desire to make mossbags for their babies. A mossbag is a fabric bag laced up the front which swaddled the baby; moss was lined inside to act as a diaper (Anderson, 2011). Erin and Patyon mentioned programs in their communities that had mossbag workshops they would have liked to attend. According to Nancy, the grandparents gave her the teachings of the mossbag, which she says helps the baby grow up healthy.

Reclaiming culture. The mother's stories conveyed a desire to have cultural teaching and supports available during pregnancy and labour. As Nancy stated, "Just to have more knowledge available is what I would like to see because a lot of our people don't know or choose not to utilize anything [cultural]." Erin reiterated, "I just don't know what's out there or what cultural practices are available." Tara wanted to use cultural traditions during her labour but did not know whom to ask, and she would have liked prenatal classes that revolve around cultural teachings. Madison said she would like to see Elders that work with the hospital staff for mothers who have been affected by trauma. Madison also expressed her desire for resources for women to partake in ceremonies during their pregnancy because she felt many women do not have that opportunity. Yvette put it succinctly, "it would be nice to have cultural supports during the labour and for prenatal, like teachings, with cultural aspects that everyone could access."

The mothers spoke of the decrease of collective cultural knowledge within their families and communities. Jessica expressed how she wanted to bring back cultural traditions, but that cultural teachings were "kind of lost in our family." Tara stated she did not use traditions in her pregnancy because her family never did practice their culture when she was growing up. Maria shared: "Me and my family don't practice those just because where I'm from...where the residential school is...all of our traditions and everything were taken from us because of the residential school. So I don't practice that stuff."

Jenny said birth practices have changed for Indigenous people over the years, and that "I don't know anyone who has that knowledge, so it just seems like something that seems to be lost." Mercedes also spoke of the disruption in cultural knowledge, that "my mom didn't learn anything, so I didn't get to learn anything...I wish I could have been taught a lot more."

Reclaiming culture was essential for Mercedes because she felt so much was already lost but that she wanted to pass on any traditions she could to her children.

5.5.2. Relationships between Mothers and Health Care Providers

Empowerment is the act of granting someone power, right, or authority to perform various acts; disempowerment, then, is depriving someone of power, authority, or influence (Merriam-Webster). In telling of their interactions with health care providers, the research team came to understand the relationships as either empowering, or disempowering for the mothers.

Empowerment. Charlotte remembered some nurses were supportive, and Maria said, “My nurse I had in labour was really nice and helpful. She was good. She made me feel comfortable.” Veronica described, “The whole room was cheering for me. It was actually really wonderful. And every time I was pushing, they were like ‘you are doing so good! You got this!’” Veronica also spoke of the importance of holistic care, saying, “I could tell my physician cared about me in more ways than just a physical way...they really did care about my emotional wellbeing”.

Some mothers spoke of teaching and education as being supportive and appreciated when they were informed and allowed to ask questions. Mercedes said, “The nurse...was really nice and really helpful with the birthing tips and breathing exercises.” Erin had similar sentiments, “I liked that the doctor and that the pediatrician came in and checked on us. And she was very on point on any concerns she had.”

Several mothers gave examples of comfort measures being supportive. Yvette shared that “the one nurse was wonderful...she was really nice and kept asking me if I needed another blanket, ice, or water, and asking me how my pain was. She really made me feel comfortable.” Veronica appreciated the health care providers being positive, smiling, and gentle. Mercedes remembers her nurse was helpful when she helped with breathing exercises and rubbed her back. Kashina also appreciated the help from her nurse, “every time I got a contraction, the nurse would rub my back and like right away, my contraction would go away.” Charlotte wished with this birth, her nurse had done more teaching with her, and how with her first birth, the nurse “was amazing...she was the one who taught. She told me to relax my body and breathe through the contractions.” For her ideal birth, Charlotte said she would have “a nice nurse, good nurses...a good supportive coach.”

Kealy illustrated the impact of respectful care when she said of her experience, “They treated me fairly...I felt like a real person with a real life.” Naomi said the health care workers “respected me; they were supportive of my boyfriend being with me...they were friendly and welcoming...helpful and encouraging.” Mercedes, Jenny, Jessica, and Kashina all said they felt respected by their health care providers for most of their pregnancy and deliveries. Janice appreciated that her health care providers were non-judgmental when she asked to bring home her placenta.

Disempowerment. Despite the many helpful interactions the mothers spoke of with health care providers, unfortunately, they had some negative stories to relay as well. Instances of disempowerment conveyed through the mother’s stories include a lack of cultural understanding and support and experiences of prejudice.

Lack of cultural support. Mothers reported they did not receive care that was considerate of their culture when they went to the hospital. Of the 24 mothers interviewed, only three reported receiving cultural support during their labour; two of those three said they were cared for by midwives.

Although 22 of the mothers said they wanted cultural care in their birth, the majority of mothers reported they were never asked by health care providers about their cultural practices or needs. According to Madison, no one considered her cultural values - “it wasn’t even an option.” Erin put it succinctly, “I know that [health care providers] are aware of more practices now, but I still think there is a piece missing or a disconnect...the health workers just want to deliver the baby and then go home.” This sentiment was repeated by Yvette, who said, “No one ever suggested doing anything [cultural]. It’s kind of just come in and have your baby”. Most women expressed they would have used cultural supports if available. For example, Maria stated, “I would have liked my cultural values to be considered, but it wasn’t...it would have been nice to have some kind of tradition.” Jenny felt similarly, “they don’t really ask...you aren’t really in a place where you are comfortable – like you can’t just light up a smudge.” Maya felt they don't have the choice to do ceremony in the hospital, "it's mostly having the baby and get out...it's only based on one culture, [their] way." Charlotte felt “it would have been nice if anyone asked about my cultural traditions at all.”

The mothers shared some examples of feeling judged by health care providers. Irene said the nurses refused to believe her when she said she did not take drugs through her pregnancy,

"acting like I had this drug-addicted baby." Maya says that "it seems like when a young mom comes in, the health workers just give you that look, kind of like they are judging you...and think we are incapable of watching our kids...Getting labelled takes a person down. I think it affected my parenting...I felt like I wasn't good enough." Maya felt the health care providers did not care about her cultural values and practices.

Kealy hopes nurses could be more understanding of the situations women face when they are going through hardships in their lives, and that care providers should be compassionate and patient because having a baby can be traumatic. Yvette wished her care providers had listened to her wishes and fully explained things to her. Naomi would like to see health care providers give mothers the option to include culture in their birth so they don't have to feel uncomfortable asking – "I know I would feel kind of scared to ask because maybe they could be racist or something or rude about the whole thing".

Racist experiences. Some of the mothers described interactions with their care providers during the hospital stay, which they felt were racially charged. During Jenny's experience, she explains, "They grouped all the First Nations couples right by the [nurse's] desk! Like why did they group all the First Nations together? It just felt odd."

In Janice's story, she said, "racial discrimination is a very real thing that everybody deals with in the hospital. Even if you are better or not addicted to anything, or severely addicted - you are still the shade of brown...the reality is, that's just how people think; it's automatic. As soon as you walk through the door and are a Native person, I feel it. And the thing is, coming from a healthcare provider, it's very insulting."

Maya believed racist incidents with health care workers occur because "they just think Native people aren't capable because of past experiences working with them I guess...I felt prejudiced against both times I had my babies." Janice spoke of how health care providers treated her partner poorly, and would not let him stay overnight with her in the hospital. Jenny had a similar experience, "My partner is a visible minority; I can fly under the radar under my own. But once they see my partner and his long hair, it's like a switch flips. Once they know I'm Indigenous it makes it so hard." Veronica spoke of her experience as a non-visible Indigenous woman, "I do think I live in a racist community. I see people getting different care than I get right before or right after me just because of the colour of their skin." In her story, Jessica said, "They didn't believe me when I said that I was in labour. So that was kind of unfortunate...there

were a few women [put] ahead of me, but I had my baby before all of them...it could have been discriminatory – I don't know.”

Mercedes felt similarly, saying “I felt really judged...because I'm young and First Nations, and there are a lot of stereotypes around our women”. She said she had to go to the hospital for complications during her pregnancy, but declined many medications because “They asked if I was a drug user, and it was really embarrassing to be asked that.” Janice expressed how in her experience, “I didn't need the judgment from the nurses. It wasn't really a good experience.” As evidence of how negative comments can be harmful, one mother said the comments from her nurses really brought her down, and Cindy said “Those negative comments were really detrimental to me.”

5.5.3. Access

Access to Elders. Yvette thought having an Elder there for her pregnancy would help her with traditions, and “it might have made me calmer and help mentally.” Maria thought, “It would be good if there were Elders to pray...like if I had a high-risk pregnancy or if I had complications.” Jenny said she would have liked to have an Elder to talk to during the hard times of her labour. Maya said, “I would have liked an Elder to come. But the nurse said only immediate family were allowed to come.” Maya felt an Elder would be able to support her and guide her on what to do with the baby's umbilical and the amniotic sac.

Services and programming. The mothers spoke about the barriers to accessing programming. Maria said she would have liked to use KidsFirst, a program that helps parents in vulnerable situations but that she did not meet the program requirements, “I guess I needed to be in a tougher situation.” Tara would have accessed programming, “but I didn't really have the means to get down there.” Erin also faced challenges and said there are services and programs she would have used, “Like I would go, but it's tough to get to.” Yvette echoed these thoughts, and said she couldn't get to programming because “I was too pregnant to get on a bus.” Naomi, from a rural community, understood the difficulty of accessing programs as well, “I'm pretty independent...but some people are limited or don't have a license or vehicle, and hiring someone to take you to town or the city is expensive...I worry about moms getting to their appointments.”

Cindy believes there are not enough services for Indigenous mothers, “the traditional person who works in our community has over 100 families on her caseload.” Veronica said, “I wished there were more information and more variety of support available” regarding her

experiences with postpartum depression and expressed the desire for a sense of community. Charlotte also thought there should be more supports, “specially for moms new to a big city...some women go straight into postpartum depression.” Erin would like to see programs tailored for age, “I feel like they are really for young moms.” Janice also wished for support from other mothers, such as sharing circles for mothers in the hospital.

Some mothers were able to access cultural supports during their pregnancy. Kealy spoke of access to Indigenous teachings in her community and she especially appreciated “the sacred methods to breastfeed, the moss bag making, and baby star blanket making.” Kashina said, “They have these cultural days and parenting and culture workshops at my reserve, you make blankets and moccasins and stuff like that.” Maria said she used KidsFirst, where they “did beading and could make moccasins for our baby.” Maya spoke of her desire for access to language programming to promote her culture, and to have sharing circles led by Elders to facilitate knowledge sharing.

Maya described how she wanted to attend prenatal classes, but the first time she went, she felt discouraged because the person working there suggested Maya should give her baby up for adoption because she was so young, and she never went again. Another mother who was suffering from Post-Traumatic Stress Disorder and Post-Partum Depression shared she was hesitant to be forthright with the nurse during the assessment for postpartum depression: “I couldn’t say I ever had thoughts about harming my baby. They would get social services to come.” Other mothers cited anxiety related to social services as they experienced negative interactions with them from earlier births in their teens.

5.5.4. Choice

Care provider/birth support worker. The mothers spoke about how they wished they had more choice in their health care providers, including their desire for access to midwives and doulas, as well as Indigenous nurses.

Cindy, Madison, Maria, and Maya would have used a midwife if one had been available. Veronica thinks, "there is much that can be done to make the experience better for Indigenous women – I can't stress midwifery enough...I would really loved to have that option for a midwife". Brittany echoed these sentiments, "Indigenous midwives would be really good and beneficial, just because there's lots of [Indigenous mothers], so we could probably relate to them." Erin felt midwives would be more engaged in the birth and help make it a cultural

experience, less cold and regimented. Nancy believed Indigenous midwives would be more comforting for her, “to know that they know the culture and that they know your boundaries and the protocols...I think the whole birth experience would be different if I would have had a First Nations midwife - because it's such a big thing for a baby to be born in our culture.”

Some mothers spoke of doulas, for example, Jenny said, "it would be nice to see a postpartum doula subsidized and paid for...otherwise it's not affordable." Madison had similar thoughts, "doulas are expensive ...and even an Indigenous doula would be nice. It would mean a lot." Erin felt doulas could improve mothers' experiences, "I find a lot of First Nations women deliver on their own...and I just find that it would be nice to have that support of a doula." Charlotte expressed the desire for improved availability to doulas, and that “I did try to have a doula, but there are only a handful in the city”. Brittany also said she would have used a doula if one was available for her, but "I'm a student, so I can't afford that...If I could have accessed them, that would have been nice."

There was a desire amongst the mothers for more Indigenous nurses. Maya thought, "It would be best to have nurses who are Native because you feel more comfortable and they know from experience.” Mercedes had similar sentiments, saying, "I think women would be more comfortable if they had more people of their cultural background."

Birth site/location. Cindy expressed disappointment with having to leave her rural community to have her baby, and that her ideal birth would be at home, "for the whole privacy thing. It's embarrassing... I'm totally vulnerable. And then my family would feel more comfortable and we wouldn't have to get a sitter...it was hard being away from home." Jessica wished she could have had her baby at the family hospital near her home that has a midwife birth clinic, but had to go to the city because of complications. Carrie explained her situation, "they usually send out pregnant ladies two weeks before their due date...It was hard because I had three other kids and I was worried about them...I wanted to leave [the hospital] and go home right away." When Kealy gave birth, she remembers “I wanted to cry like at every minute...You just want people there who you know and are familiar with." Madison, Naomi, and Maya expressed their desire for the option to birth elsewhere than a learning hospital; Maya described her ideal birth experience would be closer to nature.

Birth process. Cindy had to travel from a rural community to the city for the birth of this baby, and said she felt like she did not have the control she did when she had her other children

in her community; “In [the city], they are like put your legs here, put your arms here, and they kept on insisting you have to put your [legs] here...they were in my space; I didn’t like it, it’s gross.” When Nancy expressed a desire to birth in a non-supine position, she said “I felt like I was treated like a child [in the hospital] - that’s the way it is...no one really listens to me.” Madison and Erin wished their care providers had taken more time to speak with them and give her a chance to make choices. For Erin, “they phrased it in a way that I don’t really have a choice. Like I’m not being asked.” Kealy wanted more teaching and options, and said she would like to see nurses work with mothers to help give them some control. Maya spoke of how she felt her health care providers were encouraging her to take pain medication just to make their jobs easier, “they didn’t want to hear my scream I guess.” Madison felt her hospital experience was toxic and that the health care providers never gave her the chance to try for a natural birth.

5.5.5. Resilience

Despite the challenges the mothers experienced when birthing in the hospital, their stories conveyed resilience, both in their worldviews and understanding of their experiences, and in their willingness to share their stories.

Some mothers spoke of the importance of moving forward in a positive way for themselves and their children. Kealy, for instance, said, “I don’t want my children to ever feel the way I felt as a child growing up. I just need to be more in-tune with my culture...I want them to see that I’m still proud to be who I am. And the first step is just going to ceremonies and just like learning more about the culture.” Nancy also identified her cultural roots as a source of resilience, that the teachings she received from Elders changed her perspective and helps her to be more aware of her children and their needs, and how to be a more dedicated parent.

Janice showed awareness and understanding through her words, “I can’t imagine all the stories that a nurse must see in order for them to make racial judgments...They had to have seen lots of things. They have a lot of hatred inside of them.” Veronica also showed an understanding of the care she received, “like my doctors did the best they could with a system that wasn’t designed for Indigenous traditions to be included”. Veronica stated, “I feel very fortunate because I’m educated and I’m a middle-class person and I come off as white to most people. So I have a lot of privileges in my situation. But I see people around me struggling and that’s really disconcerting...if I’m barely holding my head above water and I feel privileged then I can’t even imagine what other people are going through.”

Mercedes also showed understanding and awareness: “I don’t think everything is all bad. People don’t try to seem rude or come off as racist or anything, but I just feel like if people could be more considerate about how others feel, especially other backgrounds.” Regarding her treatment, Janice felt the night staff compared to day staff was more understanding, and thought perhaps because it is quiet and less stressful at night could explain why the night staff seemed more caring towards her.

Jessica showed awareness of her and her partner’s situation when she said, “I felt like I was ready to go home, and when we had to stay in the hospital, it was a lot of back and forth for my partner. We are able to afford it – the gas money, food – but I don’t think that others could.”

Mothers also showed resilience in their adaptability, for example, Heather knew that her birth plan could change if complications arose and was prepared for that, and Nancy said she had a simple birth plan because she knew anything could change. The mothers demonstrated gratitude and appreciation for what they did have available to them; Naomi expressed how fortunate she felt her reserve was, as they regularly ran workshops and events for health and wellness that she found helpful - “Other reserves are really broke so they don’t have money to do that kind of stuff.” Christine showed her resourcefulness as she accessed as many services as she could, being a single mother. Veronica showed acceptance of others and a desire to share knowledge through education and programming for both Indigenous and non-Indigenous mothers - “I think there is power in sharing Indigenous ways and being with people who are not Indigenous. I think there is lots to share with others. We also have a lot of immigrants here and I think it would be wonderful to hear from them and see how they have done things or how they are handling situations.”

Kealy spoke of her pregnancy as a direct source of resilience - “My pregnancy really saved me...I stepped back from [my culture] as a child because I was ashamed from all the abuse I suffered. And now I’m starting to get into it again after going through that grieving process. I’ve actually been participating in more Round Dances. I’m going to a feast in July, and another Sundance. I’m super excited to just have received my First Nations name...There are so many things that I’m going to do differently with being at the hospital, and I really want to be heard next time. I want to ask some questions and say that this is how I want it to be, and I want to be heard! I just want to be in control and I want it to go my way...So now I’m a lot more

comfortable with myself. I feel like I can go anywhere and I don't care if you don't like me for my heritage.”

Janice spoke about how she wanted to participate in the study as a way to advocate for the importance of culture, especially from the beginning, and to help moms to learn it's never too late to learn. Jenny shared that her participation in the study motivated her to seek additional training to help other mothers who go through experiences like she did.

5.6. Discussion

The mothers' stories revealed that cultural practices and teachings related to pregnancy and birth are meaningful, but that there is a gap in cultural knowledge for both mothers and health care providers. The data shows that while these mothers do have cultural knowledge, they desire more support from health care providers and access to culturally safe services without fear of repercussion. The mothers were also aware that a significant amount of traditional knowledge related to pregnancy and birth have been suppressed, and saw a need to reclaim and practice culture in birth. Given the diversity of the mothers interviewed, and the fact that cultural practices are not the same for all Indigenous people (Bruyere, 2012), the practices described in the interviews are not generalizable to all Indigenous mothers. Furthermore, each community and family may have traditions unique to them.

The mothers had many stories of empowering interactions with healthcare providers. Interestingly, these positive experiences were often during basic care and comfort measures. For instance, the mothers who reported positive interactions with their nurse commonly used words such as helpful, nice, supportive, and comforting. Other common phrases describing positive interactions were “they actually listened.” Respect and supportive were other words the mothers used to describe positive interactions with health care workers.

The mothers' stories indicate a lack of acknowledgment and understanding on behalf of health care professionals towards the unique cultural needs of Indigenous women. As the research team collectively analyzed the data, the prevalence of a dominant society existing in hospital settings became apparent; a phenomenon that links back to colonization (Bruyere et al., 2011), and that there may be a difference in worldviews between First Nation and Métis birthing values compared to western medical paradigms of birth. The majority of mothers had challenges or negative experiences at the hospital; however, they spoke of hope and of their joy at having

their newborn baby at the end of it all. The mothers showed resilience through their realistic perspectives and understandings.

Chapter 6: Discussion

Previous research with Indigenous mothers in Canada indicates they experience less desirable health outcomes than non-Indigenous populations, and these health inequities extend to their infants and children as well. This thesis intends to understand better the experience of Indigenous mothers who gave birth in a hospital in a Canadian province to promote culturally safe care and health outcomes for Indigenous mothers and their children.

6.1. Summary of the Main Findings

The team used participatory action research (PAR) and patient-oriented research (POR) methodologies as theoretical frameworks for the research study, and a narrative inquiry approach to guide data collection and analysis. Data collection involved semi-guided individual interviews with Indigenous mothers who gave birth in a hospital, and Bartlett's (2007) collective consensual data analytic procedure (CCDAP) with a group of researchers, health care providers, one Elder, and five mothers. The five overarching themes that arose from the CCDAP were: culture, relationships, access, choice, and resilience. These five main themes are discussed in the context of existing research in this section.

6.1.1. Culture. Our results show these Indigenous mothers in Saskatchewan desire improved access to culturally safe care, including more opportunities to learn about and engage with their cultural teachings and practices, which have been interrupted as a result of colonization processes. One cultural practice several mothers shared is the care of the umbilical cord and placenta. For Indigenous people, the cord represents the child's connection to the land and where they come from (Anderson, 2011). Elders say many Indigenous youths are lost because the hospital threw their cord away and so they are always searching (Olson, 2013); this demonstrates the power of ceremony for Indigenous mothers and their families related to childbirth, and how something irrelevant to western medical models is critical for healthy child development in Indigenous health models. Two mothers spoke of the importance of traditional foods in pregnancy; in her study with Indigenous mothers, Sokoloski (1995) found participants believed foods such as wild meat and fish, carrots, potatoes, rice, and berries were especially beneficial during pregnancy. Three mothers shared stories about the importance of naming the baby, and the role of their grandparents in giving the name. Anderson (2011), in her oral history with knowledge keepers, reports one of the most critical roles of Elders in welcoming new life

was giving a “spirit name” to the baby (p. 52). The spirit name is sacred, offering protection to the child, and creates a connection between Elders and infants (Anderson, 2011).

A recurrent theme in the interviews was the security their culture brought to the mothers during their pregnancy and labour. Culture and ceremony offer coping strategies and comfort to the women and family during labour; many non-Indigenous perspectives isolate cultural traditions in the birth experience, but cultural practices are vital for some Indigenous people’s health outcomes (Bruyere, 2012; Kelm, 1999; NACM, 2016). Indigenous traditions and cultural practices are a lifestyle, and there must be deep appreciation of the ceremonies related to birth (Bruyere, 2012). In an interview about traditional midwifery with Rose Roberts, Maria Linklater, a highly regarded cultural leader and mentor from Thunderchild First Nation, Saskatchewan, shared:

Our way is so beautiful, it is like a ceremony. And that’s not looked at in the other culture. But, in our culture it’s a ceremony, everything is a ceremony...grandparents preparing for grandchildren, parents, the siblings to be ready to meet the baby. You know, that context to feel good together, to hold your little sister right away...There is lots of differences in what we do...it has to do with our culture (Linklater, 2002).

The mothers in this study expressed concerns of a decline in individual and collective cultural knowledge, which Brown et al. (2011) found to be a dominant theme in their community based participatory and ethnographic study with rural mothers. In their study, participants spoke of the loss of traditional practices, and the necessity of reclaiming cultural birth knowledge to improve the health outcomes of mothers, children, and communities (Brown et al., 2011); this desire for cultural reclamation was echoed throughout our study. They also found (Brown et al., 2011) participants lacked the ability to give birth as a family and community, similar to what mothers in our study reported, especially those residing in rural and remote areas.

It is important to remember that Indigenous people are not homogenous in their cultural identity or expressions; communities will vary in how they relate with Indigenous and western belief systems (Birch et al., 2009; Lavell-Harvard & Lavell, 2006). It is essential to understand that culture is a lifestyle and cannot be taken out of context; it requires deep respect, and health care providers who work with women in childbirth must understand the value of cultural care (Bruyere, 2012).

6.1.2. Relationships. The care that Indigenous mothers receive can positively or negatively influence their experience of birth (Birch et al., 2009). In our study, we heard stories from mothers of both empowering and disempowering interactions with health care providers. When health care providers offer respect, dignity, choice, and empowerment, they can enhance health outcomes, especially for people from marginalized populations (Birch et al., 2009). Some mothers in our study experienced respectful care through encouragement and comfort measures, but expressed a desire for more education. In one study with Indigenous mothers, participants reported improved birth experiences when their health care providers provided genuine caring and respect for the mother and her cultural identity (Birch et al., 2009). When asked if they received cultural care or support during their birth, only two of the 24 mothers interviewed responded yes, and these two mothers were cared for by midwives.

Participants in Brown et al. (2011) study with rural mothers reported: “a revolving door experience with nurses and physicians that caused anxiety, undermined trust, and limited their options for developing a relationship with care providers who would see them through pregnancy and birthing” (p.111). These findings compare to the mothers stories of feeling disconnected from their health care providers; as one participant stated, “They just want to deliver the baby and go home.” Sadly, we also heard stories from the mothers of judgment, discrimination, and racism. There were some examples of empowering care, but the majority of interactions the mothers described were disempowering. In a study exploring experiences of rural mothers who have to leave home to birth, there were more reports of nurses being unhelpful rather than helpful during their labour and birth of their baby, and this is a problem identified elsewhere in Canada (Chamberlain & Barclay, 2000).

6.1.3. Access. Access to Elders during birth came up in the interviews, and three mothers spoke directly of their desire to have an Elder available to them in the hospital. In Indigenous culture, Elders play an essential role in connecting with the baby right from the beginning, and grandfathers and grandmothers were always available during the birth, and present to enact ceremonies and celebrations (Anderson, 2011).

Mothers interviewed in this study also expressed the desire for access to culturally appropriate services for Indigenous mothers. Inequitable access to prenatal care for Indigenous women is well documented (Smith, Edwards, Varcoe, Martens, & Davies, 2006). Sokolowski (1995) found Indigenous women desire positive interactions with care providers, but in accessing

prenatal care, communication with the staff was less than ideal and that appointments were rushed and impersonal. Similarly, we heard mothers tell of their anxiety related to accessing social services because of past interactions, and the reality of the lasting colonial influence in child welfare systems (Tait, Henry, & Walker, 2013).

6.1.4. Choice. Western health care systems generally hold health care providers as the experts and decision-makers (Birch et al., 2009), but the mothers shared their desire for more information and increased choice in care provider, birth location, and birth process (such as birth positions and interventions they receive). Allowing for increased participation leads to improved experiences of labour (Birch et al., 2009). In their comparison of two groups of women, those able to remain in the community for birth and those who had to be transferred to an urban centre, Chamberlain and Barclay (2000) found women who had to leave lacked choice, especially regarding the place of delivery and how it was carried out. We heard from ten mothers living in rural areas, and of these three mothers expressed disappointment at having to leave their home communities to birth in an urban centre. Several mothers, regardless of rural/urban location, wanted the choice to have their baby elsewhere than learning hospitals. For some women who must leave their communities to birth, there are significant physical, emotional, and financial stressors influenced by the availability of resources and challenges of traveling (Brown et al., 2011; Chamberlain & Barclay, 2000).

Just as we heard from mothers who felt they did not have a choice in their birth process, and desired a more natural process, Brown et al. (2011) also found the idea of a natural birth seemed to be a part of the women's expectations or hopes. Chamberlain and Barclay (2000) report mothers in their study were encouraged by health care providers to be on their backs for delivery, instead of squatting or kneeling (Chamberlain & Barclay, 2000); we heard similar stories from the mothers.

6.1.5. Resilience. Resilience is a process of adapting well after experiencing trauma, tragedy, threat, or significant stress (APA, 2019). The American Psychological Association (2019) identifies several factors that contribute to resilience, which are: capacity to make realistic plans and carry them out; a positive view of yourself; skills in communication and problem solving; and the capacity to manage feelings and impulses. These concepts of resilience emerged through the mothers' stories, for example communication and understanding of health care providers and other mothers. Some of the mothers expressed gratitude and appreciation for the

resources they had, and a desire to share their resources with others and advocate for improved services and health care Indigenous mothers.

The TRC (2012) discusses the resistance and resilience demonstrated by children who were sent to the residential schools, played out in community, classroom, playground, kitchen, and fields; this refusal to be assimilated was a crucial factor in the eventual recognition of federal officials that the schools were an irredeemable failure. Children who lived through the schools have shared their truths, advancing the fight for Indigenous rights in Canada - in sharing their stories, these mothers prove their resilience and willingness to claim their space in society. The act of the mothers sharing their stories in itself is an act of resilience, in that “the sharing of personal experiences provides a way of releasing hope and its healing powers” (Geddes, 2017, p. 17). The mothers described their cultural roots as a source of resilience for them and in their parenting. Indigenous people show tremendous resiliency and strength in the fact that their cultures remain despite attempts to erase them. According to the APA (2019), research indicates the primary factor in resilience is caring and supportive relationships within and outside the family; relationships that develop and offer encouragement and reassurance can support a person’s resilience. With this in mind, health care providers can increase women’s resilience in offering them support and empowering care.

6.2. Strengths and Limitations

One strength of this study is the number of participants, as 24 is a large sample for the methods chosen. The inclusion of mothers from a diverse geographical background is another strength of the study; participants came from a total of 22 origin home communities, offering a diverse representation. Another distinguishing feature that gives strength to this study is the participation of four of the interviewed mothers in the research process; in particular, the collective data analysis adds validity to the study and is a significant strength.

Limitations include that, given the large sample and sizeable geographical region, some participants were unable to be contacted for transcript review or to participate in the next phase of the research study (beyond the scope of this thesis). Similar to Sokolowski (1995), since there are 22 different origin homes and seven different cultural groups represented by 24 participants in this study, there are too few informants to consider differences between groups. Therefore, results must be interpreted with the understanding that Indigenous people are not homogenous in their cultural identities and expressions. It is impossible to summarize the mothers' stories and to

convey them over the length of time since the project began; this provides a snapshot of these mothers' experiences and is not to be taken as truth or to be generalized to all Indigenous mothers.

6.3. Implications

The results of this study have a number of implications for health care professionals who work with Indigenous mothers. Birth is an inevitably painful experience, but with proper support and encouragement, and attention to the cultural values of the mother, health care providers could help to lessen the trauma and vulnerability these women experience.

The loss of traditional lifestyles and inability to enact cultural practices and beliefs could be an attribute of maternal health inequities for Indigenous women compared to non-Indigenous women; one study showed Indigenous women expressed desire for healthier traditional diets but had no access to such foods (Sokoloski, 1995). Given this, it could be prudent for health care providers to turn their attention to promoting traditional practices to reduce health inequities and improve pregnancy outcomes for Indigenous mothers and their infants. This can be accomplished by engaging with communities, examining current systems and beliefs, and providing culturally safe care.

6.3.1. Engage with communities to develop policy and research. To address power imbalances between Indigenous peoples and the health care system, health care providers should form partnerships with Indigenous partners and communities to develop policy and research (Birch et al., 2009). Educators, policy makers, and health care providers should engage with Elders to understand their perspectives and seek their expertise of how to safely practice cultural ceremonies in the birthing process (Bruyere, 2012). If mothers are able to have an Elder with them during birth, engage them and ask them if there is anything they require.

6.3.2. Examine current systems and beliefs. Cultural safety can be improved through the acquisition of knowledge and examining attitudes; however, it requires support systemically at all levels to change practice and to examine social and political influence on health models (Birch et al., 2009). To provide culturally safe care health care providers must understand the complex histories and systemic oppression that shape the reality of Indigenous mothers; it is not enough to reduce cultural care to a list of traits or practices (Lavallee, Diffey, Dignan, & Tomascik, 2016).

Health care providers should advocate for the inclusion of health practices outside the western medical paradigm, including spiritual and cultural ceremonies; educator and curriculum developers should focus on importance of spiritual care for mothers (Birch et al., 2009; Bruyere, 2012). Health care providers should also advocate for improved services for Indigenous mothers outside of the hospital, including access to cultural supports, services and programming. Moving forward as professionals we must find ways for Indigenous health models and western health models to exist side by side (Bruyere, 2012).

6.3.3. Provide culturally safe care. Continued efforts are needed to offer culturally safe care for Indigenous mothers who birth in hospital and their families. Health care providers may have good intentions to care for Indigenous mothers, but the western medicalization of birth has led to loss of traditional birth practices and ceremonies for Indigenous families (NACM, 2016). According to Bruyere (2012), “the medical model has served to dehumanize the sacred birthing experience” (p. 42). While health care providers might be concerned of the women’s safety, the safety of her family and the mothers’ emotional safety is often overlooked in the delivery of health care (Brown et al. 2011). Although there is some comprehension amongst health professionals of the consequences of women feeling culturally isolated during the birth, there is still much to do to provide culturally safe care (Chamberlain & Barclay, 2000). The mothers stories expressed they want to be supported in their cultural practices; therefore, health care providers should advocate for the inclusion of traditional ceremonies in the birthing process (Bruyere, 2012). The importance of family in the birth process and as part of the mothers’ cultural practices is evident, and healthcare providers should understand the role that family and community play in the lives of Indigenous peoples (Birch et al., 2009).

Indigenous spirituality is not something that can be read about, there is a deep respect that goes along with it (Bruyere, 2012). That being said, there are ways we can support women who must practice their Indigenous cultural and spiritual practices to have a safe birth experience. Many nurses are trained in holistic health and therapeutic touch, which aligns with Indigenous beliefs (Bruyere, 2012); this kind of education should be provided to all health care providers who work with pregnant Indigenous mothers. It is important to be aware that every community has their own unique protocols, but health care providers can be equipped to support mothers and families to have the best birth experience possible. Health care providers should develop awareness around birthing modalities that place equal value on the emotional, mental, and

spiritual health as they do on physical health. This can be as simple as explaining procedures to the mother and her family, providing encouraging words and basic comfort measure, and creating space for the mother's cultural needs.

Indigenous cultural practices are diverse, so it is important to ask questions and become familiar with common cultural practices in the communities around ones' place of work. If the woman doesn't have any specific cultural requests when she comes to have her baby, health care providers should be able to make suggestions if an Elder is not available. If the woman has reached this point in her pregnancy journey, and there are no Elders available, it could make a difference in the mothers' experience and ability to enact cultural practices when she leaves the hospital. Some simple questions health care providers can ask to help provide culturally safe care for Indigenous mothers and their families are: Are there any songs or music you would like me to help you play? Did you know about the traditional teachings of the umbilical cord and placenta? If you would like to keep it, you can freeze it until you find an Elder to give you the proper information.

6.4. Directions for Future Research

There is increasing evidence of the impact of colonial processes on Indigenous women's health and associated inequities, but there is limited knowledge of how this influences maternity care and the birthing experiences and outcomes of Indigenous women (Brown et al., 2011). This study provides a foundational understanding of the experiences of Indigenous mothers when they give birth in hospitals in one Canadian province, but more research is needed to eliminate the health inequities between Indigenous mothers and their children and the non-Indigenous population. There is an overall lack of research with Indigenous mothers in Canada (Brown et al., 2011) and considerable more work needs to be done to improve policy, practice, and access to the health care system for Indigenous mothers (Birch et al., 2009).

A natural progression of this work is to compare outcomes between Indigenous mothers who birth in a hospital without cultural supports and Indigenous mothers who were able to birth at home or in their community with a midwife. It would also be beneficial to better understand the experiences of different cultural groups better, for example, Cree compared to Métis women. Additionally, further research is necessary to develop hospital-based models of care for Indigenous women giving birth in hospital settings (Birch et al., 2009). A greater focus on the experiences of partners of Indigenous mothers who birth in hospital could produce interesting

findings and solutions to improve maternal and child health outcomes. More broadly, research is also needed to determine the effects of cultural practice on the health outcomes of Indigenous mothers and children. Future research should adopt participatory, and community-focused methodologies, and engage Indigenous communities throughout the research process.

6.5. Conclusion

Our study adds to the ongoing understanding of the birth experiences of Indigenous mothers in Canada in hospital settings. We were able to determine the role and value of cultural practices in the participant's pregnancy and birth experiences. We also identified some common challenges for all Indigenous mothers, regardless of their geographic residence, as well as some unique challenges experienced by mothers living in rural and remote communities. Our findings support the need for culturally safe care for Indigenous mothers who give birth in hospital, which could help improve health outcomes and decrease inequities for Indigenous mothers and their infants. In establishing a connection to culture from the beginning of their lives, health care providers can support the wellbeing and cultural identities of Indigenous children.

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Appendixes

Appendix A

Interview Consent Form

Interview Consent Form

Please read this consent carefully and feel free to ask any questions that you may have.

Purpose of the study: The reason we are doing this research study is to get a better understanding of the experience Indigenous mothers go through when they give birth in hospital.

We have asked you to take part in the research if you have given birth in the last three years, and identify as First Nation, Metis, or Inuit. You will be asked to do an interview with a trained researcher, where you be asked to speak about your birth. It should take no longer than an hour. The interview will be audio recorded, or, you may write your answers.

Potential Risk: If any questions upset you, the interviewer will discuss these concerns with you. If the researcher or yourself are concerned about your physical or psychological health you will be encouraged to contact the appropriate resources. We will try not to use direct quotes from the interviews. If a direct quote has to be used, it will be anonymous to protect your identity.

Compensation: You will receive \$50 as a token of our appreciation for you time and effort to participate in the interview. Childcare and transportation will be provided.

Confidentiality: Confidentiality of all information shared is assured. Your survey will only be identifiable by a code number to protect your identity. Audio recording of the interview will be transcribed, edited and de-identified and will be provided to you for checking of the inconsistencies. Audio records, hard copies of the survey questionnaire, and consent forms will be kept under lock and key in a secure cabinet in the custody of Dr. Angela Bowen at College of Nursing for a minimum of five years after completion of the study. The de-identified electronic master data files will be stored in a single use DVD and a dedicated secure flash drive and will be only shared via password protected CD with the research team for the purpose of analysis. Only the research team will have access to the master files and raw data at all times. Upon completion of five years or when it is no longer required, the records will be appropriately archived as per the University of Saskatchewan data storage policy.

Right to Withdraw: You are volunteering for the study, which means you are free to withdraw at any time without having to give any reasons. You do not have to answer any questions you do not want to. Please feel free to ask any questions at all.

Questions: If you have any questions or need more information about this study before or during participation, you can contact investigators, Dr. Angela Bowen in the College of Nursing, University of Saskatchewan at 966 8949, or her Research Assistant, Carrie Pratt, at indigenous.birth@usask.ca.

Summary results of the study will be available on the College of Nursing website at <https://www.usask.ca/nursing/>.

The University of Saskatchewan behavioral Sciences Research Ethics Board has approved this study on October 6, 2017. If you have any questions about your rights as a participant please call the Research Ethics Office at 306-966-2975.

Consent to participate: I have read and understood the above; I have had an opportunity to ask questions and my questions have been answered to my satisfaction. I consent to participate in the study described above; I understand that I may withdraw this consent at any time. A copy of this form has been given to me.

I grant permission to be audio taped: Yes: ___ No: ___

I wish to remain anonymous: Yes: ___ No: ___

I wish to remain anonymous, but you may refer to me and quote me by a pseudonym: Yes: ___
No: ___

I wish to give oral consent only: Yes: ___

No: ___

The pseudonym I choose for myself is: _____

Name of the Participant	Signature of the participant	Date
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Name of the Interviewer	Signature of the interviewer
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Appendix B

Transcript Release Form



Transcript Release Form

Please read this form and sign if you agree to allow your interview to be transcribed and submitted for researcher review.

Indigenous Women's Perspectives for Culturally Secure Birth

In agreeing to participate in the Culturally Secure Birth research project, you agree to partake in an individual interview. You may also be invited to partake in a talking circle group with other Indigenous mothers.

Transcript review is a process where you, the participant, are given a copy of your interview to review before it is used by the research team.

By signing this form, you agree to allow your oral or written interview to be transcribed into text, and then to be returned to you so you can read it to make sure it says what you want it to. When I am happy that the interview text matches what I said, I will return the transcript to the research team so they may use it for data analyses.

I understand that my information will be kept private and confidential.

I, (Participant Name) _____ agree to allow my interview for the Culturally Secure Birth study to be transcribed into text, and provide to me for review to make sure it is accurate to what I want to say.

Signature: _____

Date: _____

Researcher Name: _____

Researcher Signature: _____

Date: _____

Appendix C

Interview Guide

Demographics:

1. Age?
2. Where do you live?
3. Is this your first baby?
 - a. If yes: when did you have him/her?
 - b. If no: How many other children do you have?
4. When did you have your last baby?
5. Where did you give birth?
6. Where else have you given birth?
7. Where do your children live?
8. Did you have a support person with you? Would you share who that was?
9. What is your relationship status? (single, married, widowed, divorced, common law, other)
10. What kind of birth? (Vaginal, C-section, assisted – forceps, vacuum)
11. Were there any complications in?
 - a. Pregnancy?
 - b. Labour?
 - c. With baby? (premature, went to ICU, hemorrhage, high blood pressure, diabetes)

Interview Questions

12. Please tell me the story about _____'s birth?
13. Can you share any traditions that you used in your birth experience or with your baby since she/he was born?
 - a. Were there some that you weren't able to practice? Can you tell me about those? Why do you think you weren't able to include them? (opportunity, didn't know, no time, changed hospitals)
14. Did you feel that your culture and values were considered in your birth experience? In what ways? Positive/negative? Prenatal, hospital, after the baby was born...

- a. Did anyone ask you about traditions that you may want to practice? (pregnancy, hospital, after baby born), and did they help support any requests you had?
15. Did you have a birth plan?
 - a. If yes, can you share what things were important for you in your birth
 - b. If no, why not?
 - c. Was your birth plan honoured?
 - d. If no, why do you think that was?
16. What services for Indigenous women have you used during pregnancy and since you gave birth to ___? (Food for Thought, KidsFirst, Healthy Mother Healthy baby, Saskatoon Mother Centre).
 - a. Do you know of any other services that might have been available that you didn't use? Why didn't you use them?
17. Did you feel respected by health care workers during your pregnancy and birth and since ___ was born?
 - a. If yes: How did you experience that?
 - b. If not, what could be done to make it better for other women?
18. Would you like to discuss or talk about something that is important to you about the birth of your baby you feel we haven't talked about today?

Appendix D

Data Analysis Day – Information Sheet

Thank you for your commitment to participate in the *Data Analysis Day for the research project “Culturally Safe Birth”* funded by the Jim-Pattison Children’s Hospital and Saskatchewan Health Research Foundation.

We will meet on December 19th from 8:00am – 4:30pm at **West Winds Primary Health Centre. 3311 Fairlight Drive, Saskatoon SK, S7M 3Y5. Room 110A.** There is free guest parking. Once inside the clinic, follow our signs downstairs or take the elevator to lower level to Room 110A.

Coffee/drinks, light breakfast, snacks, and lunch will be provided.

Please notify carrie.pratt@usask.ca ASAP if

*you have any food restrictions * OR

If you need assistance arranging childcare

The Jim Pattison Children’s Hospital Foundation who are the sponsors for this study are sending a photographer to take photos of us doing the analysis. If you are opposed to having your photo taken and shared, please notify us so we can ensure your privacy is protected.

In the event you are unable to attend, or if you have any questions, kindly notify carrie.pratt@usask.ca or angela.bowen@usask.ca

DECEMBER 19, 2018 DATA ANALYSIS DAY

AGENDA:

8:00 – 8:30: Sign in/welcome and breakfast (Micisotan Café Catering)

8:30 – 9:00: Prayers and smudge with Elder Eileen Thomas (in Elders room, 2nd floor)

9:00 – 10:30: Collective Data Analysis – introduction to method, clustering

10:30 – 10:45: Refreshment break

10:45 – 12:00: Collective Data Analysis – clustering

12:00 – 12:30: Lunch (bannock taco catered by Bannock Express)

12:30 – 2:15: Collective Data Analysis – clustering

2:15 – 2:30: Refreshment Break

2:30 – 4:00: Collective Data Analysis – confirming and labeling themes

4:00 – 4:30: Closing

**Research Grant “Culturally Secure Birth”
Data Analysis Day December 19th
Project Background**

We have interviewed 24 First Nation and Metis mothers who shared their experiences of giving birth in four Saskatchewan hospitals: Royal University Hospital, Regina General Hospital, Prince Albert Victoria Hospital, and Meadow Lake Hospital.

We attempted to gain an even distribution of mothers from urban and rural locations (rural = 10, urban = 14).

This study uses a participatory design. The following research questions guide are meant to guide the study design, focus the interviews, data collection, and the interpretation of the findings:

1. What are Indigenous women’s experiences giving birth in a tertiary care centre?

- a. What do Indigenous women want and expect from maternity care professionals (e.g., nurses, obstetricians, family physicians, and midwives) when they give birth?
 - b. What cultural practices and traditions do Indigenous women find comforting during birth?
2. In what ways do rural/remote Indigenous women experience birth?
 3. In what ways do urban Indigenous women experience birth?
 4. What policy recommendations will improve cultural security of women giving birth?

At this point, we are bringing the research team together to collectively analyze the findings from the 24 interviews. We are using Bartlett's Collective Consensual Data Analytic Procedure (CCDAP) as a framework to guide the data analysis session. Together, the research team will arrange the coded cards into categories and themes to understand what the women's interviews tell us. More information will be provided the day of, so that the process is clearer.

Reference:

Bartlett, J.G., Yoshita, I., Gottlieb, B., Hall, D., Mannell, R. (2007). Framework for Aboriginal-guided decolonizing research involving Metis and First Nations person with diabetes. *Social Science and Medicine*, 65(11). <https://doi.org/10.1016/j.socscimed.2007.06.011>

<https://www-sciencedirect-com.cyber.usask.ca/science/article/pii/S0277953607003449>